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WESTSIDE REHAB & CARE CENTER	**601 NORTH COLUMBIA WEST FRANKFORT, IL 62896**

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F 000	INITIAL COMMENTS	F 000		
F 280 SS=E	Annual Licensure and Certification Survey. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update the plan of care to reflect significant weight loss, black box warnings, fall interventions and/or failed to ensure that residents and responsible parties were invited to participate in the care planning process for 3 of 16 residents(R3, R5, and R9) reviewed for care plans in the sample of sixteen and for 10 residents (R17- R26) in the supplemental	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 280	Continued From page 1 sample. Findings include: 1. According to R9's Care Plan, which was most recently updated on 2/18/14, R9 has a plan for "Resident will maintain nutrition and tolerate current diet." According to the Monthly Weight Grid - September 2013 through February 2014, R9 lost 17% of her initial weight in a five month period. According to laboratory values dated 1/1/14 R9 has experienced a decline in her visceral protein status. On 2/24/14 at 10:40 a.m. E7, Dietary Manager, stated that R9 can be choosy, sometimes has a poor appetite and sometimes only wants to eat corn flakes. According to the February 2014 Physician's Order Sheets, nutritional shakes have been ordered at meals and high calorie supplements have been added at medication passes due to R9's declined nutritional status. The Care Plan does not reflect these concerns nor does it address the additional strategies which have been implemented. 2.a. On 2/27/14 at 3:00 p.m., when asked whether she had been involved in R5's care planning meetings, Z2, R5's family member, stated, "I haven't been to a meeting like that. I've talked to the Director of Nursing, but as far as meeting, I don't know about that." b. According to the facility's untitled incident log, R5 sustained falls in the facility on 11/29/13, 12/7/13, 12/17/13, 1/14/14, 2/9/14, and 2/11/14. R5's Care Plan, most recently updated on 2/18/14, documents no new strategies to prevent	F 280		

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F 280	Continued From page 2 falls between 8/1/13 and 2/7/14. 3. R3's February, 2014 Physician's Order documents that R3's birthday is 8/13/39 which indicates that R3 is 74 years old. This same Physician's Order documents that R3 receives Seroquel 25 milligrams (mg) daily at 8:00 AM with a start date of 11/25/13 and Seroquel 50 mg daily at 5:00 PM with a start date of 11/25/13. R3's 11/25/13 typed Physician Progress Note documents that R3 has a diagnosis of Psychotic Like Behavior Secondary to Alzheimer's Dementia. According to PDR.net, Seroquel carries a FDA (Food and Drug Administration) Boxed Warning, "Elderly patients with Dementia-Related Psychosis are at an increased risk of death. Not approved for the treatment of patients with Dementia related Psychosis". R3's current plan of care does not include monitoring for the risk factors associated with Seroquel as related to the FDA Boxed Warning. On 2/28/14 at 10:10 AM, E2 (Director of Nursing), stated that R3's current Care Plan does not include monitoring for risk factors of the Seroquel as related to the FDA Boxed Warning. 4. On 02/26/14 at 11:00 am, all ten residents (R17-R26) present at the group interview indicated they and their families are not being notified of Care Plan meetings. On 02/26/14 at 3:25p.m.,E2 stated that E8, Care Plan Coordinator, does not send written notification of Care Plan meetings to families or residents.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 3 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update fall prevention plans to prevent subsequent falls and monitor implementation of preventive strategies for 1 of 5 residents reviewed for falls (R5) in the sample of 16. Findings include: According to the facility's undated incident log, R5 sustained falls in the facility on 11/29/13, 12/7/13, 12/17/13, 1/14/14, 2/9/14, and 2/11/14. R5's Care Plan, most recently updated on 2/18/14, documents no new strategies to prevent falls between 8/1/13 and 2/7/14. According to the facility's undated incident log, following the fall on 11/29/13, the facility decided to "sit R5 near the nurses station for closer observation if no one is in the dining room." After the 12/7/13 fall, the facility decided to use "non-slip material placed under buttock in w/c (wheelchair)." After the 12/17/13 fall, the facility decided to "assist R5 into bed and then remove headphones and place in nightstand." Following the 1/12/14 fall, at which point R3 was found on the floor with alarm not sounding, the facility	F 323		

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F 323	Continued From page 4	F 323		

decided to replace the alarm. Following the 2/11/14 fall, R5 received a scoop mattress, low bed, and floor mat.

