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	146126	A. BUILDING _____ B. WING _____	06/12/2013

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OUR LADY OF ANGELS RET HOME	1201 WYOMING AVENUE JOLIET, IL 60435

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F 518	Continued From page 53 periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure one (E13) of three staff members interviewed was aware of outlets powered by the emergency generators. This has the potential to affect all residents of the facility. Findings include; During the environmental tour E13, certified nurses aid, was interviewed regarding where and what the red outlets were. E13 said, "I'm new. I don't know that." Review of E13's staff training sheets did not list any training about loss of electricity and emergency power.	F 518		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.686b) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs Psychotropic medication shall not be prescribed or administered without the informed consent of	F9999		

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the resident, the resident's guardian, or other authorized representative. (Section 2/106.1 (b) of the Act) Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of medications shall be described.

Based on record review and interview, the facility failed to obtain consent for anti-depressant medications for 2 (R101, R104) of two residents sampled for psychotropics, out of a sample of five.

Findings include:

R101 was admitted to the facility on 5/14/13 with multiple medical diagnoses including Alzheimer's disease and Depression. R101's MAR (Medication Administration Record) from May 2013 reflects that R101 had been receiving Wellbutrin and Trazadone since 5/14/13. Both medications are classified as anti-depressants. R101's clinical record did not contain consents for these two medications.

R104's POS (physician order sheet) reflects that R104 has been receiving Escitalopram 20 mg daily (equivalent of Lexapro), originally ordered 11/29/11 and refilled 5/8/13. This medication is classified as an anti-depressant. R104's medical record did not contain any consent for this medication.

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On 5/29/13 at 10:30 am, E19 (LPN) stated she did not have consents on these medications for R101 and R104 because she had been told they did not need consents for these medications. She stated she had been told this by E6 (LPN/MDS Coordinator). E19 stated she did not have consents for medications in any separate binder; if she had them they would be in the medical record.

On 5/29/13 at 1:35pm E6 stated she is over the psychotropics at the facility and her duties include rounding with the psychiatrist. E6 stated it is up to the individual nurse to know which medications require consents and to obtain the consents. She agreed that Wellbutrin, Trazadone and Lexapro require consents.

(AW)

300.1210b)
300.1210d)6
300.1220b)3)
300.3240a)

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

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, record review, and interview the facility failed to evaluate and analyze falls of two residents (R12, R10) out of eight reviewed for falls in the sample of 16.

As a result of this failure R12 was sent to the hospital with swelling to the left eye, an abrasion to the right elbow and diagnosed with a forehead contusion. As a result of this failure R10 sustained bruising and a hematoma to her face and head.

The findings include:

1. Review of R12's admission face sheet and current physician's orders (5/2013) showed R12 was admitted to the facility on 3/20/13 with diagnoses including Diabetes Mellitus and Weakness. Review of the facility's incident reports showed R12 had nine fall incidents from 3/31/13 to 4/27/13. Six of the falls occurred on the night shift (11p -7a) and three of the falls occurred on the evening shift (3p - 11p). Two of the falls were noted with injuries.

A facility incident report dated 3/31/13 at 12:55 a.m. showed R12 was found on the floor, face down in her bathroom, lethargic, with blood splattered by the sink. R12 stated she "hit her forehead." The incident report documentation showed R12's skin was cool and clammy. R12's blood sugar was 38. 911 was called. Her right elbow bleeding and an abrasion was noted. R12

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was sent to a nearby hospital where she was admitted for 24 hour observation and diagnosed with a forehead contusion.

In observation and attempted interview with R12 on 5/30/13 at 11:20 a.m., R12 was up in her wheel chair in the A200 Wing hallway. R12 was confused but with infrequent periods of lucid thoughts. R12 stated, "I fall when I go to the bathroom. My legs get weak. I trip or I fall."

On an incident dated 4/15/13 at 6:30 a.m. documentation showed R12 was found in her room next to the bed. Slight swelling was noted to her right knee/ankle.

Further review of incident reports for R12 showed seven of the nine falls occurred in R12's room. One of the falls occurred in R12's bathroom and one fall occurred in the facility chapel. Review of the falls showed six of the falls occurred between approximately 1:00 a.m. and 3:30 a.m.

Further review of nursing documentation showed no evaluation or analysis of R12 falls with the times of R12's falls being addressed. No analysis or evaluation of showing the location of R12 falls was addressed and no evaluation or analysis addressing most of R12's falls had occurred on the night shift.

The plan of care did not address closer monitoring of R12 during the night shift, closer monitoring of R12 while in her room and/or closer monitoring or implementation of intervention between the hours of 1:00 a.m - 3:30 a.m.

E2 (Director of Nurses) on 5/30/13 at 3:45 p.m. said R12's falls had not been evaluated or

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analyzed in an attempt to identify patterns/trends to possibly prevent further falls.

2. On 5/28/13 at 11:10 a.m. R10 was observed in her wheel chair on the second floor B wing hallway. R10 was noted with massive deep purple bruising to the left head and face area. The purple bruising extended from R10's left parietal/temporal head to beneath her left chin. The bruised sites included R10's left eye, left side of nose and left cheek.

Review of R10's incident reports showed R10 had a fall on 5/16/13 at 5:40 a.m. Incident documentation showed R10 "Had a fall in her room when she got out of her chair to walk, legs got shaky and fell hitting her left temporal area on the bed. Hematoma and abrasion to left head." Further review of facility incidents showed R10 had three falls at the facility from 1/15/13 to 5/16/13.

On 5/29/13 at 3:40 p.m., R10 said, "I fell. I got up to go to the bathroom, lost my balance and fell." R10 was observed with a golf ball sized hematoma to the left temporal/parietal head as well as the massive purple bruising to her left face. In regards to the hematoma R10 stated, "It hurts when I touch it. They wanted me to go to the hospital when I fell but I refused because it costs too much money."

Review of R10's admission face sheet and current physician's orders showed R10 had diagnoses which included Hypoglycemia, Hypertension, and Cataracts. Review of R10's fall assessment showed no name and no date. Review of blood glucose monitoring flow sheets for April and May 2013 showed R10 had frequent

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F9999	Continued From page 60 low blood glucose levels in the early mornings. Review of R10's medical record showed no documentation R10's falls were evaluated and/or analyzed to address R10's diagnoses of hypertension, hypoglycemia or cataracts. Review of R10's fall plan of care showed no interventions addressing hypertension, hypoglycemia, or cataracts as possible contributing factors of R10's falls. On 5/30/13 at 4:00 p.m., E2 (Director of Nurses) said R10's falls were not evaluated and/or analyzed for patterns/trends to identify possible reasons for R10's falls. (B)	F9999		