STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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 000	INITIAL COMMENTS FOSS Survey Annual Licensure and Certification Survey Licensure Complaint follow-up to survey of 5/8/12 Complaint # 1271621/IL57699 300.1210 b 300.1220b)3) 300.3240a)	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		

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

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F 225	Continued From page 1 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse and failed to report allegations of abuse within the specified time frames. The facility also failed to ensure facility staff reported allegations of abuse in a timely manner. The facility also failed to ensure their investigation was complete prior to submitting their conclusion to the state agency. These failures apply to three (R21, R41 and R42) out of three facility abuse investigations. Findings include: The facility investigation file regarding allegation of abuse dated 10/21/12 reflects that during this investigation, on 10/29/12, E2 (Director of Nursing) received a write-up in her mailbox reporting a CNA for refusing to assist R21 to the washroom. This was reported by the nurse who worked the evening shift the night before. The investigation file does not contain an interview	F 225		

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F 225	Continued From page 2	F 225		

with R21. This investigation file does not contain any evidence this allegation was reported to the state agency. On 5/31/13, E1 (Administrator) stated they could not find any evidence to reflect this allegation had been reported.

On 5/31/13 at 9:30 am, E2 stated their staff have been instructed to report abuse or suspicions of abuse right away. If they are working an off-shift, there is always an on-call person they can call to report these issues to. E2 said she did not get a telephone call regarding this allegation. She stated she realized that staff had not reported several allegations right away, despite being trained to do so.

The facility investigation file of abuse allegation dated 11/20/12 says on the morning of 11/21/13, E2 received a message from a nurse describing instances of possible abuse she had witnessed between a CNA (certified nursing assistant) and R41 and R42 the prior evening. This was not reported by the nurse at the time of the occurrence, but instead she left a message for E2 to receive the next day. This allegation involved a CNA handling a resident roughly and verbally threatening a resident and another instance of not assisting a resident to the washroom when requested. This investigation does include some resident interviews, but they are not identified clearly in the report. Additionally, the final report, dated 11/27/12, indicates in the conclusion E2 was going to pursue termination of the 2 CNAs involved. However, on 5/31/13 at 9:30 am, E2 stated they had determined the real problem was with one of the CNAs and she was terminated. The second employee was suspended, then retrained and put

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F 225	Continued From page 3 on a performance improvement plan. This was confirmed by review of the two personnel files. However, this differs from the conclusion in the final report. The facility investigation file for R18 with an incident date of 4/15/13 documents an investigation of resident abuse towards staff. The IDPH notification reflects an incident date of 4/15/13 and a preliminary reporting date of 4/17/13. A copy of a fax transmittal addressed to IDPH also reflects an initial notification date of 4/17/13. A fax transmittal sheet provided by E2 on 6/4/13 reflects a final notification date of 5/10/13. The final report notification also provided by E2 on 6/4/13 also reflects a final report date of 5/10/13. Both notification dates are outside of the time frames for reporting	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy on abuse regarding timely reporting to the state agency regarding allegations of abuse, timely reporting of suspicion of abuse by staff to Administration and failed to incorporate the Elder Justice Act into the facility abuse protocol. These failures involve three (R18, R41 and R42)out of	F 226		

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F 226	Continued From page 4 three abuse investigations. Findings include: E1 (Administrator) said on 5/30/13 at 1:30 pm, he was not familiar with the Elder Justice Act and it had not yet been incorporated into the facility's abuse policy. He also stated he was not familiar with the reporting times designated in the act, but assumed crimes would need to be reported right away. During the initial tour on 5/28/13 and environmental tour conducted 5/29/13-5/31/13, there were no postings regarding the Elder Justice Act until 5/31/13, after making E1 and E2 (Director of Nursing) aware of the requirements of the act. A review of facility policy entitled "Abuse and Neglect" reflects definitions of the different types of abuse and describes the facility's process for the seven components to abuse prohibition, including screening, training, prevention, identification, investigation protection of residents and reporting. There is no mention of the Elder Justice Act. Also, there is no mention of the facility's procedure and responsibility for reporting crime, including reporting time frames. The facility policy on abuse , under the section entitled reporting, states, "...Initial Report-a report of abuse must be reported to the Illinois Department of Public Health. As soon as it has been determined there is reasonable cause to suspect misappropriation, the Illinois Department of Public Health will be notified. A written report will be faxed containing the resident's name, age,	F 226		

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F 226	Continued From page 5 diagnosis, mental status and the type of incident being reported. ...The initial report will also address the steps the facility has taken to protect the resident from further harm...Final Investigative Report-Within 5 working days, the results of all investigations must be reported to the Administrator, IDPH, and to any other appropriate public authority". The facility investigation file regarding an allegation of abuse against a resident (R18) from 4/15/13 indicates initial notification to the state agency on 4/17/13. A fax transmittal provided by E2 on 6/4/13 indicates a final notification to the state agency on 5/10/13. The final report of incident provided by E2 on 6/4/13 also indicates a date of 5/10/13. During follow-up interview with E2 on 5/31/13 at 9:30 am, E2 stated staff have been trained to report abuse or suspicions of abuse immediately. If there are any abuse concerns on off-shifts, staff are to call the on-call person to report these issues. E2 stated she realized in several instances, staff were not reporting right away, which they have been trained to do. She stated that staff get trained in abuse prohibition at orientation and yearly. Abuse investigation file with incident date of 11/20/12 indicates E2 received a message from a staff person wanting to discuss instances of possible abuse she had witnessed the evening prior. She described questionable staff interactions with R41 and R42. This was not reported by staff immediately, but left on a message to E2 to get the next day.	F 226		

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F 226	Continued From page 6 The facility investigation file with an incident date of 10/21/13 contains a report by E2 indicating on the morning of 10/29/13, while investigating an allegation of abuse for R20, she found a write-up in her mailbox reporting a CNA for not assisting a resident with toileting, from the prior evening. This was reported by a nurse by leaving a note for E2 to receive the next day, rather than it being reported at the time.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide an appropriately fitting air mattress for one resident (R7) and a plate guard for assistance in eating for one resident (R8). This is for two residents in the sample of 16 (R7 and R8). The findings include: On 5/28/13 at 10:15 a.m. R7's bed was observed. R7's bed was a bariatric bed which had multiple lumpy areas noted. Upon closer examination of R7's bed beneath the linens it was noted R7 had an old vinyl type air mattress.	F 246		

