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F 333	Continued From page 12 Coreg - used for hypertension. Adverse reactions include: hypotension, stroke, bradycardia, fatigue, dizziness. Glipizide - used for adjunct to diet to lower glucose level in patients with Type 2 diabetes. Adverse reactions include: Anorexia, headache, nausea, vomiting and weakness. Hypoglycemia may follow excessive dosage. Lasix - used for Acute Pulmonary Edema and edema. Adverse reactions include: vertigo, headache, dizziness, orthostatic hypotension, pancreatitis and hepatic dysfunction. Lisinopril - used for hypertension. Adverse reactions include: orthostatic hypotension, hypotension, dizziness, headache, fatigue and hyperkalemia. Flagyl - is an antiprotozoal drug used for bacterial infections, Clostridium difficile, etc. Adverse reactions include: headache, seizures and neutropenia. Flomax - used for Benign Prostatic Hypertension. Adverse reactions include: orthostatic hypotension, dizziness and headache. Levaquin - is an antibiotic indicated to treat sinusitis, skin infections, bronchitis, etc. Adverse reactions include: encephalopathy, seizures, colitis and hypoglycemia.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 300.1210b)5) Section 300.1210d)6) Section 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 13 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. Restorative measures shall include, at a minimum, the following procedures: 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. Section 300.1210d)6). 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the Facility failed to provide adequate supervision for 2 of 2 resident's (R2, R4) reviewed for falls in the sample of 5. This failure resulted in both R2 and R4 experiencing falls while being toileted. R2	F9999		

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sustained an impacted subcapital fracture of her right hip. R4 sustained a fracture of her left femur.

Findings include:

1. The Facility "Accident/Incident Report" for R4, dated 12/12/11, documents that at 7:40 AM "while transferring off toilet, resident became combative with Certified Nurses Aide (CNA) hitting and scratching, trying to sit mid-transfer. Staff lowered resident to the floor with residents left leg bent behind resident. Resident is alert with confusion. While being toileted with staff, CNA stood resident up off of the toilet. According to the CNA, the resident then became agitated and started hitting and scratching staff. Resident then started to lose balance and staff lowered resident to the floor with the gait belt. Resident was noted with her left leg bent behind her and right leg straight out in front of her. Resident admitted to the hospital with femur fracture".

The "Accident/Incident Reports" for R4 documents that she experienced previous falls while walking in the Facility on 8/6/11, 8/25/11, 10/7/11 and 11/7/11. These reports document the following:

"8/6/11, 1:00 PM, Resident was walking with staff and was lowered to the floor with the gait belt. No injuries". The investigation does not document potential causative factors or corrective actions based on the causative factors.

"8/25/11, 12:45 PM, No injuries noted. Resident was lowered to floor by staff utilizing a gait belt. Resident was being walked by a CNA with gait belt when resident started to sit down and was lowered to floor". The investigation does not document potential causative factors or

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corrective actions based on the causative factors.

"10/7/11, 10:00 AM, CNA was assisting the resident to the bathroom with the gait belt when resident took about 4 steps and her legs gave out. Second CNA lowered her to the floor. No apparent injuries". The investigation does not document potential causative factors or corrective actions based on the causative factors.

"11/7/11, 10:00 AM, Resident was being transferred from her wheelchair to her recliner when her legs buckled and she was lowered to the floor by the CNA. There are no potential causative factors documented on the investigation. The "Plan of Action to Prevent Reoccurrence" documents "therapy to screen for transfers, possible two staff transfers".

During an interview with E3, Restorative Nurse, on 1/11/12, at 2:05 PM, it was confirmed that the investigations into R4's falls were not complete. E3 said that she does remember actions which were taken for most of R4's falls. These actions are as follows:

E3 stated that for the fall on 8/6/11, the Facility decided to institute rest breaks while they were walking with R4. E3 said that R4's family did not want R4 to use a wheelchair, as was suggested by the Facility. E3 said that R4 has a lot of behaviors - "if she wanted to sit, she would just sit right down". E3 confirmed that the Facility did not document potential causative factors for the fall.