The 2/9/14 fall was not represented on the document, however on 2/26/14 at 11:00 a.m., E2, Director of Nurses, stated that this fall occurred when an unnamed food service worker moved R5 out of the dining room, that R5 became confused, and rolled her wheelchair into a room and attempted to transfer. E2 stated that the facility at that time re-educated the worker not to move R5.

When E2 was asked on 2-26-14 at 11:00 a.m. during interview whether food service staff routinely assisted residents from the dining room, E2 said that they sometimes helped some residents. When asked where the new interventions to prevent R5 from falling were documented, E2 stated that it would be written in the Shift Report Book, and the information would be verbally passed to the next shift. When asked how the new interventions were monitored and evaluated, E2 stated that they would know that the new intervention was working if R5 did not fall again.

According to the facility's (undated) Fall Prevention policy and procedure document, "Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed and comments will be written on the Fall Tracking Form and any new interventions will be written on the care plan." and "The unit nurse will place documentation of any new intervention on the CNA (Certified Nurse Aide) assignment worksheet." When E2 was

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F 323	Continued From page 5 questioned on 2-26-14 at 11:00 a.m. regarding documentation of the new interventions on the CNA worksheets, E2 stated that this information was not placed on the worksheets. E2 stated that the information was provided to staff anecdotally.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the	F 329		

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F 329	Continued From page 6 facility failed to ensure adequate monitoring and supervision of medication risk factors for 1 of 5 residents (R3) reviewed for psychotropic medication in the sample of 16. Findings Include: 1. R3's February, 2014 Physician's Order documents that R3's birthday is 8/13/39 which indicates that R3 is 74 years old. This same Physician's Order documents that R3 receives Seroquel 25 milligrams (mg) daily at 8:00 AM with a start date of 11/25/13 and Seroquel 50 mg daily at 5:00 PM with a start date of 11/25/13. R3's 11/25/13 typed Physician Progress Note documents that R3 has a diagnosis of Psychotic Like Behavior Secondary to Alzheimer's Dementia. According to PDR.net, Seroquel carries a FDA (Food and Drug Administration) Boxed Warning, "Elderly patients with Dementia-Related Psychosis are at an increased risk of death. Not approved for the treatment of patients with Dementia related Psychosis". R3's clinical record does not have any documentation that R3 is being monitored for the risk factors associated with Seroquel related to the FDA Boxed Warning. On 2/26/14 at 1:40 PM, E2 (Director of Nursing), during interview stated that the facility is not monitoring R3 for the specific FDA Boxed Warning related to Seroquel.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 7 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to date opened insulin vials, and discard expired medications for 2 of 16 residents (R8, R13) reviewed for labeling and	F 431		

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F 431	Continued From page 8	F 431		

storage issues in a sample of 16 and 2 residents (R27, R28) in the supplemental sample.

The findings include:

During observation of the medication control room's medication storage refrigerator, on February 28, 2014 at 10:15 AM the following was found:

R27's Lantus insulin vial was opened with no date to indicate when the vial was opened for use and the box containing the vial had a fill date of February 6, 2014.

R28's Lantus insulin vial was opened with no date to indicate when the vial was opened for use and the box containing the vial had a fill date of February 17, 2014.

R8's Humalog insulin vial was found opened with no date to indicate when the vial was opened, and the box containing the vial had a fill date of January 28, 2014.

R13's box of Acetaminophen 650 mg suppositories was expired and had the following typed on the label: "Discard after 1/14/14".

On February 28, 2014 at 10:30 AM, E14, Registered Nurse, during interview reported there were no dates on the Lantus insulin vials and verified the policy of the facility is to date insulin vials when they are opened.