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F 246	Continued From page 7 This was an inflatable air mattress with many pocketed air sections. The air mattress was the size of a twin size bed, which did not fit R7's bariatric bed. The air mattress only fit the middle of R7's bed. If R7 turned to the right or left side while in bed she would not be laying on the air mattress. On 5/29/13 at 11:30 a.m. E17 (CNA) showed how the air mattress was applied to R7's bed. E17 said at this time this air mattress was placed on R7's bed to help protect her skin. E17 also stated this was the only type of air mattress provided for R7. E17 said the air mattress only fits the middle of the bed and the air mattress was not wide enough to fit the entire mattress on R7's bed. According to the medical record R8 is a 91 year old male with diagnoses including COPD, (chronic obstructive pulmonary disease), Hypertension, Coronary Artery Disease and Gout. R8 is on a regular consistency diet with no chewing difficulty. Dietary documentation of 04/11/13 completed by Z1 (registered dietician) notes R8 shows a significant weight loss with a 9 lb loss over the past month, from 147lbs in March, 2013 to 138lbs in April, 2013. Z8 further notes R8 has had an overall decline per staff and is having difficulty feeding himself. He is feeding better with a plate guard which has been provided but still needs minimal assistance by staff at times. Z1 recommends the addition of a house supplement 120 ml twice each day to help prevent further weight loss. On 05/10/13 Z8 documents R8 is taking his supplement well, has a plate guard and adaptive cup. R8 was observed in the dining room at lunch time	F 246		

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F 246	Continued From page 8 between 12pm and 1pm on 05/30/13 and 05/31/13. On 05/30/13 R8 did not have a plate guard in place and was not observed receiving assistance to eat. On 05/31/13 R8 was observed being assisted by staff with his meal. His plate guard was not in place but was put on the plate after staff were asked about it.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure beds were maintained in good working order. This deficient practice affected one resident 1(R2) of 16 residents in the sample and two residents in the supplemental sample (R19 and R44). Findings include; During the tour on 5/28/13 R2, R19 and R44's beds squeaked very loudly when they were raised. R19 said, "Every bed squeaks. It is very annoying."	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 9 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure assessments for four residents (R13, R1, R3, R5) in a sample of 16	F 272		

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F 272	Continued From page 10 were comprehensive, specific, accurate and individualized to address resident's care needs. Findings include: R13's May POS (physician order sheet) shows R13 is 85 years old with diagnosis including Multiple myeloma, Huntington's Chorea and arthritis. Review of R13's MAR (medication administration record) shows R13 is administered Oxycontin every 12 hours and Vicodin every 6-8 hours. Review of R13's plan of care dated 2/14/13 for pain states R13 has a potential for pain and discomfort related to arthritis and multiple myeloma. The goal is to maintain acceptable level of comfort (as expressed by R13) through next review. The interventions listed are generic approaches, they are not specific or individualized for R13's pain issues. 2. R1's pressure sore to the coccyx was observed on 5/29/13 at 8:45am along with E5 (wound nurse) and found R1 to be alert and oriented. The wound was observed to have a pink wound bed and measured 1 x .5 x .6 cm. Review of the care plan for R1's skin integrity dated 5/4/13 is not specific or individualized. It does not address prevention, the care and treatment of the existing pressure sore nor does it list the specific interventions including individualized risk factors and interventions to prevent further skin breakdown 3. According to the medical record R3 is an 87 year old female with diagnoses including Alzheimer's Dementia with Behavioral Disturbance, Depression and Delusions. R3's current POS (physician ' s order sheet) includes an order for the antipsychotic medication Risperdal 0.5 mg. (milligrams) by mouth 2 times per day.	F 272		

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F 272	Continued From page 11 R3's most current MDS full assessment (minimum data set) was completed on 05/06/13. In Section E (behaviors)R3 does not trigger for hallucinations, delusions, delirium or any other behaviors. However, Section V (Care Area Assessment-CAA Summary) is not reflective of the assessment in Section E (behaviors). R3 is listed as having Delirium and receiving psychotropic drugs. The Indication for the use of psychotropic medication lists " antipsychotic medications for anxiety and depression " . 4) According to the medical record R5 is an 80 year old female with diagnoses including Depression and Alzheimer's Disease. R5's current physician's order sheet (POS) for the month of May 2013 lists the following psychoactive medications: Seroquel 25 mg bid (2 times per day), Effexor 150mg daily and Ativan 1 mg every 4 hours prn (as needed). According to the MDS (Minimum Data Set) dated 04/13/13 Section C, R5 scored 13 on the BIMS (Brief Interview for Mental Status) making her cognitively intact. In Section D- Mood R5 has no mood symptoms triggered. In Section E- Behavior R3 is not triggered for hallucinations or delusions. In Section I- Active Diagnoses R5 triggers for Depression and Alzheimer ' s Disease. However, in Section V (CAA) R5 is triggered for psychotropic drug use with a care plan. CAA (care area assessment) documentation explains R5 takes psychotropic medication for Psychosis, Depression and Alzheimer's; none of which were triggered in her initial MDS assessment.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 12 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure one resident was accurately assessed on the MDS (minimum data set) in the area of cognition (R12), failed to ensure one resident was accurately assessed in the area of pain (R13), and failed to accurately assess one resident in the area of psychotropics	F 278		

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F 278	Continued From page 13	F 278		

(R9). This applies to three residents out of a sample of 16.

Findings include:

R9's April and May 2013 medication administration record (MAR) indicated Seroquel 25 mg twice a day and Haloperidal 2 mg. three times a day were signed off as given.

R9's Minimum Data Set (MDS) section N Medication Antipsychotic was marked zero indicating R9 received no antipsychotic medications in the last 7 days. R9 has been receiving Seroquel and Haloperidal every day.

E1 said, "I will check with the MDS people to see why it wasn't checked.

Observation of R12 on 5/30/13 at 11:20 a.m. noted R12 to be up in her wheel chair in the A 200 Wing hallway.

At this time R12 was asked about her frequent falls at the facility. R12 was noted to be alert but very confused at times. R12 was talkative with lucid thoughts expressed infrequently. R12 was voicing a flight of ideas and was not able to remain on the subject matter.

Interview with E18 (RN) on 5/30/13 at 11:40 a.m. noted E18 to say, "R12 is very confused. She has been very confused since she was admitted to the skilled care area."

