STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146070	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN WILLOWS NURSING CENTER	**1600 NORTH BROADWAY, PO BOX 370 SALEM, IL 62881**

(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 000	INITIAL COMMENTS	F 000		
F 242 SS=D	Annual Licensure and Certification Survey 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 record review and interview, the facility failed to respect a resident choice regarding a desire to get out of bed for 1 of 11 residents (R5) reviewed for resident choices in the sample of 11. The findings are: 1. R5 is an 86 year old resident with diagnoses that include Parkinson's Disease, Anxiety, Depression and Alzheimer's Dementia, as listed on the December 2013 Physician Order Sheet (POS). R5's most recent Minimum Data Set (MDS) dated 11/20/2013 indicates that R5 scored 14 out of 15 on a cognition scale indicating he is alert, oriented and able to make decisions. This same MDS indicates a zero for behaviors during this assessment period. A current Behavior Tracking & Behavior Modification Plan for the dates of July 8, 2013 thru this survey date lists behaviors which include	F 242		

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

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

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F 242	Continued From page 1 "yelling out at staff while call light is in reach". It documents that this behavior occurred on 7/8//2013 and 8/4/2013 and the intervention was to remind resident to use the call light. Nurses Notes for 8/4/2013 indicate that beginning at 3:00 am, R5 was yelling out that he was hot, having removed his gown and kicking his sheet off. Nurses Notes for 8/4/2013 indicate that at 4:00 am, R5 was yelling out that he wanted to get up and was informed by nurse that it was too early to get up. Nurses Notes for 8/4/2013 indicate that at 4:30 am R5 was yelling out every 2-3 minutes, "wanting to get up". The nurses note indicates that R5 was gotten up at 5 am and had been yelling loudly, asking to get up. No other behaviors of yelling out at staff are documented on this behavior tracking after the 8/4/2013 documentation. On 12/12/2013 at 2:00 pm, E5, Registered Nurse, verified the above documentation and further stated that R5 had agreed to remain in bed after the 4:00 am request but then continued to yell out to get up. The current Care Plan with a review date of 11/26/2013 lists "Impaired Socialization" as a problem area. There are no behavior concerns addressed on the Care Plan. R5 was interviewed on 12/11/2013 at 10:00 am., R5 stated that he felt staff didn't want to listen to him and would make him wait when he wanted to get out of bed and that it sometimes took "too long" to answer his call light.	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	F 282		

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F 282	Continued From page 2 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 provide compression hose as indicated in the plan of care for one of eleven residents (R3) reviewed for the plan of care in the sample of eleven. Findings include: On 12/11/13 at 1:00 p.m., R3 was sitting in a wheelchair and was not wearing compression hose. Both lower extremities were swollen. At this time, R3 stated that R3 had asked the doctor about getting compression hose as they help decrease pain and swelling in R3's feet. R3's Physician Order Sheet for 12/2013 includes an order written 11/23/13 for " knee high compression hose to both lower extremities." R3's Care Plan includes an approach dated 11/23/13 for " knee high compression hose to bilateral extremities as ordered."	F 282		
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	F 329		

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F 329	Continued From page 3 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to provide a rationale for the continued use of psychoactive medications, failed to attempt gradual dose reductions of the medications, and/or failed to monitor for adverse consequences of antipsychotic medications for 2 of 3 residents (R2, R5) reviewed for psychoactive medications in the sample of 11. Findings include: 1.a) R2's December, 2013 Medication Administration Record (MAR) documents that R2's birthday is 12/17/27 and lists R2's diagnoses which include Depression and Alzheimer's. R2's December, 2013 Physician Orders Medications and Treatments record notes	F 329		

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F 329	Continued From page 4	F 329		

that R2 receives Haloperidol 1 milligram (mg) tablet three times daily for diagnosis of Depressive, Combative, Screaming Behavior. This record also indicates that R2 was admitted to the facility on 1/3/13 and has been receiving Haloperidol 1 mg three times daily since 1/22/13.

The initial entry on R2's Behavior Tracking and Behavior Modification Plan, dated 2/8/13, documents behaviors of resistive to changing clothes, resisting bathing, hitting, kicking, slapping,verbal abuse (cursing-extreme profanity), and confused (has a reputation of talking rudely, rough and abruptly). The next two documented entries on this form, dated 5/11/13 and 6/13/13, note R2's behavior on these days as verbal abuse (cursing-extreme profanity) and arguing with staff and other residents "about anything and everything". The next entries on this form are in the month of November, 2013 with a total of 11 entries and then in the month of December, 2013 with a total of 10 entries. The behaviors addressed in the months of November, 2013 and December, 2013 are verbal abuse (cursing-extreme profanity), argues with staff and other residents "about anything and everything", and refusing to take medication. R2's Nurses Notes dated from 3/10/13 to 11/20/13 do not document any combative or aggressive behaviors.

