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	14E848	A. BUILDING _____ B. WING _____	07/30/2015

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DECATUR REHAB & HEALTH CARE CT	136 SOUTH DIPPER LANE DECATUR, IL 62522

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F 000	INITIAL COMMENTS	F 000		
F 221 SS=D	Annual Licensure and Certification Survey 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and document a medical diagnosis or medical symptoms justifying the use of a physical restraint for one (R4) of two residents reviewed for restraints in the sample of 10. Findings include: An undated facility policy titled "Physical Restraint/Enabler Policy" states "Physical Restraints shall not be used for the purpose of discipline or convenience. Physical restraints is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's own body....." On 7/28/15 during a tour of the facility at 9:40 am, R4 was sitting in the dining room in a geriatric chair with a tray table attached to the chair. R4 was propelling the chair with R4's feet. On 7/28/15, 7/29/15 and 7/30/15 at approximately	F 221		

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

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F 221	Continued From page 1	F 221		

12:00 pm, R4 was eating lunch with a tray table attached to the geriatric chair. R4 was eating food from a plate placed on the tray. On all occasions R4 was sitting upright in the chair and had good trunk control. R4 was able to move all extremities at will.

The Physician Order Sheet (POS) dated July 2015, documents the following diagnoses for R4: Hemorrhagic Cerebral Vascular Accident (Left Side Effect) and Dementia. The same POS documents an undated entry for a geriatric chair with tray table.

There was no Telephone Order documentation in the Medical Record for R4 to have a tray table. R4's Physician Progress Notes did not document any information on the geriatric chair with the tray table.

The Care Plan for R4 dated 5/21/15, does not document an update or revision to include the use of a restraint. There is no staff guidance on placement or release of the table tray on R4's geriatric chair. R4's Care Plan does document that R4 is in the Restorative Walking Program and is walked by staff using a walker and a gait belt. R4's medical record contained no assessment for the need of a restraining device.

The facility report titled "Fall Log" dated September 2014 through July 2015 documents that R4 has had 14 falls.

On 7/29/15 at 11:20 am E1, Administrator stated "We walk (R4) with a walker, (R4) is not safe to walk (alone). The tray was put on to prevent (R4) from getting out of the chair and falling." E1 acknowledged that there was no assessment, no

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F 221	Continued From page 2 consent, no identification of medical symptoms or diagnosis for the use of the restraint. On 7/30/15 at 9:45 am E2, Director of Nursing stated that E2 had spoken to E3, Licensed Practical Nurse about the order E3 had wrote on the Physician Order Sheet (POS) for a tray table. E2 stated "(E3) did not get a (physician's order) for the tray table. (E3) just wrote it on the (POS). E2 stated that R4 can rise from the wheelchair if there is no tray table. E2 stated that R4 can not remove the current tray table. E2 stated "we put one on that (R4) can't get off, because (R4) has broken several others." On 7/30/15 at 11:35 am, E7, Care Plan Coordinator and Restorative Nurse acknowledged that the Care Plan for R4 did not document the use of a restraint. E7 stated "I knew that was going to be a problem when I saw that." E7 stated that the tray table restraint was used on R4 because of all the falls. E7 stated "(R4) has destroyed several trays and gotten up from the chair and fallen. R4 is able to get out of the chair, but is not safe." On 7/30/15 at 2:30 pm R4 was asked to remove the tray from the geriatric chair and was not able to do as requested by E2, Director of Nursing.	F 221		
F 280 SS=D	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.	F 280		

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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 observation, interview and record review, the facility failed to document in the Care Plan the use of an anti-psychotic medication on one (R4) of ten residents reviewed for Care Plans in the sample of 10.

Findings include:

The facility policy titled "Psychotropic Medication Policy" dated 12/30/13, documents the following: " Any resident receiving any psychotropic medication will have certain aspects of their use and potential side effects addressed in the resident's Care Plan at least quarterly. The Care Plan will identify target behaviors causing the use of psycotropic medications. The Care Plan will address the problem, approaches and goals to address these behaviors...Attempts to rule out social and environmental factors as causative agents will be made in the Care Plan Assessment.

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F 280	Continued From page 4 The Physician Order Sheet (POS) dated July 2015 documents the following diagnoses for R4: Hemorrhagic Cerebral Vascular Accident (Left Side Effect) and Dementia. The same POS documents a current order for ABHR (Ativan 1.25 milligrams (mg), Benadryl 12.5 mg, Haldol 0.5 mg, Reglan 10 mg) to inner wrist every four hours. The May 2015 POS documents an order dated 5/11/15 for Haldol 1 mg Intramuscularly (IM) every 24 hours as needed. The Care Plan for R4 dated 5/21/15, does not document an update or revision to include anti-psychotic use. There is no staff guidance on the monitoring of potential side effects or the potential adverse events of Haldol. On 7/30/15 at 11:35 am, E7, Care Plan Coordinator acknowledged that the Care Plan for R4 did not document the use of an anti-psychotic. E7 stated "I knew that was going to be a problem when I saw that."	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	F 323		