Review of R12's admission face sheet showed R12 had been admitted to the facility on 3/20/13. R12's 14 day MDS (minimum data set) was

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F 278	Continued From page 14 dated 4/1/13. R12's scoring for cognition on the MDS was scored at 14, meaning R12 had no cognitive impairment. Interview with E2 (Director of Nurses) on 5/30/13 at 3:45 p.m. noted E2 to say R12 has been confused since admitted to the skilled unit on 3/20/13. E2 also verified the information documented for cognition on R12's 14 day MDS was wrong. E2 stated and provided on 5/30/13 at 2:10pm the only pain assessment to date for R13 was the one included in the admitting nursing assessment dated 2/14/13. It is not comprehensive and there has not been a comprehensive pain assessment performed that includes an analysis of factors such as underlying causes, location and radiation of pain, frequency, timing and duration of pain, and factors that may precipitate and alleviate the pain. Review of R13's plan of care dated 2/14/13 for pain states R13 has a potential for pain and discomfort related to arthritis and multiple myeloma. The goal is to maintain acceptable level of comfort (as expressed by R13) through next review. The interventions listed are generic approaches, they are not specific or individualized for R13's pain issues.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to develop comprehensive, realistic, individualized and specific plans of care in the areas of falls, behavior tracking/monitoring, and pain.

This is for five residents in the sample of 16 (R12, R13, R3, R5, R1).

The findings include:

Review of R12's admission face sheet showed R12 was admitted to the facility on 3/20/13 with diagnoses including Weakness, Anxiety, and Depressive Disorder.

Observation of R12 on 5/30/13 at 11:20 a.m. showed R12 to be very confused and voicing a flight of ideas. R12 at this time was noted not being able to remain on subject matter. Review of nursing documentation from 3/20/13 to 4/30/13

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showed frequent documentation R12 was confused.

A review of facility incident reports for R12 showed R12 had 9 fall incidents from 3/31 to 4/27/13. The circumstances surrounding R12's falls included attempting to self transfer, rolling out of bed, attempting to go to bathroom etc... As noted above, R12 is very confused.

A review of R12's fall care plan dated 4/5/13 showed the plan of care included unrealistic interventions. One intervention included, "Have call light in reach at all times." Another intervention included, "Encourage sturdy shoes with non-skid soles." As mentioned above, R12 is a very confused resident and would not understand how to use the call light even if it was within reach. A review of R12's nine fall incidents showed R12 did not use the call light when these incidents happened.

In addition, R12 probably would not understand the encouraging of use of sturdy shoes with non-skid soles due to her impaired cognitive level.
R13's May POS (physician order sheet) shows R13 is 85 years old with diagnosis including Multiple myeloma, Huntington's Chorea and arthritis. A review of R13's MAR (medication administration record) shows R13 is administered Oxycontin every 12 hours and Vicodin every 6-8 hours.
Review of R13's plan of care dated 2/14/13 for pain states R13 has a potential for pain and discomfort related to arthritis and multiple myeloma. The goal is to maintain acceptable level of comfort (as expressed by R13) through

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next review. The interventions listed are generic approaches. They are not specific or individualized for R13's pain issues.
2. R1's pressure sore to the coccyx was observed on 5/29/13 at 8:45am along with E5 (wound nurse) found R1 to be alert and oriented. The wound was observed to have a pink wound bed and measured 1 x .5 x .6 cm.
A review of the care plan for R1's skin integrity dated 5/4/13 is not specific or individualized. It does not address prevention, the care and treatment of the existing pressure sore nor does it list the specific interventions including individualized risk factors and interventions to prevent further skin breakdown
According to the medical record R3 is an 87 year old female with diagnoses including Alzheimer's Dementia with Behavioral Disturbance, Depression and Delusions.
R3's most current MDS full assessment (minimum data set) was completed on 05/06/13. In Section I (active diagnoses) R3 triggers for Depression, Alzheimer's Disease and Non-Alzheimer's Dementia. In Section V (Care Area Assessment-CAA Summary) R3 is listed as having Delirium and receiving psychotropic drugs. The Indication for the use of psychotropic medication lists " antipsychotic medications for anxiety and depression " .
R3's current POS (physician's order sheet) includes an order for the antipsychotic medication Risperdal 0.5 mg. (milligrams) by mouth 2 times per day. Progress notes completed by Z2, APN (Advanced Practice Nurse on 08/16/12 describe R3 has been at her baseline behavior, is calm and cooperative, with less complaining about the " growth " in her skin. She is eating and sleeping well. Z2's note

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further explains R3's diagnoses are Alzheimer's disease, Dementia with Behavioral Disturbance, Alzheimer's with late onset, with Depressed Mood and Delusions. Z2 lists R3 ' s medications as klonopin for anxiety, Risperdal for psychosis and Celexa for depression. R3's current care plan dated 05/21/13 notes her current problems as anxiety/depression, hallucinations and or delusions, agitation and other behaviors. Her goal is to display less than one episode per week of these problems through the next review. However the psychotropic medications are not listed and the targeted behaviors for each medication are not identified. Behavioral tracking sheets for the months of March and April 2013 do not distinguish between the psychoactive medications or describe the specific targeted behaviors for each medication. There is also no recommendation or written plan in the care plan for a gradual medication reduction.

According to the medical record R5 is an 80 year old female with diagnoses including Depression and Alzheimer's Disease. R5's current physician's order sheet (POS) for the month of May 2013 lists the following psychoactive medications: Seroquel 25 mg bid (2 times per day), Effexor 150mg daily and Ativan 1 mg every 4 hours prn (as needed). According to the MDS (Minimum Data Set) dated 04/13/13 Section C, R5 scored 13 on the BIMS (Brief Interview for Mental Status) making her cognitively intact.

In Section V (CAA) R5 is triggered for psychotropic drug use with a care plan. CAA documentation explains R5 takes psychotropic medication for Psychosis, Depression and Alzheimer's. R5's care plan for psychotropic medications lists anxiety, depression, agitation and behaviors as her problems. Her goal is to

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F 279	Continued From page 19 have no side effects from the use of psychotropics and to receive the benefit of her medications. However, R5's medications are not listed on the care plan, no target behaviors are listed for each medication and there is no specific plan for the reduction or possible elimination of these medications. Under interventions the care plan only states to monitor signs and symptoms of possible side effects from psychotropic medications.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one resident received a topical pain patch per product directions/recommendations (R19) and failed to ensure the dosage was labeled on a narcotic pain medication before administration to one resident (R20). This is for two residents in the supplemental sample (R19 and R20). The findings include: 1. On 5/29/13 at 7:50 a.m. during the morning medication administration observation E7 (RN) was observed putting topical pain relieving patches on R19. E17 placed two topical patches	F 282		

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side by side on R19's right knee and two topical patches on R19's right upper back/shoulder area. Observation of the boxed container of the topical patches showed no directions for use.

At this time, E7 to said, "We put these pain patches on R19 everyday and we change them as needed. She wears them all day and night. She can have up to 10 per day. We use four at a time. Two to her right knee and two to her right shoulder."

