STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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F 000	INITIAL COMMENTS	F 000		
F 276 SS=D	Annual Licensure and Certification Survey 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, staff failed to complete quarterly psychoactive medication assessments for one of five residents (R7) reviewed for psychoactive medications in the sample of eight. Findings include: R7's Physician's Orders for March 2012 lists current orders for Risperdal 0.25mg (milligrams) at bedtime(antipsychotic); Ativan 1.0mg twice daily,as needed, for anxiety (anti-anxiety); and Lunesta 1mg as needed at bedtime (hypnotic). The start dates for each of these medications is listed as 8/24/11. The most recent "Psychotropic Medication Quarterly Eval (evaluation)" for R7's Risperdal, Ativan and Lunesta are each dated 11/15/11. On 3/7/12 at 11:30 a.m. E12, Assistant Director of Nurses, stated she was unable to find any additional assessments for the Risperdal, Ativan or Lunesta.	F 276		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 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 record review and interview, the facility failed to provide safe transfer technique and assistive device for 1 of 4 residents sampled for falls (R8), out of a sample of 8, by failing to utilize a sit-to-stand lift as directed. This failure resulted in an ankle fracture for R8. Findings include: According to admission records and the Physician's Order Sheet for 9/11, R8 had multiple diagnoses including Cerebrovascular Accident (CVA), Pneumonitis, Pulmonary Embolism and Peripheral Vascular Disease. Hospital records show that R8 had a Right Hip Fracture following a fall on 8/2/11. The diagnosis of Osteoporosis was added at that time. The Minimum Data Set (MDS) dated 9/7/11 assessed R8 with no memory problems and minimal cognitive impairment. The MDS also stated that R8 did not ambulate and required extensive assistance for transfers and toileting. Interdisciplinary Notes dated 9/18/11 for 9/17/11 states the following: "CNA (Certified Nurse Aide) reported to nurse in the afternoon of 9/16/11 that	F 323		

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resident's right ankle got twisted while she was being transferred from toilet to WC (wheelchair). Nurse assessed right ankle for any possible problems such as dislocation or fx (fracture), but found no signs of any problem; resident denied pain and discomfort when ROM (range of motion) was done on rt (right) ankle. However, daughter notified this evening that res.(resident) rt ankle was swollen. Nurse found ankle to be swollen, warmer than the left leg and res. c/o (complained of) discomfort when moved. . . . .send res. to ED (emergency department) for evaluation and treatment. . . ." R8 returned to the facility the same day (9/17/11) with a splint for a Trimalleolar Fracture of the right ankle.

The Initial Notification report to IDPH (Illinois Department of Public Health) stated that R8 was "lowered to floor" and sent to the hospital for treatment. The Resident Incident Report dated 9/17/11, stated that E7 (CNA) took R8 to the bathroom by wheelchair, and transferred from the wheelchair to the toilet. E7 stated that R8's "ankle got twisted while she (R8) was being helped from toilet to WC. Nurse assessed right ankle for any possible signs of dislocation or FX, but did not find any. . . ."

The Incident Report Follow-Up dated 9/19/11 stated that R8 was to be transferred with a type of lifting device. The report continues that on Friday, September 16, 2011, E7 assisted R8 from the wheelchair onto the toilet. When R8 finished and stood for E7 to clean her and pull up her pants, R8 "started to get weak and go down on the floor. {E7} let her (R8) down slowly onto the floor. {E7} reported that her (R8) body was twisted to the left (she has right sided weakness

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from previous CVA). {E7} noticed that her right ankle was twisted and facing out when she was on the floor. . . ." R8 denied any pain or discomfort at this time. E7 got R8 up and placed her in the wheelchair by herself at this time, prior to having R8 examined by the nurse. E8 (nurse) assessed R8 when E7 informed him of the incident. E8 also found the range of motion in the ankle was within normal limits, and R8 did not complain of pain. (E8 did not document this assessment at the time - not until the 9/18/11 late entry.) R8 was again assessed on 9/17/11 at 3:51am with no changes and no complaints of pain. On 9/17/11 at 5:30pm was when R8's daughter told the nurse that R8's right ankle was swollen. The physician was notified and R8 was sent to the hospital.

Hospital X-ray report of 9/17/11 confirms the diagnosis of Trimalleolar Fracture of the right ankle.

The careplan reviewed on 8/10/11 states that R8 had right-sided weakness from the CVA and was weight-bearing as tolerated on the right, from the hip fracture of 8/2/11. The careplan also states that for transfers, staff was to use the "{sit-to-stand assistive device}at present. . . .Be sure that my right leg is properly positioned on the platform of the {lift}. Be sure and cue me to stand up straight when I am on the lift. . . ."

The Transfer Directive completed by Physical Therapy on 8/11/11 also stated that this type of lift referred to as the "Red lift" was to be used for R8, and also gave instructions for proper positioning as noted in the careplan.

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F 323	Continued From page 4 On 3/7/12 at 11:50am, E2 (Director of Quality Assurance) confirmed that E7 transferred R8 improperly, that E7 should have used the lift device and did not. E2 stated that E7 had asked R8 if R8 used the lift and R8 stated she did not.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, staff failed to administer medications as ordered for four of four sampled residents (R1, R2, R3, R6), in a sample of 8. There were four medication errors out of 49 opportunities for error, resulting in a 8.16% medication error rate. Findings include: 1. On 3/5/12 at 12:50pm, E5, Registered Nurse(RN), flushed R2's PICC(Peripheral Intravenous Central Catheter) line with 10cc(cubic centimeters) of Normal Saline following the infusion of Vancomycin. E5 then started an infusion of Piperacillin. Following the infusion of the Piperacillin at 1:20pm E5 flushed the PICC line with 10cc of Normal Saline. The Physician's Order dated 3/4/12 states to flush the PICC line with 5cc of Normal Saline after each use. E5 verified on 3/5/12 at 12:50pm and 1:20pm that	F 332		

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she flushed R2's PICC line with 10cc of Normal Saline. At 2:25pm E5 stated after reading the Physician's Order that the PICC line should have been flushed with 5cc following each use, not 10cc.

2. On 3/6/12 at 9:30am, E4, RN, administered Omeprazole 20mg(milligrams) to R3 with apple juice. The pharmacy label on the package of Omeprazole states, "Take before food/meal."

On 3/6/12 at 9:30am R3 states he had already eaten breakfast that morning.

E2, Director of Quality Assurance stated on 3/6/12 at 11:00am that breakfast on the unit is served from 7:00-9:00am.

The 2007 8th Edition of Lexi-Comp's Drug Reference handbook states Omeprazole "should be taken on an empty stomach; best if taken before breakfast."

3. On 3/6/12 at 9:50am E4 administered Diltiazem ER(Extended Release) 180mg to R6. The pharmacy label on the package of Diltiazem states, "Take on an empty stomach."

R6 stated on 3/6/12 at 9:50am that she ate breakfast that morning between 8:00-8:30am.

4. On 3/7/12 at 8:35 a.m. E6, RN, administered 5 milliliters (ml) of liquid Docusate Sodium 50 milligrams/5 ml to R1. The 5 ml would equal 50mg of the Docusate Sodium. Prior to administering the medication E6 verified that she was administering 5ml. R6's Physician Order and Electronic Medication Administration Record

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F 332	Continued From page 6 dated March 2012 lists a Physician's Order dated 3/6/12, directing staff to increase R6's Docusate Sodium from 50mg twice daily to 100mg twice daily. On 3/7/12 at 9:05 a.m. E6 confirmed she had given the Docusate 50mg in error and should have given 100mg.	F 332		