After R4 fell on 8/25/11, E3 said that she asked R4's family if the Facility could utilize a wheelchair for transporting R4. E3 said that R4's family refused however, they suggested that staff follow R4 with a wheelchair when staff are ambulating R4. E3 said that therapy evaluated R4 at that time. Therapy told E3 that R4 had

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reached her maximum potential and was not a candidate for additional therapy. E3 said that R4 had no signs of weakness - she would just sit down. E3 confirmed that the Facility did not document potential causative factors for this fall.

E3 said that she spoke to R4's family about making an appointment for R4 with the psychiatrist as she felt that R4's falls were due to behaviors. E3 said that soonest that the psychiatrist could see R4 was in February 2012. E3 said that she contacted R4's physician, and they changed the times of R4's Seroquel. E3 confirmed that the Facility did not assess for any other causative factors besides behaviors.

E3 said that she remembers asking therapy to screen R4 for utilizing two staff members while transferring R4 after her fall on 11/7/11. E3 said that therapy did not assess R4 until 11/16/11 and when they did assess her, it was for wheelchair positioning - not for her falls. E3 confirmed that the Facility did not institute two person transfers for R4.

During an interview with E2, Director of Nursing, on 01/11/11, at 2:30 PM, E2 stated that the Facility felt that R4's falls were caused due to her behaviors. E2 confirmed that the Facility's investigations into R4's falls did not document potential causative factors with subsequent corrective action based on those factors.

R4's Minimum Data Set (MDS), dated 11/11/11, documents: behaviors of inattention, disorganized thinking; requires extensive physical assistance of one person for transfers, bed mobility and ambulation; unsteadiness in transfers, walking and moving on and off the toilet; and, no impairments in range of motion.

R4's Care Plan, with a start date of 3/7/11 documents the following: "Problem in moderate

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cognitive impairment, anxiety/anxiousness, agitation, tearfulness/crying episodes. Has diagnoses of Alzheimer's, depression and anxiety. Will frequently attempt to self transfer or ambulate. Not always compliant with safety measures. Vision poor in right eye. Currently taking an anti-depressant, anti-anxiety and anti-psychotic". Approaches for this problem includes: "Remind R4 about the personal alarm system and what it means to her. Monitor Frequently. Walk as needed with appropriate discipline. Verbal reminders not to rise without assist". R4's plan of care also documents a "Problem" of "has impaired safety with risk for falls related to impaired mobility, impaired cognition, poor balance and poor safety awareness. She fell at home in November 2010 and fractured her left wrist. She attempts to self transfer frequently and a personal alarm is in place at all times to remind her to sit back down". Approaches for this problem document the following: "E4 is to rest in recliner after dinner. Offer rest periods when ambulating. Verbal reminders not to ambulate or transfer without assist". R4's plan of care does not address how the number of staff members that should be present when transferring R4. R4's plan of care does not address her legs bucking while she is walking.

R4's hospital "History and Physical Examination", dated 12/20/11, documents that "the patient had a fall and sustained a left femur fracture. She was admitted to the hospital and had surgical repair on 12/13/11. The patient was fairly lethargic and more confused than usual. Once the patient was stable from a medical/orthopedic standpoint, there was initial discussion about extended-care facility transfer.