The facilities pharmacy protocol for storage of Lantus insulin states "expires 28 days after opening or removing from refrigerator, which ever

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F 431	Continued From page 9 comes first. Do not refrigerate after first use".	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 10	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to monitor an ongoing skin rash, failed to provide isolation and failed to adequately collect and document data for the purpose of investigation and surveillance of a skin rash for 2 of 2 residents (R6, R9) reviewed for rashes in the sample of 16, and 2 residents (R29, R30) in the supplemental sample.

Findings include:

1. A History and Physical dated 12/22/13 from a hospital stay states, "(R9) is rising about the bed and scratching and has multiple what appear to be bug bites on her chest, abdomen, and hips that she continues to scratch at," and "The patient has multiple macules on her body that appear to be consistent with bug bites. They appear to be pruritic as the patient continues to scratch all surfaces of her skin. The macules are on her chest, abdomen, buttock, groin area, legs and arms, very few on her back."

A separate History and Physical from the hospital stay, dated 12/21/13, states, "Pruritic rash. I suspect the patient's rash could be due to scabies versus bed bugs. The patient is being treated with permethrin per dosing recommendations."

When questioned on 2/27/14 at 3:00 p.m. regarding the treatment, E2, Director of Nurses,

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F 441	Continued From page 11 stated that the Permethrin was given for itching. The Infection Control Log was reviewed for December 2013 and January 2014, and no documentation of the rash nor the treatment was present. 2. On 2/26/2014 at 3:50 PM, R6 was observed in the hallway in the North Hall hallway scratching his arms and chest. An extensive red, raised rash and multiple scabbed areas were noted to R6's arms and trunk and a build-up of dry, crusty skin between fingers was noted. On 2/26/14 at 4:10 PM, E5, Registered Nurse, stated during interview that she has been employed at the facility "about a month" and has noticed the rash and scratching during that time. On 2/27/2014 at 10:00 AM, R6 was observed laying in bed on his right side. An extensive red, papule like rash was noted covering R6's back and chest area. Less extensive areas of the same type of rash were noted on R6's buttocks and upper legs. R6's hands and between fingers were noted to have reddened areas with thickened yellow crusty patches. E3, Licensed Practical Nurse was present and stated that R6 has had the rash about a month, with it recently developing the yellow crusty areas on his hands. E3 stated that R6 was scheduled to see a Dermatologist this same day. At 4:30 PM, E2, Director of Nurses, stated that R6 had been diagnosed with Norwegian Crusted Scabies. Documentation from R6's visit to Southern Illinois Dermatology on 2/27/2014 states "Multiple erythematous crusted patches to arms, hands,	F 441		

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face, neck and chest. Upper body exam deferred by patient. Assessment: Norwegian Crusted Scabies. R6 was returned to his semi-private room after returning to the facility with a diagnosis of Norwegian Crusted Scabies. The Center for Disease Control and Prevention at www.cdc.gov recommends isolating patients with "crusted scabies" from other patients who do not have it due to its increased risk of transmission related to being infested with a large number of scabies mites, and the presence of skin scales and crusts that can be shed by the infected person.

On 2/28/2014 at 10:00 AM, R6 was observed to be in his room in bed; R6's room mates, R29 and R30 were also present in the room. There was no indication that isolation precautions were being utilized at this time.

On 2/28/14 at 10:35 AM, E4, Certified Nurse's Aide, stated that R6's rash has worsened in the last month and that he scratches a lot.

On 2/28/2014 at 10:40 AM, E2, Director of Nurses stated that the dermatology referral was made at the beginning of this month in response to the rash becoming more prevalent.

Documentation of R6's visit to Southern Illinois Dermatology Office Visit dated 9/24/2013 states "Patient is here for recheck of scabies. He was treated with Elimite Cream and retreated in 1 week. Assessment: Post Scabetic Pruritis.