During reconciliation of R19's medications an order was noted dated 4/29/13 for the topical medication patches with the order noting R19 could have up to 10 patches per day.

When reading requested product information the directions included:

1. Apply to affected area not more than 3 to 4 times daily for 7 days. (As noted above, R19 had been receiving these topical pain patches since 4/29/13).

2. Remove patch from the skin after at most 8 hours application.

The product information also included:

1. Do not use otherwise than directed.

2. The risk of heart attack or stroke may increase if you use more than directed or longer than directed.

Review of R19's medical diagnoses included Hypertension and Atrial Fibrillation.

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F 282	Continued From page 21 During medication pass observed on 5/29/13 at 6:45am, E16 (nurse) was observed to be preparing medications to be dispensed from bubble cards for R20. The bubble card containing R20's hydrocodone did not display the dosage of the medication. E16 confirmed the same in addition to agreeing multiple dosages had been previously administered to R20 from this medication card. E16 stated as a nurse, the dosage of every medication should be apparent along with the other pertinent information prior to the administration of any medication to a resident. E16 stated she would have to call pharmacy to verify that the dosage of the medication was the correct amount ordered prior to administering it to R20. R20 ' s physician order sheet dated for the month of May 2013 showed an order reading Hydrocodone-APAP 5-325 1 tablet by mouth twice daily. E16 called pharmacy with the numbers stamped on the pills and verified it was the correct dosage as ordered by the physician.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to perform a	F 309		

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F 309	Continued From page 22 comprehensive pain management regimen specific to one (R13) of six residents reviewed for pain in the sample of 16. Findings include: Review of POS (physician order sheet) dated 5/17/13 shows R13 has an order for Oxycontin 20 mg by mouth every 12 hours. Review of R13's MAR (medication administration record) shows R13 is administered the medication as prescribed. R13 also has an order for Hydrocodone/APAP 10/500 every 6 to 8 hours as needed. The MAR shows R13 was administered this medication 13 times during May 2013. R13's May POS (physician order sheet) shows R13 is 85 years old with diagnosis including Multiple myeloma, Huntington's Chorea and arthritis. R13 was observed to be lying on her bed on 5/30/13 at 2:30pm, alert and oriented. R13 stated she has bone cancer and it has spread to most of her body. R13 said it is also in her spine, which is what causes her back pain, mostly during the day when she is up and about. But R13 also said she usually gets up with a back ache. When asked more specific questions about her pain, R13 stated she does not like to complain or think too much about it. R13 was asked why she continuously flexes her hips down into the bed and R13 replied that it makes her back pain feel a little better. When asked if the facility provides any non-pharmalogical pain relief, R13 stated no. E2 stated and provided on 5/30/13 at 2:10pm the only pain assessment to date was the one included in the admitting nursing assessment dated 2/14/13. It is not comprehensive and there has not been a comprehensive pain assessment performed that includes an analysis of factors such as underlying causes, location and radiation	F 309		

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F 309	Continued From page 23 of pain, frequency, timing and duration of pain, and factors that may precipitate and alleviate the pain. Review of R13's plan of care dated 2/14/13 for pain states R13 has a potential for pain and discomfort related to arthritis and multiple myeloma. The goal is to maintain acceptable level of comfort (as expressed by R13) through next review. The interventions listed are generic approaches, they are not specific or individualized for R13 ' s pain issues.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to identify when one resident's (R1) pressure ulcer was first observed. Once identified, the facility failed to comprehensively assess the wound and develop individualized approaches specific to R1's risk factors and needs. This is for one of three residents reviewed for acquired pressure sores in the sample of 16. Findings include: R1's admitting MDS (minimum data set) dated	F 314		

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F 314	Continued From page 24 5/4/13 shows R1 had a stage II pressure sore upon admission of 4/29/13. The CAA (care area assessment) dated 5/6/13 states " ...(R1) has a present stage II to her bottom she received in the hospital ...will proceed to care plan. " This information is inconsistent and contradictory with the facility's Weekly Pressure Ulcer Report dated 5/6/13 - 5/13/13. It shows R1 was identified with a stage II pressure sore to the coccyx on 5/9/13, measuring 1.4 x .2 x .2 cm with macerated edges. The physician order sheet (POS) dated 5/7/13 shows the first treatment order for this wound was obtained on 5/9/13, making it unclear if there was a delay in treatment of this wound (if it was identified at the time of admission on 4/29/13 as shown on the MDS and CAA) or if the wound developed in the facility as stated on the wound report. The admitting nursing note of 4/29/13 also indicates that the wound was not present on admission: " other than a small bruise to the right knee, the rest of R1's skin is dry and intact. " Observation of R1's pressure sore to the coccyx performed on 5/29/13 at 8:45am along with E5 (wound nurse) found R1 to be alert and oriented. The wound was observed to have a pink wound bed and measured 1 x .5 x .6 cm. E5 was asked for the comprehensive assessment of the wound (including contributing risk factors and which risk factors can be removed or modified) and stated one had not been done. A review of the care plan for R1's skin integrity was not specific or individualized to R1 ' s specific needs. E5 stated she assessed the wound for the first time on 5/13/13 and at that time obtained an order to change the original treatment order from 5/9/13. E5 also stated she did not have an opportunity to document on the wound because	F 314		

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F 314	Continued From page 25 there was no computer available at the time but the facility has since ordered a computer dedicated to the wound program. E5 confirmed it is unclear if R1 was admitted with this wound on 4/29/13 or if it was first observed by staff on 5/9/13.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one resident had a medical reason for an indwelling catheter (R2), failed to ensure a bladder training program was developed and initiated when the catheter of one resident was removed (R2) and failed to ensure catheter care was performed correctly on two residents to prevent possible urinary tract infections (R2 and R17). This is for one resident reviewed for catheters inside the sample of 16 (R2) and one resident in the supplemental sample (R17). The findings include:	F 315		

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1. On 5/28/13 at 2:30 p.m. R2 was observed sitting up in her wheel chair in her room. R2 was noted with a strong urine odor.

R2 at this time said she has an indwelling catheter and has had the catheter for approximately two yrs. R2 stated when she is up out of bed she wears a leg bag. When R2 was asked why she had an indwelling urinary catheter she was not quite sure why she had the catheter. R2 stated, "They took it out one time but I share a bathroom with another lady who is in the bathroom all of the time. I couldn't get to the bathroom and I had accidents so they put the catheter back in. I wish it was out. I didn't ask them to put it back in but they did. They did give me a bedside commode to use when the catheter was out but I didn't use it. People were coming in the room all of the time and that is not private. I want to use the bathroom in private."