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F9999	Continued From page 18 However, given her history of recurrent delirium and postoperative status, it was recommended to stabilize her mental status and nutrition while providing physical therapy. Family is aware that the patient's prognosis is guarded at this time related to her age, dementia and postoperative status. She has a component of failure to thrive at this time". R4 was readmitted to the Facility on 1/3/12. R4's Physician Order Sheet documents that R4 was admitted to hospice on 1/6/12. 2. The Facility "Incident/Accident Report" for R2 documents that on 11/26/11, at 1:45 PM, "Resident was observed on the floor with her back against the wall and both lower extremities extended toward the toilet. This 89 year old female was admitted to the Facility on 2/3/11, and is currently on hospice care with the following diagnoses of End Stage Congestive Heart Failure, Myocardial Infarction, Pulmonary Edema, Atrial Fibrillation, Parkinson's, dementia, osteoporosis and history of Deep Vein Thrombosis. Prior to the fall, resident is alert with confusion, able to make needs and wants known at times. Prior to fall, resident's transfer and ambulation status is assist of one staff with gait belt, moderate to maximum assist with wheeled walker. On 11/26/11, staff observed resident in upright sitting position, back against wall with legs extended forward, in bathroom. Upon nurse's exam, resident was complaining of pain to right hip, pain medication given and pain was monitored. Physician notified and new orders received to send to Emergency Room (E.R.) to evaluate and treat. At 6:45 PM, on 11/26/11, resident returned to the Facility via stretcher with a diagnosis of right hip fracture. New orders	F9999		

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received for bed rest and continue comfort measures".

The "Investigation Conclusion" for this incident documents "Resident was toileted in the shower room. As staff turned away to grab wipes, resident attempted to get up or may have leaned forward too far. Shower room toilet does not have a toilet riser and handle bars like R2 has in her bathroom in bedroom does, so resident did not have the arm bar support. R2 also had regular socks on which can cause a slick surface".

On 1/10/12, at 2:10 PM, E2 stated that the CNA involved in R2's fall was fired as she left the resident while R2 was sitting on the toilet and did not stand by her side. E2 said that the CNA went to get something out of the cupboard.

The "Final Report" from R2's visit to the E.R. on 11/26/11 documents "Patient brought in by Emergency Management Services. Patient fell onto right side at nursing home. Fall was witnessed by staff. No loss of consciousness and patient did not hit head. Patient complains of pain to right hip/leg. Patient has dementia and combative. Long discussion with Power of Attorney. R2 is a hospice patient. Family not wanting further treatment - wanting comfort. Will adjust pain management and discharge".

R2's radiology report from the hospital E.R, dated 11/26/11, documents that "There is an impacted subcapital fracture of the right femur. Generalized osteopenia".

Facility nurses notes document that R2 was transported by ambulance to the hospital on 11/26/11 at 2:20 PM, and returned to the Facility at 6:45 PM. The following is documented in R2's nurses notes:

"11/26/11, 7:30 PM, R2 attempted to use

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F9999	Continued From page 20 bedpan but pain was too severe. Indwelling catheter inserted. Tolerated well. Morphine and Ativan given. 11/27/11, 1:50 PM, Has been sleepy most of the day. Hospice has been called related to R2's lethargy. 11/28/11, 1:30 PM, Resident very lethargic today. Continues on bedrest. Resident did not eat or drink today. 12/1/11, 7:00 AM, Resident continues to be lethargic, not easily aroused. Resident not alert enough to suck on straw for drinks. 12:00 PM, R2 continues to be lethargic. Yells out when turned and repositioned. 6:40 PM, Daughter came running from the resident's room saying "Mom said that she can't breathe". Resident not in respiratory distress but coughing. Tried to place resident on oxygen but resident refused. 12/3/11, 12:20 AM, Resident expired." R2's "Fall Risk Assessment", dated 10/10/11, documents that R2 was at "High Risk" for falls. R2's MDS, dated 10/21/11, documents that R2 sometimes understood verbal content-responded adequately to simple, direct communication only; had short and long term memory problems; had moderate impairment in cognitive skills for daily decision making; behaviors of inattention and disorganized thinking; did not ambulate; required the extensive assistance of one staff member for transfers and toilet use; and had unsteady balance in moving on and off the toilet. (B) 300.1210d)1) 300.3240a)	F9999		

