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COMFORT HARBOR HOME	114 WEST 2ND STREET MILAN, IL 61264

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Z 000	COMMENTS Annual Licensure Licensure Follow up survey to 10/25/2010 Comfort Harbor Home failed to follow thier Plan of Correction for 330.1510a)1)20, 330.1510C)2)d), and 330.1710g). Comfort Harbor Home is in complaince with thier plan of correction for 330.715b), 330.910a), and 330.3620g).	Z 000		
Z9999	FINDINGS LICENSURE VIOLATIONS: 330.1510a)1)2)3) 330.1510d)2) 330.1710g) Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. 1) Medication policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written program of care and services. 2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who	Z9999		

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Z9999	Continued From page 1 supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy. 3) If facility policy permits residents to be totally responsible for their own medication, with written permission from the attending physician, the resident and attending physician shall be given written statements concerning what the responsibilities of the facility, the resident and the physician are if the resident, or any other person, suffers harm as a result of the resident's handling his or her own medications. d) All medications on individual prescription or from the licensed prescriber's personal supply shall be labeled as set forth in Section 330.1530(f). 2) Attending physicians shall review the medication regimen of each resident at least every six months. This review shall be documented in the resident's record. Section 330.1710 Resident Record Requirements g) A medication administration record shall be maintained which contains the date and time each medication is taken, name of drug, dosage, and by whom administered. A medication administration record is not required for residents who have been approved by their physician to be fully responsible for their own medications under Section 330.1510(d)(2). These requirements were not met as evidenced by:	Z9999		

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Continued From page 2

Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician, failed to clarify and obtain physician's orders for medications administered by facility nurses, failed to accurately record medication administered by facility nurses, failed to obtain the physician's permission for residents who self administer their medications, and failed to have the physician review the residents' medication regime every six months for three of three residents (R1, R2, and R3) on the sample of three and four residents (R4, R5, R6, and R7) on the supplemental sample.

Findings include:

1. The history and physical from the Veterans' primary care clinic dated 6/9/11 documents that R1 has diagnoses of Diabetes Mellitus type two, Hypothyroidism, Bipolar disorder, Hypercholesteremia, Dementia and Delusions. According to this history and physical with laboratory work, R1 was receiving Metformin HCL 500 mg twice a day, Glipizide 5 mg daily, Gemfibrozil 600 mg twice a day and Olanzapine 10 mg ½ tab at night. On this date, the Metformin HCL was increased to 1000 mg twice a day. R1's Blood Glucose IA was high at 318 with the normal being between 65-100. The Hemoglobin A1C was high at 11.1 with the normal being between 4.4-6.4. Blood Glucose monitoring was ordered to be done three times a day.
The admission face sheet documents that R1 was admitted to this facility on 8/22/11. The facility physician ordered Gemfibrozil 600 mg bid, Glipizide 5 mg daily and Olanzapine 10 mg 1/2 tab at night. The Metformin HCL or the blood glucose monitoring was not ordered.
The September, October and November

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Medication Administration Record(MAR) documents that R1 was receiving Glipizide 10 mg daily, Metformin 600 mg twice a day and Olanzapine 10 mg ½ tablet at night.
On 10/31/11, E3 (Licensed Practical Nurse) stated that R1 was not receiving Metformin, the medication is not available. The "Metformin 600 mg" documented on the September, October and November MAR is really Gemfibrozil 600 mg twice a day which is being signed out and given as Metformin. There is no blood glucose monitoring being done.
The Medication Reconciliation Summary from the primary care doctor at the VA Medical Center dated 10/27/11 documents that R1 is to take Gemfibrozil 600 mg twice a day for triglycerides, Glipizide 5 mg every day for diabetes, Metformin HCL 1000 mg twice a day for diabetes and Olanzapine 10 mg one half tablet at bedtime. Blood Glucose monitoring as needed.
On 11/2/11 at 11:00 AM, E3 stated that the Veterans clinic is sending R1's Metformin HCL 1000 mg, but it is still not here.
2. R3's October 2011 Medication Administration Record documents that R3 is receiving Levimer Insulin 30 units in the AM and 30 units in the PM along with Novolog 10 units in the AM, 7 units at noon and 8 units at night. R3 has a sliding scale for Novolog to be given four times a day according to the results of R3's blood glucose monitoring.
On 11/1/11 at 1:30 PM, E3 (Licensed Practical Nurse) stated that R3 is alert and oriented and takes her own medications. E3 stated that he fills her seven day pill box with oral medications and she self administers them. E3 stated that R3 keeps her insulin in her room, does her own glucose monitoring and administers her Insulin herself.
On 11/1/11 at 2:00 PM, R3 stated that she is