Review of physician's progress notes dated 4/19/12 showed documentation R2 has stage II chronic kidney disease and "chronic Foley catheter due to retention". No other medical diagnosis was noted for use of the indwelling catheter.

Review of a facility Indwelling Urinary Catheter Screening Tool done for R2 showed the tool has scarce documentation and limited information. This assessment tool only showed R2 had an indwelling urinary catheter, had a physician's order and R2 had stage III chronic kidney disease and stress incontinence. No further medical reason was given for the indwelling catheter. Further review of R2's physician's

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orders showed there was an order to discontinue R2's indwelling catheter on 10/29/12.

Nursing documentation on 10/30/12 showed R2's indwelling catheter was removed on 10/30/12. Further review of nursing documentation from 10/30/12 to 11/19/12 showed R2 was frequently incontinent of urine.

During interview with E2 (Director of Nurses) on 5/30/13 at 4:00 p.m. E2 was asked if a bladder retraining program was developed and initiated for R2 when R2's indwelling catheter was removed. E2 stated no retraining bladder program and/or toileting program was developed or initiated for R2. E2 stated there was no restorative nurse at the facility at that time and no bladder retraining program and/or toileting program was initiated for R2.

Review of a facility Urinary Incontinence Assessment for R2 dated 11/12/12 showed summary with comments, "Appropriate for bladder training program however, indwelling catheter reinserted 11/19/12."

2. On 5/29/13 at 8:30 a.m. E10 (CNA) was observed performing catheter care on R2 with standby assistance of E11 (CNA). E10 grabbed a moist disposable wipe and wiped R2's right and left groin area, wiping up and down to both sites. E10 then wiped downward on the catheter tubing. Next, E10 wiped up and down on the catheter tubing with an alcohol wipe. E10 never opened up the labia to clean the labia area or the urethral entry site of the indwelling catheter.

E10 also explained R2 wears a leg bag when

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she's up in the wheel chair. E10 proceeded to remove R2's urinary drainage bag and attach a leg bag to the indwelling catheter. E10 explained R2's drainage bag is changed one time a week and the leg bag is changed every two to three days. E11 stated and demonstrated how the drainage bag and leg bag are rinsed out at the sink in R2's room, emptied in the bathroom toilet, put in a plastic bag and tied to a hand rail in the bathroom.

Observation of the drainage bag and leg bag showed they were not dated to identify date when last changed. Further observation and interview noted E10 and E11 to say the drainage bag/leg bag connection sites are not capped when stored in the plastic bags.

Review of R2's lab work showed R2 has a history of urinary tract infections.

3. On 5/30/13 at 1:35 p.m. E12 (CNA) was observed performing catheter care on R17. E12 sprayed R17's perineal area with peri wash. E12 grabbed a moist wipe and wiped upward on R17's perineal area. E12 grabbed a second moist wipe, wiped upward on the perineal area, then wiped downward on the catheter tubing with the same wipe. R17's urinary meatus was never exposed and the entry site to the catheter was not cleaned.

Interview with E12 at this time noted E12 to say she had not been inserviced on catheter care in over a year. Review of the facility's nursing inservices on catheter care verified E12's statement.

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F 315	Continued From page 29 Further interview with E12 noted E12 to also state R17's drainage bags and leg bags are rinsed every day at the sink, stored in a plastic bag, and tied to a hand rail in the resident's bathroom. On 5/31/13 at 11:30 a.m. R17's urinary drainage bag was observed hanging in a plastic bag tied to a hand rail in R17's bathroom. The tubing was not capped at the connection site and the bag was not dated. E2 (Director of Nurses) on 5/30/13 at 4:00 p.m. said,"They (CNA's) should really change out the catheter bags every day." Information presented from the facility on "Care of Patients with Long-Term Indwelling Urinary Catheters" showed: "Daily bag decontamination with a diluted (1:10) bleach solution has been found effective in reducing bacterial colony forming units...). As noted above, the drainage bags and leg bags are only rinsed with water.	F 315		
F 323 SS=G	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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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 was sent to a nearby hospital where she was admitted for 24 hour observation and diagnosed with a forehead contusion.

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F 323	Continued From page 31 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 analyzed in an attempt to identify patterns/trends to possibly prevent further falls.	F 323		

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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 low blood glucose levels in the early mornings. Review of R10's medical record showed no

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F 323	Continued From page 33 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.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure timely interventions were implemented for one (R8) of three residents reviewed for weight loss in the sample of 16. As a result, R8 sustained a significant weight loss of approximately 10% over a six month period. Findings include:	F 325		

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F 325	Continued From page 34 According to the medical record R8 is a 91 year old male with diagnoses including COPD, Hypertension, Coronary Artery Disease and Gout. R8 is on a regular consistency diet with no chewing difficulty. R8's weight record indicates in November of 2012 he weighed 155 lbs. Over the next six months he sustained a continual unplanned weight loss. His most recent recorded weight in May of 2013 is 133 lbs. This is a 22 pound weight loss, greater than 10 percent in 6 months. Dietary documentation of 04/11/13 completed by Z1 (registered dietician) notes R8 shows a significant weight loss with a 9 lb loss over the past month, from 147lbs in March, 2013 to 138lbs in April, 2013. Z8 further notes R8 has had an overall decline per staff and is having difficulty feeding himself. He is eating better with a plate guard which has been provided but still needs minimal assistance by staff at times. Z1 recommends the addition of a house supplement 120 ml twice each day to help prevent further weight loss. On 05/10/13 Z8 documents that R8 is taking his supplement well, has a plate guard and adaptive cup. Z1 further documents R8 has lost five more pounds with a current weight of 133 lbs for May, 2013. Z1 recommended R8's supplement to be increased from two times per day to four times per day. However, documentation in the record reflects Z1's recommendation was not acted upon until 05/21/13 (11 days later.) R8 was observed in the dining room at lunch time between 12pm and 1pm on 05/30/13 and 05/31/13. On 05/30/13 R8 did not have a plate guard in place and was not observed receiving assistance to eat. On 05/31/13 R8 was observed being assisted by staff with his meal. His plate guard was not in place but was put on the plate after staff were	F 325		

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F 325	Continued From page 35 asked about it.	F 325		
F 329 SS=E	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 observation, record review and interview the facility failed to identify target behaviors for the use of antipsychotic medications. The facility also failed to obtain a consent prior to the administration of an antipsychotic medication for one resident (R13).	F 329		

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The facility also failed to plan for a gradual dose reduction for three residents (R9, R3, R5). These deficient practices affected four (R9, R3, R5, R13) out of seven reviewed for psychotropic medications out of a sample of 16.

