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PRESENCE OUR LADY OF VICTORY	20 BRIARCLIFF LANE BOURBONNAIS, IL 60914

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F 000	INITIAL COMMENTS Annual Licensure and Certification survey.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to actively seek information about one resident's dietary preferences that were important to him. This applies to one resident (R8) in the sample of 18 reviewed for dietary restrictions. Findings include: On 8/13/13 during an individual interview R8 said he does not like the mechanical soft diet he is receiving. He said it is all ground up and terrible. R8 said his family has been bringing in food so he can eat. R8 was visited at the noon meal on 8/15/13 in the dining room at 11:05 am when he pointed to the ground meat and said it is slop. R8 said he had this kind of food when his dentures broke, but now has dentures. R8's face sheet records his readmission date as 7/22/13. A dietary note written by E12, the registered dietitian, on 8/2/13 indicates R8's weight is down to 104.8 lbs which is a 5.2 lbs loss since re-admission. R8's intake is poor at meals per nursing, but R8 did eat a bag of potato chips	F 242		

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

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F 242	Continued From page 1 before lunch today. The facility will continue to monitor acceptance of his dietary supplement and record his weight and intake of meals. During an interview with E12 on 8/15/13 at 11:00am she stated R8 was on a mechanical soft diet before he left the last time, so the diet was continued on re-admission. E12 was not aware the family has been providing outside food of regular consistency which R8 has been eating. E12 did not consider R8's preference for whole foods and dislike of the mechanical soft diet until after this interview. R8's diet was changed to regular consistency on 8/15/13. On 8/16/13 at 1:20pm R8 said he likes the regular food they have given him today. It is not mush like before.	F 242		
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, interview and record review the facility failed to ensure Medication Administration Records (MARs), Treatment Administration Records (TARs) and Physician's Order Sheets (POS) were recapped and reviewed for accuracy every month. This applies to 1 of 18 sampled residents (R8) and 1 resident in the supplemental sample (R19), reviewed for physician's orders accuracy. The findings include: 1) On 8/15/13 at 8:30 AM, R19 received 8AM	F 282		

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F 282	Continued From page 2 medications, including Enalapril (Vasotec) 10 milligrams (mgs) by mouth. On 8/15/13 at 10:00 AM, R19's 8/1/13- 8/31/13 POS did not include Enalapril as a prescribed medication. R19's 7/22/13-7/31/13 POS includes a 7/23/13 physician (MD), order for Vasotec (Enalapril), 10 mgs by mouth twice a day. 2) R8's 8/1/13- 8/31/13 POS includes MD order for Peg tube (G-tube) feedings of Jevity 1.2 at 80 milliliters (ml) and water flush every 4 hours. On 8/14/13 at 2:00 PM, R8 stated he never had a G-tube and R8's abdomen was observed without a gastrostomy tube present. On 8/15/13 at 2:30 PM, E13 (Licensed Practical Nurse) stated R8 never had a gastrostomy tube. On 8/16/13 at 10:00 AM, E1 (Administrator), stated the facility has a nurse responsible for reviewing the upcoming months POS for all residents, to make sure the orders are accurate. Facility's POS Amendment and Reconciliation policy includes: upon receipt of printed POS, the facility is responsible for verifying the printed POS with the current POS in patient's chart.	F 282		
F 309 SS=G	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:	F 309		

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F 309	Continued From page 3 1) Based on record review and interview the facility failed to ensure timely physician notification and follow up to abnormal X-ray result which resulted in a delay in further diagnostic testing and medical treatment for a fracture. This applies to 1 of 1 residents (R1) reviewed for diagnostic follow up in a sample of 18. This failure resulted in an 11 day delay in medical evaluation and treatment of R1's acute left distal radial fracture and prolonged, un-resolved pain due to fracture not being stabilized. The findings include: R1 has a history of recurrent falls. R1 has had 8 falls in the last nine months, including a 6/30/13 fall resulting in an acute fracture of the left distal radius. Facilities 6/30/13 incident report includes: R1 fell at 10:15 PM. R1 was observed on the floor between the bathroom and the bedroom doorway with no complaint of pain. R1's call light was sounding. R1's progress notes include: - 7/1/2013 at 7:00 AM stated: R1 complained of pain with swelling to her left wrist at 2:00 AM. R1 stated at that time she thought she had caught herself with that hand when she fell earlier. R1 had ice applied to the wrist for the swelling. R1 also received tylenol for the pain. R1 then went back to bed, sleeping the rest of the night. R1 did complain of pain again upon arising. - 7/1/2013 at 9:15 AM stated: R1 s physician was notified of the fall. The physician ordered an X-ray of R1's left wrist. - 7/1/2013 at 1:09 PM includes: a portable X-ray was completed. R1 received tylenol at that time for further complaints of pain. R1 ' s left wrist remained swollen and R1 was guarding the wrist for protection. The progress note dated 7/1/2013 at 1:57 PM	F 309		