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F9999	Continued From page 21 Section 300.1210 General Requirements for Nursing and Personal Care 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the Facility failed to correctly administer medications to the resident it was prescribed for 1 of 5 residents (R1) reviewed for medications in the sample of 5. This failure resulted in R1 being hospitalized for hypotension and hypoglycemia. Findings include: The "Medication Incident Report", dated 12/30/11, 8:45 AM, documents that "R1 was given the wrong medications. The nurse was told his room number was 408. The nurse called him by another patients name and this patient never corrected the nurse. There was no picture in resident's Medication Administration Record (MAR) as he was just admitted yesterday". R1's nurses notes document that he was admitted to the Facility from the hospital on	F9999		

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12/27/11, following surgery for a small bowel obstruction. R1's "Initial Plan of Care", dated 12/27/11, documents that R1 had problems with potential for: falls due to weakness; dehydration due to diuretic use; nutrition and pain due to recent surgery; and altered breathing due to a history of lung cancer and Chronic Obstructive Pulmonary Disease.

R1's "Physician's Progress Notes", written and signed by E6, Nurse Practitioner, document "12/30/11, 11:30 AM, Patient is 82 year old man who was recently admitted to Facility from hospital for additional therapy. This morning, he received another patients medications in error, including Lisinopril, Glipizide, Coreg, Lasix, Flagyl and Levaquin. R1 states that at the present time, he does not feel very well and is very nauseous. He has not actually vomited at this point but, feels he could at any time. His appetite has been poor thus far and he is unsure if he can eat the soup that was just brought to him. He does take Lasix on a daily basis due to a history of Congestive Heart Failure (CHF) but the dose today was double his usual dose. Will continue with 30 minute vital sign checks and begin Accuchecks every hour. Should patient become un-stable at any time, including drop in blood pressure below parameters, loss of consciousness or if we feel patient needs to be monitored more closely for any reason, we will immediately transfer him to the hospital. Will consider adding intravenous fluid to help flush medication from patient's system, however given his history of CHF we will need to proceed carefully. Explained to patient the importance of eating and drinking at this time and frequency throughout the afternoon to avoid hypoglycemic episode."

R1's physician's orders, dated 12/30/11 (no

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time given) document the following: "Please place intravenous (IV) heparin lock and start D5 1/2 Normal Saline at 50 cubic centimeter's (cc) per hour for diagnoses of Dehydration and Hypotension. Monitor BP every hour until 9:00 PM and if Systolic BP remains above 90 mmHg, may then check BP every 2 hours. Call for BP less than 85 mmHg. Accucheck's every hour until blood sugar remains above 80 for 3 consecutive readings and patient is eating, then in the morning and at bedtime. May give Glucose 1 tube as needed for blood sugar less than 70 or 1 ampule of Glucagon SQ as needed if blood sugar less than 70. 3:00 PM, Give 1 tube of Glucose orally now for blood sugar of 66 and recheck blood sugar in 15 minutes. Increase D5 1/2 Normal Saline to 100 cc's per hour.

4:30 PM, Certified Nurses Aide (CNA) reported blood pressure (BP) low, 76/44 mmHg. Hypotension - believe acute drop in BP due to medication peaking, which could lead to acute renal failure, secondary to lack of perfusion. For this reason, believe it would be best for a patient to be transferred to the emergency room for additional support and monitoring. Intravenous fluid continued for transport".

R1's Emergency Room notes documents that "patient is sent from nursing home after he's had persistent hypotension after he was given the wrong medications earlier today. He became hypotensive and despite IV hydration at the nursing home, remained hypotensive. When he arrives at the emergency room he remained asymptomatic other than his blood pressure is low with a systolic blood pressure in the 70's. Electrocardiogram (EKG) shows sinus bradycardia with a ventricular rate of 59. Nothing acute. Patient was stable on arrival. Patient was

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given 2 boluses of 0.9 normal saline 250 milliliters each bolus with improvement of his blood pressure to a systolic pressure in the 90's". R1's nurses notes document "12/31/11, 2:00 AM, Spoke with hospital. Resident admitted with diagnosis hypotension".