Findings include;

R9's admission record records R9 is a 96 year old female with multiple diagnoses including dementia, Alzheimer, delusions, anxiety and agitation.

R9's medication administration record (MAR) for April and May 2013 records R9 received the antipsychotic medications Seroquel 25 mg. twice a day and Haloperidol 2 mg. three times a day. The MAR records the Seroquel was ordered on 1/23/13 and the Haloperidol was ordered on 4/11/12.

During the survey from 5/28-31/13, R9 was calm with staff and did not exhibit any behaviors related to her anxiety and agitation. When interviewed on 5/28-31/13 R9 was quiet and not easily aroused. On 5/28/13, R9 was observed on the floor by the bed without injury or pain.

R9's Minimum Data Set (MDS) section E, E0200 is marked zero for behaviors and behaviors were not triggered for care planning. The assessment does not indicate R9's undesirable target behaviors. R9's Care Assessment Area (CAA) for use of psychotropic medications had no documentation to indicate target behaviors for the use of antipsychotic medications.

R9's 4/2/2013 care plan for psychotropic drug

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use for Haloperidol and Seroquel did not identify target behavior or least restrictive non-pharmalogical interventions. R9 did not have a detailed plan for reduction of each psychotropic medicine.

On 5/28/13 at 3:15, E20 said R9 has agitation, crying spells, unlocks her chair and bed alarms, wanders and resists care.

According to the medical record R3 is an 87 year old female with diagnoses including Alzheimer's Dementia with Behavioral Disturbance, Depression and Delusions.
R3 ' s most current MDS full assessment (minimum data set) was completed on 05/06/13. In Section C (cognitive patterns), R3's summary score for cognition is 14 out of a possible 15. (very minimal cognitive impairment.)
In Section E (behaviors)R3 does not trigger for hallucinations, delusions, delirium or any other behaviors.
In Section I (active diagnoses) R3 triggers for Depression, Alzheimer's Disease and Non-Alzheimer's Dementia. In Section V (Care Area Assessment-CAA Summary) R3 is listed as having Delirium and receiving psychotropic drugs. The Indication for the use of psychotropic medication lists " antipsychotic medications for anxiety and depression " .
R3's current POS (physician ' s order sheet) includes an order for the antipsychotic medication Risperdal 0.5 mg. (milligrams) by mouth two times per day. Progress notes completed by Z2, APN (Advanced Practice Nurse) on 08/16/12 describe R3 has been on her baseline behavior, she is calm and cooperative, less complaining about the " growth

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F 329	Continued From page 38 " in her skin. She is eating and sleeping well. Z2's note further explains R3's diagnoses are Alzheimer's disease, Dementia with Behavioral Disturbance, Alzheimer's with late onset, with Depressed Mood and Delusions. Z2 lists R3's medications as klonopin for anxiety, Risperdal for psychosis and Celexa for depression. Z2 recommends continuing the medications for stability with no reduction recommended. R3's current care plan dated 05/21/13 notes her current problems as anxiety/depression, hallucinations and or delusions, agitation and other behaviors. Her goal is to display less than one episode per week of these problems through the next review. However the psychotropic medications are not listed and the targeted behaviors for each medication are not identified. Behavioral tracking sheets for the months of March and April 2013 do not distinguish between the psychoactive medications or describe the specific targeted behaviors for each medication. There is also no written plan in the record for a gradual medication reduction. According to the medical record R5 is an 80 year old female with diagnoses including Depression and Alzheimer's Disease. R5 was observed on two different days. She was seated in her wheelchair, alert, calm and responded to her name with a smile. R5's current physician's order sheet (POS) for the month of May 2013 lists the following psychoactive medications: Seroquel 25 mg bid (2 times per day), Effexor 150mg daily and Ativan 1 mg every four hours prn (as needed). According to the MDS (Minimum Data Set) dated 04/13/13 Section C, R5 scored 13 on the BIMS (Brief Interview for Mental Status) making her cognitively intact. In Section D- Mood R5 has no mood symptoms triggered. In Section	F 329		

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E- Behavior R3 is not triggered for hallucinations or delusions. In Section I- Active Diagnoses R5 triggers for Depression and Alzheimer's Disease.
In Section V (CAA) R5 is triggered for psychotropic drug use with a care plan. CAA documentation explains that R5 takes psychotropic medication for Psychosis, Depression and Alzheimer's. R5's care plan for psychotropic medications lists anxiety, depression, agitation and behaviors as her problems. Her goal is to have no side effects from the use of psychotropics and to receive the benefit of her medications. However, R5's medications are not listed on the care plan, no target behaviors are listed for each medication and there is no specific plan for the reduction or possible elimination of these medications. Under interventions the care plan states to monitor for signs of increasing depression or anxiety, crying spells, total withdrawal from care and conversation. A progress note completed by Z2 on 10/13/12 describes R5 as being resistive to care, affect flat, minimally communicative and slow to respond. R5's diagnoses are listed as Alzheimer's Disease, Alzheimer's with late onset, with depressed mood and Dementia due to Alzheimer's with behavioral disturbance. Z2 also documents it is not possible to determine if underlying psychotic symptoms are present. However, Z2 recommends R5 be started on Seroquel 25 mg at bedtime for Agitation/psychosis and to continue with Effexor XR 150mg daily for depression.
R5 was seen again by Z2 one month later on 11/11/12. Z2's notes describe R5 as getting more resistive to care these past few days, refusing to go to the toilet and change her diaper (according to staff.) Z2 again writes it is not possible to

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F 329	Continued From page 40 determine if underlying psychotic symptoms are present. However Z2 recommends an increase in Seroquel to 25 mg twice a day, again for agitation/psychosis. R5's behavioral monitoring sheet for April, 2013 lists target behaviors as increased confusion, increased depression and signs and symptoms of anxiety. However, these behaviors are not identified anywhere else in the record as R5's targeted behaviors. Review of R13's POS (physician order sheet) dated for the month of May 2013 shows R13 has an order for Risperdone 0.125 mg at HS (bedtime). E6 (MDS coordinator) was asked to provide the consent and corresponding documentation (targeted behaviors and indication for use) for the use of Risperdone on 5/29/13 at 9:40am. A consent for Psychoactive Medication was provided on 5/30/13 and dated the same, with E2 (director of nursing) stating there had not been a prior consent for R13's Risperdone. E2 also stated there is no documentation identifying the indication for use other than the diagnosis of Dementia with Behavioral Disturbance. E2 also said there are no identified targeted behaviors for the utilization of Risperdone for R13.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to administer one resident's (R43) medication as ordered. This	F 333		