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indicates the X-ray results were received and faxed to R1 ' s physician.
The X-ray report dated 7/1/2013 shows R1 has moderate to diffuse osteopenia. The impression is as follows: diffuse wrist soft tissue swelling, suspicion for old fracture deformities of the base of the ulnar styloid and distal radial metaphysis, concern now for acute nondisplaced oblique fracture of the base of the radial styloid. The radiologist suggests a CT-scan to confirm the fracture.
The progress notes of 7/1/2013 at 8:58 AM and 7/2/2013 at 4:11 AM state R1 ' s left wrist remains swollen, discolored and causes pain if moved.
The progress note dated 7/2/2013 at 8:59 AM states that the physician has not called regarding the left wrist X-ray results. There was no indication the facility reattempted to notify the doctor for orders. The physician did not call the facility about the X-ray until 7/11/2013. At that time a CT- scan was ordered as well as an orthopedic appointment.
R1 continued to complain of left wrist pain during the 11 days (6/30/2013-7/11/2013) after the fall, but the facility did not follow up with the physician for any new orders. R1 was only receiving tylenol for pain.
The progress note dated 7/15/2013 shows R1 returned from an orthopedic appointment with a short arm cast due to a fracture of the radial/ulnar bone of the left wrist.
On 8/16/2013 at 10:50 AM, Z1 (physician for R1) said he did not see R1's X-ray report until he found it on his desk on 7/10/2013. He called and ordered a CT-scan of the left wrist for the next morning. He didn't recall the facility calling to check if he received these X-ray results. He would have ordered the CT-scan of the left wrist for R1 as soon as he saw the report to confirm

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the fracture. R1 has poor healing ability due to diagnosis which include diabetes, renal failure and advanced age. There would be negative outcome in the delay in treatment since R1 was having pain. "
On 8/16/2013 at 8:40 AM, E1 administrator said she thought R1 had an old fracture identified on the X-ray not a new one. " E1 also stated if the physician is notified the nurses document this in the progress notes.

2) Based on interview and record review the facility failed to effectively communicate a shift to shift report with the dialysis center, failed to implement an individualized care plan for dialysis residents and failed to have a policy and procedure for the care of dialysis patients. This applies to 1 of 1 residents (R1) reviewed for dialysis in a sample of 18 and 4 residents (R20 - R23) in the supplemental sample.
The findings include:
On 8/15/2013 at 1:25 PM, E7 (AM shift nurse) stated they send a dialysis communication sheet with the resident when they go to the offsite dialysis center. E7 stated this form is then returned with the patient upon return to the facility. The form has information regarding pre and post weights completed at the dialysis center, patients condition, if patient was seen by the physician, had new physicians orders, oxygen given, medications given, laboratory draws completed and any additional information. E7 also stated these forms should be filed in the resident record. E7 then went to the record of R1 and R23 to locate the dialysis form. R1 had none filed in the record and R23 had one file in the record.
On 8/15/2013 at 1:29 PM E8 (registered nurse) stated the dialysis form should be located on the

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F 309	Continued From page 6 individual resident records. E8 reviewed R1's chart and found no dialysis communication forms. E8 stated the ambulance staff hand the form to the PM nurse. E8 also stated sometimes the communication form is not returned from the dialysis center. The nurse on duty should call and have the communication form faxed back to the facility if it is forgotten. E8 then began shuffling through a stack of papers on the nurses desk and found one dialysis communication form mixed in with other papers. On 8/15/2013 at 2:35 PM E9 (PM nurse) stated when the dialysis communication form is returned to the facility it is placed on the nurses clip board then filed in the resident record. All care plans for dialysis patients (R1, R20 -R23) have identical problems, goals and approaches. The care plans are very generalized. On multiple occasions through-out survey process the facility administrator was asked for a dialysis policy. On 8/16/2013 at 10:00 AM E1 (administrator) stated the only policy the facility has regarding dialysis communication process written on 8/15/2013. There is no policy with emergency bleeding procedures, fistula site checks, or any dialysis process.	F 309		
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.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to provide adequate supervision, monitor and analyze the effectiveness of fall interventions, communicate and train staff regarding fall interventions and failed to ensure safety alarms were maintained in working order to preventing recurrent falls.
This applies to 1 of 6 residents (R1) reviewed for falls in the sample of 18.
This failure resulted in R1 sustaining a fracture of the distal radius of the left wrist.
The findings include:
R1 has a diagnosis which includes end stage renal disease, diabetes, chronic anemia, osteoporosis and anxiety disorder.
R1's Minimum Data Sets (MDS) dated 2/4/2013 and 5/2/2013 include:
requires limited assistance of one staff for all transfers, ambulation and toileting and has frequent incontinence episodes.
R1 is on a prompted toileting program (taken to the toilet every 2 hours while awake), per facility tolieting program list. R1 knows when she needs to urinate and will self- initiate toileting by trying to get up out of bed or self transfer from the wheelchair.
R1 had two falls related to toileting issues (6/30/2013 and 2/6/2013). R1's 6/30/13 fall incident report includes: at 10:15 PM, R1 told staff she was trying to get off the toilet unassisted when her wheelchair moved because one brake was not locked. R1 complained of pain in her left wrist at 2:00 AM 7/1/2013. R1 sustained a fracture of the distal radius of the left wrist.
During 8/13/2013, 10:00 AM and 8/14/2013, 10:00AM interviews, R1 stated "I fell here and broke my wrist." R1 also indicated she took