The Hospital "Clinical Resume" for R1, dated 1/5/12, documents that he was discharged from the hospital on 1/5/12 and sent to another facility. This "Clinical Resume" documents that R1 was hospitalized due to "Accidental overdose at the nursing home. This 82 year old gentleman had been discharged following surgical procedure with a small bowel resection and lysis of adhesions, and status post wound dehiscence and abdominal wall closure on December 12th. He had gone to the nursing home for therapy. There, he received medications that were not his including Norvasc, Flagyl, Flomax, Levaquin, aspirin, Coreg, lisinopril, glipizide and Lasix. He developed significant hypoglycemia and hypotension and was brought to the E.R. He was admitted and resuscitated from these matters and the rest of his course was relatively unremarkable, although he did have difficulty with urinary retention".

During an interview with E5, Licensed Practical Nurse, on 1/10/12 at 3:00 PM, E5 stated that R1 was sitting in the hallway and someone told her the wrong room number for R1. R1 was a new admit and she could not recall what he looked like. E5 said that she called R1 by the wrong name twice and he never said anything. E5 said that R1 told her that there were more medications than he was used to but, E5 said new resident's often say that. E5 said that she was working down the hall when she overheard one of the therapists asking R1 if he went by R5's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146026	A. BUILDING _____ B. WING _____	C 01/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	**3400 WEST WASHINGTON SPRINGFIELD, IL 62702**

(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) COMPLETION DATE
F9999	Continued From page 25	F9999		

first name. R1 said "No, I'm (R1)". E5 said that's when she knew she had made an error. E5 said that she immediately reported her error to R1's physician and E2, the Director of Nursing. E5 said that R1 had been complaining of nausea before he got the wrong pills and also stated that his blood pressure runs low.

R1's physician's orders, dated 12/27/11, documents the following medications: Amiodarone 200 milligrams (mg) orally (po) on Monday, Wednesday and Friday; Aspirin 81 mg daily; Lasix 20 mg daily; Protonix 40 mg daily; Ativan 0.5 mg three times a day as needed; Tylenol 1000 mg three times a day as needed; and Reglan 10 mg morning and bedtime.

R5's physician's orders, dated 12/1-12/31/11, documents the following medications: Norvasc 5 mg daily; Aspirin 81 mg daily; Coreg 6.25 mg twice a day; Glipizide 5 mg daily; Lasix 40 mg daily; Lisinopril 20 mg daily; Flagyl 500 mg three times a day; Simvastatin 40 mg at bedtime; Flomax 0.4 mg daily; and Levaquin 500 mg daily.

The 2012 Nursing Drug Handbook documents the corresponding indications for usage and adverse reactions for the following medications which R1 received in error:

Norvasc - used for chronic stable angina. Adverse reactions include: fatigue, dizziness, light headedness. Because drug is metabolized by the liver, use cautiously in patient's with severe hepatic disease.

Coreg - used for hypertension. Adverse reactions include: hypotension, stroke, bradycardia, fatigue, dizziness.

Glipizide - used for adjunct to diet to lower glucose level in patients with Type 2 diabetes. Adverse reactions include: Anorexia, headache, nausea, vomiting and weakness. Hypoglycemia

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F9999	Continued From page 26 may follow excessive dosage. Lasix - used for Acute Pulmonary Edema and edema. Adverse reactions include: vertigo, headache, dizziness, orthostatic hypotension, pancreatitis and hepatic dysfunction. Lisinopril - used for hypertension. Adverse reactions include: orthostatic hypotension, hypotension, dizziness, headache, fatigue and hyperkalemia. Flagyl - is an antiprotozoal drug used for bacterial infections, Clostridium difficile, etc. Adverse reactions include: headache, seizures and neutropenia. Flomax - used for Benign Prostatic Hypertension. Adverse reactions include: orthostatic hypotension, dizziness and headache. Levaquin - is an antibiotic indicated to treat sinusitis, skin infections, bronchitis, etc. Adverse reactions include: encephalopathy, seizures, colitis and hypoglycemia. (B)	F9999		