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F 323	Continued From page 5 by: Based on observation and interview the facility failed to maintain a safe water temperature in two sinks in one shower room on one of two resident corridors. This failure has the potential to affect one independently mobile resident (R2) on a sample of nine reviewed for safety and nine independently mobile residents (R15, R18, R26, R27, R28, R29, R34, R35, and R36) on the supplemental sample. Findings include: On 7/29/15 at 10:52 AM the water temperature in both hand sinks in the second shower room on the South Hall was 119 degrees Fahrenheit. On 7/29/15 at 11:40 AM E6 stated, "It (water temperature) should not be that hot." On 7/29/15 at 12:15 PM E6 stated, "I rechecked the temperature in the sinks with my digital thermometer and I got 117 degrees Fahrenheit, it's still too hot." The facility's undated list of residents who were Independently Mobile With Wheelchair (W/C), Walker and Ambulatory documents ten residents (R2, R15, R18, R26, R27, R28, R29, R34, R35, and R36) who had the ability to use the sinks unattended by staff.	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	F 329		

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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 facility failed to justify and assess for the use of an anti-psychotic medication in one (R4) of five residents reviewed for psychoactive medications in the sample of 10.

Findings include:

The facility policy titled "Psychotropic Medication Policy" dated 12/30/13, documents the following: "It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drug is any drug used without adequate monitoring, Without indications for its use. Attempt to rule out social and environmental

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factors as causative agents of the maladapted behavior. Initiate a Pre-Psychotropic Medication Assessment. Psychotropic medications shall not be prescribed prior to attempted non-pharmacological interventions to decrease behavior. Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative

The Physician Order Sheet (POS) dated July 2015 documents the following diagnoses for R4: Hemorrhagic Cerebral Vascular Accident, and Dementia. R4's POS's dated from October 2014 through July 2015 documents an ongoing order for ABHR cream (Ativan 1.25 milligrams (mg), Benadryl 12.5 mg, Haldol 0.5 mg and Reglan 10 mg), apply to inner wrist every four hours around the clock. The POS's are signed by Z1, Primary Care Physician.

The Medication Administration Records dated from October 2014 through July 22, 2015 document that R4 received the ABHR cream per the physician order.

R4's Medical Record Record does not document an initial assessment or quarterly assessments identifying indicators for the use of Haldol (anti-psychotic). There is no documented consent for the use of an anti-psychotic in R4's Medical Record. R4's Care Plan dated May 2015 does not document the use or identify behavior indicators for the need of an anti-psychotic.

On 7/29/15 at 11:20 am, E1, Administrator acknowledged that there was no assessment or diagnosis for the use of the anti-psychotic Haldol,

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F 329	Continued From page 8 for R4. E1 stated "I don't have an argument for it." On 7/30/15 at 11:35 am, E7, Care Plan Coordinator and R4's Previous Hospice Nurse stated "the Haldol was started about two months after (R4) was started on Hospice on 5/23/14. (R4) was recently taken off Hospice on 7/9/15." E7 stated R4 was given the cream because of his behaviors. E7 stated "(R4) refused to take (R4's) medications and could be combative with the staff. (R4) did not have nausea and vomiting."	F 329		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide at least 80 square feet of floor space per resident bed in 26 of 26 multiple resident rooms on 2 of 2 resident living corridors. This failure affects nine residents (R2, R4, R5, R6, R10, R11, R12, R13, and R14) reviewed for room size on the sample of ten residents, and twenty-five residents (R1, R3, R8, R9, R15 through 18, and R20 through R36) on the supplemental sample. Findings include: Historical room size documentation and actual measurements demonstrate that the double occupancy resident bedrooms do not meet the minimum required square footage of 80 square	F 458		

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F 458	Continued From page 9 feet per resident bed: Room 1 and 2 measure 77.9 square feet per bed. Rooms 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 16 (currently being used for Physical Therapy), 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 28 measure 74.3 square feet per bed. Room 27 measures 68.5 square feet per bed. Room 30 measures 77.5 square feet per bed (currently being used as the office for the Director of Nursing). The occupied resident bedrooms are equipped with the minimum required furnishings including bed, bedside table, comfortable chair and dressers. No infection control issues were identified. Residents are informed of the undersized rooms as part of the admission process and assessments of the undersized rooms are conducted during the quarterly resident care plan review to meet the resident needs. The Medicare/Medicaid Certification and Transmittal effective 9/15/14 documents all resident rooms are certified for Title 19 (Medicaid). The facility's Daily Roster dated 7/29/15 document R1 through R6, R8 through R18, and R20 through R36 reside in the undersized rooms.	F 458		