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F 333	Continued From page 41 applies to one (R43) out of 15 residents observed during medication pass. Findings include: During medication pass observed on 5/29/13 at 6:00am, E16 (nurse) failed to administered a medication as ordered by the physician. The POS (physician order sheet) shows an order dated 5/2/13 to change from Procardia 60 mg every day to Procardia 20mg po TID (three times each day). This medication was not administered by E16 nor was this medication listed on the MAR (medication administration record). During the reconciliation of the medication pass it was found no Procardia had been administered since 5/2/13. E2 (director of nursing) stated on 6/4/13 at 10:30am she thinks the Procardia medication was missed because R43 changed units and was placed in hospice at the same time.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hot foods are held at 135 degrees F. and cold foods at 40	F 371		

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F 371	Continued From page 42 degrees F., sanitize with correct chemical concentration of 50 parts per million chlorine and correct immersion time of one to two minutes in the sanitizing solution for pots and pans. This deficient practice could affect all residents. Findings include; During the lunch time tour on 5/29/13 half pint cartons of milk were 57 degrees F. in the B1 dining room, 44 degrees F. in the B2 dining room and 48 degrees F. in the C2 dining room. In the C2 dining room the container of ground chicken was 111 degrees F., the ground beef was 114 degrees F. and the mashed potatoes were 130 F. The containers of ground chicken and beef were not on the steam table but on the counter top beside the steam table. During the lunch time tour on 5/30/13 in the C2 dining room the container of ground turkey was on the counter top beside the steam table. The ground turkey was 121 degrees F. During the kitchen tour on 5/29/13 the wiping cloth sanitizing solution chemical concentration was 10 parts per million chlorine. During the kitchen tour on 5/30/13 the pots and pans were immersed in a small sink of sanitizing solution for 15 seconds. The instruction chart on the wall indicated pots and pans should be immersed for one to two minutes in the sanitizing solution. R19 and R2 complained of cold food. E4 provided a list of residents (R4, R14, R28,	F 371		

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F 371	Continued From page 43 R29 and R30) that receive mechanical soft diets.	F 371		
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 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.	F 431		

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F 431	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to ensure a medication label for one resident (R20) included the dosage of the medication to be administered. This involves one resident (R20) out of 15 observed during medication pass. The facility also failed to ensure opened medications were dated when opened. This is for two residents in the sample of 16 (R2 and R12) and five residents in the supplemental sample (R22, R19, R23, R24, and R25). Findings include: During medication pass observed on 5/29/13 at 6:45am, E16 (nurse) was observed to be preparing medications to be dispensed from bubble cards for R20. The bubble card containing R20's hydrocodone did not display the strength of the medication. E16 confirmed she did not see the strength of the hydrocodone on the affixed label. E16 stated she would have to call pharmacy to verify the strength of the medication was the correct amount as ordered prior to administering it to R20. R20's physician order sheet dated for the month of May 2013 showed an order reading Hydrocodone-APAP 5-325 1 tablet by mouth twice daily. E16 called pharmacy with the numbers stamped on the pills and verified it was the correct dosage as ordered by the physician. A corrected label was sent from the pharmacy. On 5/29/13 at 11:00 a.m. the A 200 Wing medication cart was checked with E8 (LPN). Various medications were found to be opened and not dated. The following was noted:	F 431		

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F 431	Continued From page 45 R22 - Novolin R insulin vial and Novolog Flexpen opened and not dated. R19 - Pulmicort inhaler opened and not dated, R23 - Travatan 0.004% eye drops opened and not dated R12 - Timolol eye drops, Brimonidine Tartrate 0.15 eye drops, and Novolog Flexpen insulin opened and not dated. R24 - Artificial tears eye drops opened and not dated. R25 - Humalog insulin pen and Lantus insulin pen opened and not dated. R2 - Lantus insulin pen and Novolog Flexpen opened and not dated. R22 - Lantus insulin pen opened and not dated. Multiple nasal sprays were also noted opened and not dated. At this time, E8 said, "No nasal sprays or eye drops are dated when we open them. Insulin vials and insulin pens should be dated when we open them and should be disposed of after 30 days." Review of the facility policy on Medication Administration did not address dating of medications when they are opened or disposing of medications after 30 day	F 431		
F 441 SS=F	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.	F 441		

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F 441	Continued From page 46 (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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain an infection control system which ensured the infection control log was accurate and complete, ensured	F 441		

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F 441	Continued From page 47 the infection control log identified facility acquired infections, ensured cultures were collected per facility policy, ensured glucometers were sanitized per policy, ensured biohazard garbage was not collected in the laundry room. The facility failed to ensure linens are handled in a way to prevent cross contamination of clean and soiled linen. This is for two residents inside the sample of 16 (R2 and R7) and two residents in the supplemental sample (R22 and R27) but has the potential to affect all residents at the facility. The findings include: 1. Review of the facility's infection control logs from Feb. 2013 to May 2013 showed the logs to be inaccurate and incomplete. None of the logs identified facility acquired infections. The date resolved column for the infections was the date of the last dose of antibiotic whether a repeat culture was ordered or not. The column addressing antibiotic resistance had scarce documentation. 2. Review of R7's MAR (medication administration record) and lab work showed R7 was identified with a urinary tract infection that was positive for MRSA (methicillin resistant staph aureus) on 5/7/13. R7 received ABT (antibiotic therapy - Macrobid) from 5/7/13 to 5/12/13. Repeat urine culture and sensitivity was to be done three days post ABT meaning R7 should be off of ABT for three days before the repeat culture is collected (5/16/13). Review of lab results showed R7's repeat culture was done on 5/15/13 with no MRSA. This early collection	F 441		

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F 441	Continued From page 48 could possibly render a false negative result. Interview with E 3 (ADSON - assistant director of nurses) on 5/30/13 at 9:50 a.m. noted E 3 to say R7's repeat urine culture should have been collected on 5/16/13. 3. Observation of E8 (LPN) on 5/29/13 sanitizing the multi use glucometer showed the glucometer was not sanitized per facility policy and the glucometer was repeatedly contaminated during multi resident use. On 5/29/13 at 7:55 a.m. E8 was performing blood glucose monitoring on R22. E8 wiped the glucometer with a store bought disinfectant wipe, went into R22's room and laid the glucometer on R22's bed. After performing the blood glucose monitoring E8 picked up the glucometer and laid it on the medication cart, then placed the glucometer on the glucometer case. E8 then went to R2's room, wiped the glucometer again with the store bought disinfectant wipe, place the glucometer on top of a clipboard, went into R2's room, set the glucometer on R2's bed, picked the glucometer up and again placed it on top of the clipboard, returned to the medication cart, wiped the glucometer again with a disinfectant wipe, and placed the glucometer on top of the medication cart. Information provided for the store bought disinfectant wipes showed for disinfecting, the treated surface should remain visibly wet for five minutes. This was not done when E8 wiped the glucometer. The information on the disinfectant wipes did not show the disinfectant was effective against MRSA (methicillin resistant staph	F 441		