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Z9999	Continued From page 4 taking Lantus 33 units (not Levimer) in the AM and 33 units in the PM. R3 stated that she takes Novolog 7 units in the AM, 5 units at lunch, 9 units in the PM along with Novolog sliding scale according to the results of the blood glucose monitoring results. E3 asked R3, how long have you been taking Lantus instead of Levimer? R3 stated, several months. R3 stated that she does her own glucose testing four times a day and writes it down and this is faxed to her physician every two weeks so her physician can adjust her insulin dosage accordingly. There are no current physicians' orders in the record to verify what medications R3 is supposed to be receiving. E1 (Administrator) and E3 both stated that the physicians' orders and a six month review by the physician should be in the chart. No current physician ' s orders or six month review was found in the chart and none was provided by E1 or E3. There is no physician's order allowing R3 to self administer her medications. The Medical Policy 1996 documents, " 12. All medications taken by residents must be ordered by a physician, directly from a pharmacy or by a licensed nurse. " 3. On 10/31/11 at 11:35 AM, E3 administered Donepezil HCL 5 mg, Diclofenac 100 mg, Lisinopril 20 mg and Namenda 10 mg to R6. On 11/1/11 at 1:30 PM, E3 verified that there are no current physician ' s orders on the chart. E1 and E3 stated that there should be six month physician ' s reviews in the chart. None could be found and were not provided for review by E1 or E3. 4. On 10/31/11 at 1200 PM, E3 administered Risperdal 1 mg, Carafate 1 gram and Klonopin 0.5 mg. 1 ½ tablets to R7 in accordance with the October medication administration record. There are no current physicians ' orders in the record to	Z9999		

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verify if these are the correct medications or correct doses of medications being given. On 11/1/11 at 1:30 PM, E1 and E3 both stated that the physicians ' orders and the six month physician ' s review of the medication should be in the record. E3 stated that he could go to the pharmacy and get a copy of the current physicians ' orders.

5. On 11/1/11 at 8:15 a.m., E3 (Licensed Nurse) administered medications including Aspirin 325 milligrams (mg), Folic acid 1 mg., Lexapro 20 mg., Protonix 40 mg., vitamin B1 100 mg., and one tablet of Centrum vitamin to R4. Review of R4's physician's orders included no orders for the aspirin, folic acid, vitamin B1, or Centrum. R4's record did have an order for Metoprolol 25 mgs. Metoprolol 25 mg. is not on R4's medication administration record for October 2011 or November 2011 and was not administered on 11/1/11 with his morning medications. On 11/01/11 at 1:30 p.m., E3 stated he had gone to the local pharmacy and obtained copies of R4's prescriptions. E3 provided copies of prescriptions for R4's Trazodone 150 mg at bedtime, Lexapro 20 mg daily, Metoprolol 25 mg daily and folic acid 1 mg daily dated 4/6/11 and a prescription for Protonix 40 mg daily dated 06/9/11. R4's clinical record included a transfer sheet dated 02/03/2010 which included orders for the Aspirin, folic acid, and multivitamin each with a stop date of 02/27/2010. No current physician orders were provided for and E3 confirmed the facility had no current orders for R4's vitamin B1, aspirin, or Centrum. R4's clinical record had no six month physician review of his medication regime. E3 confirmed that there was no six month physician review of medications and stated (at 1:30 p.m. on 11/1/11) that R4's physician would come in on

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Z9999	Continued From page 6 Thursday (11/3/11) and would review and sign R4's medications. 6. On 10/31/11 at 11:30 a.m., E3 (Licensed Nurse) administered Lasix 40 milligrams to R5. On 11/01/11 at 8:25 a.m. E3 administered medications including Famotidine 40 mg., Prozac 20 mg. Loratadine 10 mg., Lamictal 150 mg., Theophylline 24 400 mg and Tylenol 1000 mg. R5's clinical record does not include physician orders for Famotidine, Prozac, Theophylline. R4's clinical record included a physician's order for Lasix 40 mg. daily, but R5's Medication Administration record documents and E3 confirmed that R5 is given Lasix 40 mg twice a day. R5's clinical record included physician's orders for Prevacid 15 mg every 12 hours and Docusate sodium 100 mg daily which are not on R5's October or November Medication records. E3 confirmed that Prevacid and Docusate sodium are not administered to R5. R5 has a nebulizer machine at her bedside and on 11/2/11 at 11:00 a.m., R5 stated she does her own albuterol nebulizer treatments and administers Advair, and Spiriva inhalations and Flunisolide nasal spray herself. R5's clinical record does not include any physician statement concerning R5's self medication. R5's clinical record does not include any six month review of her medication regime. These concerns were discussed with E1 (Administrator) and E3 on 11/1/11 at 1:30 p.m., E3 verified the discrepancies between medications that the facility nurses administer and the physician's orders, lack of physician's six month review and lack of physician statement regarding R5's self medication. E3 stated that he had contacted R5's physician and was waiting for a response. 7. October 2011 and November 2011 Medication	Z9999		