R6's Physician's Order sheet for February 2014 includes an order for Hydroxyzine HCL 50 mg. (milligrams) one tablet every 6 hours as needed

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F 441	Continued From page 13 for itching. R6's Medication Administration Records for January and February 2014 document that R6 received this medication from 1 to 4 times daily in January and on 20 days during February. R6's Treatment Records for January and February 2014 include an order for "Skin Check Daily using C.R.O.P.S. Method. Clear-Red-Other-Pressure-Skin Tear." R6's skin checks for January are documented daily as "Other" and for 16 days in February. There is no clarification in R6's Treatment Record or Nurses Notes as to what "Other" means. On 2/28/2014 at 8:20 AM E6, Licensed Practical Nurse stated that she assumes the "Other" is in reference to R6's rash. The facility's Infection Control Logs from September 2013 through February 2014 do not identify R6 as having a rash. The document titled Petersen Health Care Infection Control Surveillance and Monitoring Section 2 a. states," Monitoring of the day to day operation of the Infection Control Program will be conducted by the Director of Nurses. Included in these duties are: Investigation and implementation of controls to prevent infections in the facility. Section 2 b. "Determine and direct the correct procedures necessary for the prevention of infections. This shall be done on an individual basis, applying the concepts of isolation per infection	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. BUILDING _____ B. WING _____	02/28/2014

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F 520	Continued From page 14 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement its policies and failed to establish methods of evaluating the efficacy of its Quality Assurance plan for one of five residents (R5) reviewed for falls in the sample of 16. Findings include: According to the facility's undated incident log, R5 sustained falls in the facility on 11/29/13, 12/7/13, 12/17/13, 1/14/14, 2/9/14, and 2/11/14. R5's Care Plan, most recently updated on	F 520		

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F 520	Continued From page 15	F 520		

2/18/14, documents no new strategies to prevent falls between 8/1/13 and 2/7/14.

When E1, Administrator, was asked on 2/26/14 at 10:30 a.m., for reports detailing the circumstances of the falls sustained by R5, E1 stated that those reports were Quality Assurance documents and could not be shared with the survey team.

According to the facility's undated incident log, following the fall on 11/29/13, the facility decided to "sit R5 near the nurses station for closer observation if no one is in the dining room." After the 12/7/13 fall, the facility decided to use "non-slip material placed under buttock in w/c (wheelchair)." After the 12/17/13 fall, the facility decided to "assist R5 into bed and then remove headphones and place in nightstand." Following the 1/12/14 fall, at which point R3 was found on the floor with alarm not sounding, the facility decided to replace the alarm. Following the 2/11/14 fall, R5 received a scoop mattress, low bed, and floor mat.

The 2/9/14 fall was not represented on the document, however on 2/26/14 at 11:00 a.m., E2, Director of Nurses, stated that this fall occurred when an unnamed food service worker moved R5 out of the dining room, that R5 became confused, and rolled her wheelchair into a room and attempted to transfer. E2 stated that the facility at that time re-educated the worker not to move R5.

When E2 was asked on 2-26-14 at 11:00 a.m. whether food service staff routinely assisted residents from the dining room, E2 said that they

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F 520	Continued From page 16	F 520		

sometimes helped some residents. When asked where the new interventions to prevent R5 from falling were documented, E2 stated that it would be written in the Shift Report Book, and the information would be verbally passed to the next shift. When asked how the new interventions were monitored and evaluated, E2 stated that they would know that the new intervention was working if R5 did not fall again.

According to the facility's undated Quality Assurance Daily Meeting policy, "You should be talking about falls on a daily basis and making sure that you are investigating why that person fell and what is being done to ensure that the resident does not fall again. Any incident that occurred following the previous meeting should be discussed and all Quality Care Reporting forms/Investigations should be reviewed for accuracy and completeness. Do not wait until a resident is hurt to react. The Care Plan Coordinator should take the information from the daily meeting and update the Care Plans."

According to the facility's (undated) Fall Prevention policy and procedure document, "Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed and comments will be written on the Fall Tracking Form and any new interventions will be written on the care plan." and "The unit nurse will place documentation of any new intervention on the CNA (Certified Nurse Aide) assignment worksheet." When questioned regarding documentation of the new interventions on the CNA worksheets, 2/26/14 at 11:00 a.m., E2 stated during interview that this information was not placed on the worksheets. E2 stated

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F 520	Continued From page 17 that the information was provided to staff anecdotally.	F 520		