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F 441	Continued From page 49 aureus), EBL (Extended Spectrum Beta Lactamase) C-Diff (clostridium difficile) etc... Review of the facility's infection control log showed residents had infections with these infective organisms. On 5/29/13 at 10:00 a.m., E2 (Director of Nursing) said the glucometers are to be sanitized with disinfectant wipes containing a bleach solution. The facility's policy on sanitizing glucometers states the same. 4. Observation of E15 (LPN - Wound Care Nurse) on 5/29/13 at 7:15 a.m. perform wound care on R2 noted E15 to remove the old dressing from R2's left buttock. Serous drainage was noted on R2's old dressing. E15 disposed of the old dressing as well as multiple saline soaked used dressing that was used to cleanse R2's pressure sore site into a plastic bag. E15 was observed disposing the plastic bag in the A 200 Wing Laundry Room large garbage can. A very large dark garbage bag was filled, tied, and sitting on the floor next the large garbage can. The laundry room was noted with folded as well as hanging clean clothes of residents. A laundry worker was in the room with the ironing board up and was ironing clean clothes. The large garbage can and large garbage bag was only 3-4 feet away from the clean clothes in the laundry room. E15 said this is the only utility room we have here and this is where we have to put our soiled utility. During the laundry tour E15 and E16 were working in the laundry. E15 was putting soiled	F 441		

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F 441	Continued From page 50 laundry in the washing machine. E15 had on gloves but no gown or apron. The soiled laundry was touching her arms, legs and body. E15 finished loading the washer, took off her gloves but did not wash her hands. E16 stated, "We do not have aprons or gowns. We take the linens out of the washer and put them in the dryer. We put the dried laundry in carts to go up stairs. The isolation linen will be dumped out of the bag into the washer without sorting it." E2 said, "We have one resident on isolation for extended spectrum beta lactamas bacteria." This deficient practice allows the soiled linen to touch arms, legs and body of E15 and E16. Then the clean linen is taken out and it touches the same clothing of E15 and E16 as the dirty linen touched.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure equipment, furniture, roof and air conditioner was in good repair. This deficient practice affected all residents in the facility. The facility failed to ensure that the floor in the second story dining room shared by units A2 and	F 465		

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F 465	Continued From page 51 B2 was safe and hazard free. This has the potential to affect all 48 residents who eat in this dining room; R44, R27, R12, R24, R25, R22, R2, R19, R8, R23, R10, R3, R20, R11, R13, R21, and R45 through R74. The facility failed to provide a medication cart that is clean and in good repair. Findings include; During the kitchen tour on 5/30/13 the "reach- in" refrigerator by the doors to the B1 dining room was not holding milk cartons at 40 degrees F. Milk delivered from this refrigerator ranged from 44 to 57 degrees F. The temperature log on the refrigerator door was filled out with 44 degrees F. on 5/20/13, 50 degrees F. on 5/22/13 and 46 degrees F. on 5/29/13. E4 said, "On the 29th we stopped using the refrigerator until it is repaired or replaced." During the environmental tour on 5/28/13 a chair in the C2 dining room has a broken arm. The arm is loose from the back of the chair. The arm will collapse if a resident pushes on it. A ceiling tile in the C2 corridor by room C209 is water soaked and sagging. E1 said, "We will check for pooling water on the roof." The wall behind R26's bed had bubbles under the paint. On 05/29/13 at approximately 12:30 pm residents were observed eating lunch in the dining room on the second floor of the facility. This dining room is shared by residents who reside on units A2 and B2. In the northwest area of the dining room is an	F 465		

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F 465	Continued From page 52 air conditioning unit suspended from the ceiling. On the floor below was a large wet area approximately three feet in diameter. Water was observed dripping from the ceiling unit onto the wet floor. When the wet area was pointed out to nursing staff who was next to the wet area passing medications, the nurse stated that maintenance was aware of it and they were coming to fix it. Staff was not observed making an attempt to block the area from residents who may pass by. A wet floor sign that was propped up against the wall was then placed over the wet area. During medication pass observation on 5/29/13 at 6:00am on the c wing on first floor, it was observed that the medication cart had electrical tape completely covering the left and right edges of the top sides of the cart. The overlapping pieces had dark substance at each overlapping edge, where the matter had accumulated. Supplies utilized during the medication pass could and did come into contact with the tape and the dark substance adhered at its overlapping edges. E16 (nurse) stated at the time that this is how the medication cart has been for a long time. E1 (administrator) and E2 (director of nursing) were informed of this on 5/29/13 at 4:00pm. There was no explanation or alteration to the medication cart by the end of the on-site portion of survey on 5/31/13.	F 465		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 498		

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F 498	Continued From page 53 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility inservices and interview, the facility failed to ensure CNA's (certified nurses aides) were proficient in performing catheter care for one resident inside the sample of 16 (R2) and one resident in the supplemental sample (R17). The findings include: On 5/29/13 at 8:30 a.m. E10 (CNA) was observed performing catheter care on R2. E10 was observed to perform the catheter care incorrectly. E10 used moist wipes sprayed with peri wash to perform the catheter care. E10 was observed wiping R2's left and right groin areas in an up and down motion as well as wiping the catheter tubing in an up and down motion. E10 never exposed R2's urethral meatus or cleaned the catheter tubing at the insertion site. Review of R2's lab work showed R2 had history of urinary tract infections. Observation of E12 (CNA) on 5/30/13 at 1:35 p.m. performing catheter care on R17 showed E12 also performed catheter care incorrectly. E12 used moist wipes and peri wash to wipe E12's peri area. E12 wiped R17's peri area up and down with one wipe then with a second wipe, wiped up then down the catheter tubing. E12 did not expose R17's urinary meatus to clean the site and did not clean the site of entry of the catheter.	F 498		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF ANGELS RET HOME	1201 WYOMING AVENUE JOLIET, IL 60435

(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
F 498	Continued From page 54 Interview with E12 at this time noted E12 to say she had not been inserviced in catheter care in about a year. Review of the facility's nursing inservices verified E12's statement. Further review of nursing inservices showed E10 had not been inserviced at the facility for catheter care.	F 498		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; 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		