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herself to the toilet because it took staff 45 minutes to come back and take her to the bathroom. R1 also said "my wheelchair rolled back because the brake didn't work, so I fell."
Facility incident reports document R1 has had 8 falls in the last 9 months (12/30/12 though 7/18/2013). R1 fell from the bed on 5 occasions , fell from her wheelchair on 2 occasions and off the toilet on one occasion. The 8 fall incidents all occurred between the hours of 10:00 PM- 1:45 AM. The PM shift ends at 10:30 PM and night shift starts at 10:00 PM per E1 (administrator). 6 of R1's 8 fall incidents occurred during the night shift.
R1's 7/01 and 7/10/13 incident reports state; R1 is confused and impulsive with poor safety awareness, yet the fall follow-up interventions, after sustaining fractured wrist, include to educate R1 on safety .
On 8/14/2013 at 1:10PM, R1 had two types of floor mats noted beside her bed. There was a maroon soft mat on the door side of the floor (open space in room). There was a black floor mat with an alarm mechanism attached on the window side of the bed. The alarmed mat is to sound when pressure is applied to the mat. On 8/14/13 at 1:10PM, when tested, the mat was stepped on and the alarm did not sound.
On 8/14/2013 at 1:30 PM, E6 (restorative nurse), stated the alarm mat should be on the open side of the room (door side) and the maroon mat should be on the window side of the room. E6 then stepped on the mat with no alarm going off. E6 then opened the battery pack attached to the alarming mat and stated there is a battery missing. E6 indicated the mat was not functional at that time. E6 also indicated the mat placement was not documented anywhere for direct care staff to know correct mat placement.

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R1 was observed on multiple occasions (8/14/2013 at 1:10 PM, 1:30 PM and 3:30 PM), sitting on the side of her bed (in the low position) with her feet on the soft maroon floor mat, on the door side of the room.
On 8/14/2013 at 2:00 PM, E14 certified nurse aide (CNA) stated "I am R1's CNA today. E14 stated "I placed the maroon mat towards the door. I'm not sure if there is a special way the maroon and alarm mats are to be placed. "
Review of the facility "Fall Prevention Program" shows in section G:
The facility determined identifier (un-described indicator), is directly outside of the residents rooms. Other means of communicating the fall risk may additionally include placement on the card index, medical record, care plan, physicians order sheet (POS) and medication administration record (MAR).
Section III of the Fall Policy and Procedure: states staff are to be trained on the fall prevention program and is incorporated into the new employee orientation for all staff as well as annual competency regarding resident safety.
On 8/16/2013 at 8:40 AM E1 (administrator) stated that the staff were instructed to check the alarms on seat cushions, bed and floor mats were functional before utilizing the equipment. E1 stated this was just initiated . E1 also indicated extra batteries are now available to staff at the nurses station. E1 also indicated the batteries were all stored in E6(restorative nurses) office prior to this.
On 8/15/2013 at 2:17 PM E11 (CNA) stated to know if a resident is a fall risk, look in the restorative book for residents who have sensors on their wheelchairs or beds. E11 stated these are residents who are high risk for falls. E11 showed the restorative book, that R1 should have