R2's Care Plan dated 1/3/13 and last reviewed 10/14/13, lists Problem No. 7 as - Potential to be upsetting to other residents, R2 (name) displays confused behaviors as evidenced by whistles loudly, repeatedly asks where she is, and thinks her car is in the driveway and that she can drive home. On 12/11/13 at 2:00 PM, E4 (Certified

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F 329	Continued From page 5 Nurse Aide) stated that R2 usually yells out when R2 is being changed and that R2 is probably just scared. On 12/11/13 at 11:00 AM, E5 (Registered Nurse) said that R2 does yell and may try to hit staff. On 12/12/13 at 10:20 a.m., E6 (Certified Nurse Aide) stated that R2 may yell out in the dining room. On 12/12/13 at 12:15 PM, E7 (Activity Director) stated "R2 may yell out occasionally for me but all I do is touch her hand and she stops. R2 just wants someone to talk to. R2 helps me call bingo." The facility's Consulting Pharmacy Services Consultation Report, dated 3/27/13, documents a recommendation to R2's Physician to please consider reducing the dose of Haloperidol to 0.5 mg twice a day, with the eventual goal of discontinuation, if possible or change to alternative therapy. R2's Physician responded to this recommendation with the statement, "continue prescription due to resolution of psychotic symptoms". R2's 7/17/13 Physician Order Progress Notes documents diagnoses of Hallucination, Agitation, Dementia, and Depression followed by a written progress note by R2's Physician stating, "Patient with dementia with aggression and hallucinations currently doing well. Currently symptoms controlled with current dose. He deteriorated with lower dose". There is no indication in the record that a dose reduction had been attempted since the initiation of this antipsychotic medication. The Haldol was initiated on 1/20/2013 at a dose of 0.5 mg twice daily and then increased two days later to the current dose of 1 mg three times a day.	F 329		

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F 329	Continued From page 6 On 12/11/2013 at 10:00 AM, E3 (Licensed Practical Nurse) was asked during interview by this surveyor how the Physician is made aware of a resident's response to an antipsychotic drug. E3 replied "by word of mouth" and that the staff informs the Physician while making rounds with the Physician and that the staff is with the Physician when the Physician is charting. E3 verified that there have been no attempts to decrease the current dose of R2's Haloperidol. During periodic observations made by this surveyor on 12/11/13 and 12/12/13, R2 did not have any episodes of yelling, agitation, or combative behaviors. b) R2 was admitted to the facility on 1/3/13. R2 was previously living at home and at home was receiving only 2 medications, Celexa and Metformin. R2 was initially ordered Haldol 0.5 mg on 1/20/2013 but currently receives Haloperidol 1 mg three times a day, which was an increase on 1/22/13. R2's Nurse's Notes, dated 4/21/13 at 9:15 AM, documents that R2 has "increased shakiness to head and hands". R2's Nurse's Notes, dated 4/21/13 at 8:15 PM, documents "increased tremors noted to head and bilateral upper extremities, Haldol by mouth continues as ordered". On 12/10/13 at 12:30 PM, 12/11/13 at 10:00 AM, and 12/12/13 at 1:15 PM, R2 was observed to have rhythmic movements to her right hand while calm and resting in a wheeled, reclining chair.	F 329		

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F 329	Continued From page 7 The 2014 Lippincott's Nursing Drug Guide by Lippincott, Williams and Wilkins, page 582, documents under Haloperidol Interventions, "BLACK BOX WARNING" - There is an increased risk of death in elderly patients with dementia-related psychosis; drug is not approved for this use. This same drug guide, on page 581, documents under Haloperidol Adverse Effects - CNS - Extrapyramidal Syndromes - Pseudoparkinsonism; Dystonias; akathisia, tardive dyskinesias, potentially irreversible (no known treatment). R2's current care plan, with a review date of 10/14/13, does not include monitoring for side effects of antipsychotic medication. R2's clinical record does not have any documented assessments to monitor for adverse consequences related to Haloperidol On 12/11/13 at 11:00 AM, E3 (Licensed Practical Nurse) stated that she was not aware of Black Box Warnings but that the side effects of the medications are listed on the Medication Administration Record. E3 went on to say that the facility does not do any special monitoring of side effects of antipsychotic medications and that "if we see something, we chart it and call the doctor". E3 said the facility does not monitor for side effects of the antipsychotic medications on the care plan. On 12/12/13 at 2:15 PM, this surveyor asked E3 about the rhythmic movement noted to R2's right hand. E3 replied that she did not think R2 had that tremor when R2 was admitted but E3 could not say for sure.	F 329		

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F 329	Continued From page 8 2. R5 is an 86 year old resident with diagnoses that include Parkinson's Disease, Anxiety, Depression and Alzheimer's Dementia, as listed on the December 2013 Physician Order Sheet (POS). R5's most recent Minimum Data Set (MDS) dated 11/20/2013 indicates that R5 scored 14 out of 15 on a cognition scale indicating he is alert, oriented and able to make decisions. A current Behavior Tracking & Behavior Modification Plan lists behaviors which include "yelling out at staff while call light is in reach". It documents that this behavior occurred on 7/8//2013 and 8/4/2013 and the intervention was to remind resident to use the call light. No other behaviors of yelling out at staff are documented on this behavior tracking after the 8/4/2013 documentation. The only other behavior documentation is for 9/2/2013, a behavior of grabbing at another resident and on 11/15/2013 behaviors of making sexual comments, grabbing and touching staff or other residents, The current December 2013 POS documents an order for anti-anxiety medication Alprazolam 0.25 mg 4 times a day. An untitled form provided by E3, Licensed Practical Nurse (LPN) documents that R5 has been on the Alprazolam 0.25 mg four times a day since 12-10-11. Prior to that date, R5 was taking it three times a day (from the time of his admission to the facility on 11/3/2010). Under comments, it is documented as "increased anxiety-impatient" in reference to the reason for the increase on 12-10-2011. A Pharmacy Consultation Report dated 10/17/2012 noted the 4 time a day use of the Alprazolam with a	F 329		

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F 329	Continued From page 9 recommendation to decrease to three times a day. The physician declined the recommendation without documenting a patient specific rationale. There have been no attempts at a gradual dose reduction of this anti-anxiety medication. The 11-20-2013 MDS indicates that R5's mood includes "feeling tired/low energy" and "moving or speaking slowly". There is no indication that the facility has considered R5's 4 times a day use of the Alprazolam as contributing to these mood issues.	F 329		