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Administration records document that facility nurses administer Aspirin 81 mg daily, one multivitamin tablet daily, Norvasc 10 mg daily, Metoprolol 50 mg twice daily, Simvastin 20 mg daily, and Benazepril 20 mg daily to R1. R1's clinical record only includes physician's orders for Simvastin 20 mg daily, Benazepril 20 mg daily and Amlodipine 10 mg daily. On 11/2/11 at 11:00 a.m., the medication room was checked and a bottle labeled as R1's Amlodipine 10 mg was located. E3 confirmed that R1's Medication administration record does not include Amlodipine 10 mg daily, but stated he thinks she (R1) has been getting it. On 11/01/11 at 1:30 p.m., E3 stated he had gone to the local pharmacy and obtained copies of R1's prescriptions. E3 provided copies of prescriptions for Simvastin 20 mg daily, Norvasc 10 mg. daily, Benazepril 20 mg daily and Metoprolol 50 mg twice daily. No physician's orders for R1's Aspirin or multivitamin were provided. R1's clinical record did not include any six month physician's review of R1's medication regime. On 11/1/11 at 1:30 p.m., E3 verified there were no orders for the multivitamin or aspirin and no six month physician's review of R1's medication regime.

(RB)

330.770a)
330.770b)1)2)3)
330.3410d)

Section 330.770 Disaster Preparedness

a) For the purpose of this Section only, "disaster"

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means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility.
b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following:
1) Proper instruction in the use of fire extinguishers for all personnel employed on the premises;
2) A diagram of the evacuation route, which shall be posted and made familiar to all personnel employed on the premises;
3) A written plan for moving residents to safe locations within the facility in the event of a tornado warning or severe thunderstorm warning;

Section 330.3410 Fire Alarm and Detection System
d) The fire alarm system shall be tested at least weekly.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to develop a written disaster preparedness plan, identify safe locations for moving residents, failed to post an evacuation route, failed to conduct a fire drill with simulation of evacuation, and failed to conduct weekly tests of the fire alarm system. These failures have the potential to effect all 20 residents who reside in the facility.

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Findings include:

E1 (Administrator) provided fire drill reports for the last year. These reports did not include any report of simulation of resident evacuation. On 11/02/11 at 11:45 a.m., E1 confirmed that the facility did not conduct any simulation of resident evacuation, stating that if we took all the residents outside, we "couldn't get them all to come back in."

The facility does not have a posted evacuation plan. On 11/01/11 at 1:30 p.m., E1 stated that the evacuation plan should be on the wall in the reception area, but confirmed that it was not there. E1 stated that someone must have taken it down. No disaster preparedness plan was provided by the facility administrator, E1 who stated at 1:30 p.m., on 11/1/11 that they do not conduct any tornado or disaster drills. On 11/1/11 at 1:00 p.m., E1 stated that the fire alarm system alarms directly to the fire station and that they test the system weekly, but keep no records of the testing. On 11/2/11 at 9:25 a.m., E5 (nurse aide) stated that she did not know if the fire alarm pull box alarmed at the fire station. E5 said that if there was a fire she would use the phone to call 911. On 11/02/11 at 9:30 a.m., E1 said that the alarm company that provided the facility's alarms conducts monthly checks of the system, but that she has no reports of these checks from the alarm company.

(B)

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330.1160a)
330.1160b)
330.1160c)
330.1160d)

Section 330.1160 Vaccinations
a) A facility shall annually administer a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213 of the Act)
b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, refused or medically contraindicated. (Section 2-213 of the Act)
c) A facility shall provide or arrange for administration of a pneumococcal vaccination to each resident who is age 65 or over, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the

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Z9999	Continued From page 11 facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213 of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213 of the Act) Based on interview and record review, the facility failed to provide or arrange for the administration of pneumococcal vaccination and failed to document in resident's records that a pneumococcal vaccination was administered, refused or contraindicated for three of three residents (R1, R2, and R3) on the sample of three. Findings include: R1, R2, and R3's clinical records included no information regarding pneumococcal vaccination, whether the pneumococcal vaccination had been given, refused or was contraindicated. On 11/2/11 at 11:45 a.m., E3 (Licensed nurse) stated that he thought that the facility had the documentation regarding the pneumonia vaccinations, but after searching for it, stated that he could not find any information regarding whether or not R1, R2, R3 or any of the other residents had received the pneumonia vaccination. (B)	Z9999		