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F 323	Continued From page 10 been in, with no alarm sensors listed for R1's use. On 8/15/2013 at 2:15 PM, E10 (CNA) stated if a resident has a red name tag they are a fall risk all other residents have a white name tag outside their bedroom door. On 8/15/2013 at 2:22 PM, E8 (RN) stated there is no indicator outside a residents door if they are a fall risk. E8 stated all the residents have red name tags outside the door. On 8/15/2013 at 2:30 PM, E9 (LPN) stated no the fall risk is not indicated anywhere on the MAR or the POS.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure residents have medical justification for utilization for psychotropic medication, target and / or monitor specific behaviors and track on behavior monitoring record as per facility policy, develop individual psychotropic care plans and attempt individual non-pharmacological approaches as a possible alternative to psychotropic medication use and to implement a gradual dose reduction.
These failures apply to 2 of 6 residents(R9 and R6), reviewed for psychotropic medication in the sample of 18.
The findings include:
1) R9's Interdisciplinary Quarterly Psychotropic Review form dated 4/19/13 shows that R9 uses several medications including Seroquel. This form provides a diagnosis for R9 of depression and anxiety. R9's psychiatry progress note of 4/9/13 (untimed) also provides the diagnosis of dementia with anxiety and depression. R9's August 2013 POS (Physician's Order Sheet) indicates diagnoses of anxiety and Alzheimer's with dementia. R9's 7/22/13 Interdisciplinary Quarterly Psychotropic Review form documents a diagnosis of Dementia with Behaviors, psychosis, anxiety and depression. This form documents no change in behaviors. R9's 7/9/13 untimed psychiatry note provides the same diagnoses for R9, with no specific behaviors described.
R9's care plan for mood distress with a targeted goal date of 8/1/13 does not target specific behavior for R9. It states R9 can become angry or anxious and has a history of Dementia. It notes

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R9 is on psychotropic medication for a mood problem. There is no specific description of the behaviors that the medication is targeting. There is no specific description of R9's behavior when R9 becomes angry or anxious, nor any description of what triggers this behavior. The only other care plan related to psychotropic use is for the potential for side effects from psychotropic medication, with a target goal date of 10/29/13. This care plan does not specify targeted behaviors for R9. R9's care plan for mood distress contains the following approaches for R9: encourage verbalization; approach warmly and positively; discuss feelings about placement in nursing home; introduce resident to other residents; give medication for mood and observe for side effects; offer emotional support as needed. These approaches are vague, non-specific and show no meaningful alternatives to drug therapy attempted.
On 8/13/13 at 10:10 am, R9 observed in recliner. R9 was resting in the recliner chair with no behaviors observed. R9 was also observed in her recliner chair at 10:00 am on 8/14/13, again with no behaviors observed.
R9's clinical record contains a form entitled Behavior/Intervention Monthly Flow Record. This form is not dated, nor does it contain the month or year. The behavior identified on this form for R9 is anxiety. The form contains small squares where staff is to mark down the number of episodes per shift the behavior occurs. There is a column of squares for every day of the month contained on this form. His form is blank with the exception of 4 zeros where staff are to document the number of behaviors per shift. These are on the 11th, 12th, 25th and 26th. There are no initials for these entries.
Facility policy entitled, " Psychotropic Drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145536	A. BUILDING _____ B. WING _____	08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE OUR LADY OF VICTORY	20 BRIARCLIFF LANE BOURBONNAIS, IL 60914

(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
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Ordering, Monitoring, Reduction Procedure " reflects the following under the section titled Alternatives to Drug Therapy, " When resident exhibits a behavioral change, the nursing staff will use appropriate behavioral interventions and modifications in an effort to prevent the prescribing of a psychotropic drug. Under the section which discusses monitoring of psychotropic therapy and daily documentation, it states, " Daily documentation will be done on the Behavior/Intervention Side Effect Monthly Flow Record as appropriate ...for each day of the month the behavior is observed, the number of episodes should be logged with the initials of the appropriate staff member for the shift the behavior was observed. A blank box indicates that no behavior was observed on that shift. "
On 8/13/13 at 9:50 am, E3 (MDS Coordinator) stated there is no current behavior monitoring record for R9 because currently, R9 is not exhibiting behaviors.
2) R6 has a physicians order for Risperidone 2 mg twice a day. The face sheet in R6's medical record lists dementia without behavioral disturbances as a diagnosis. According to the interdisciplinary quarterly psychotropic review form dated 6/12/12 Risperidone was increased to 2 mg twice a day from from risperidone 1 mg twice a day. There has been no attempt at a dose reduction for over a year.
According to the MDS (minimum data set) assessment under behavior has a section (E) potential indicators of psychosis to list if the resident has hallucinations or delusions or none of the above.
The behavior section also asked if physical behavioral symptoms directed toward others, rejection of care or wandering was exhibited.
The last 6 MDS assessments dated 8/1/13,

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F 329	Continued From page 14 5/3/13, 2/5/13, 11/7/12, 8/9/13 and 5/11/12 show no documentation of any hallucinations, delusions or behavior symptoms. R6's care plan dated 8/12/11 indicates R6 is exhibiting symptoms of psychosis related to auditory hallucinations. This care plan has not been updated to the current circumstances.	F 329		