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	145514	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EFFINGHAM REHAB & HEALTH CARE CTR	1610 NORTH LAKEWOOD EFFINGHAM, IL 62401

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F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	Annual Licensure and Certification Survey 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to provide medically-related social services to maintain the physical, mental and psychosocial well-being for 1 of 1 residents (R3) reviewed for depression in the sample of 10. The findings include: 1. Review of R3's admission and medical records find R3 was admitted to the facility on 5/12/10 with multiple diagnoses including : Anxiety, Depression, Psychosis with depression, Alzheimer's - Alcohol induced, Delusions Chronic Obstructive Pulmonary Disease. R3's Nursing notes dated 8/12/14 at 11:30 am state "Resident verbalized thoughts of suicide and increased depression. States he wants to "run out the front doors and onto interstate in front of a big truck" Resident does not wish to explain why he feels this way . During the initial tour on 08/24/14 at approximately 10:30 AM, R3 was sitting in a wheel chair and staff were pushing him towards the dining room. E2 (Director of Nursing), stated	F 250		

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

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F 250	Continued From page 1 R3 needs staff assistance to transfer to the wheel chair and move in the wheel chair long distances. R3's nurses notes of 08/12/14 further stated that " MD was notified, Social Services was notified. Social Services spoke with resident. 15 minute visual checks initiated. Awaiting for return call from MD. Will continue to monitor." The nursing notes have 1 further entry on 8/12/14 related to a medication change. R3's Antidepressant medication Zoloft was increased. There are 2 entries on 8/13/14 regarding no further suicidal verbalizations and the 15 minute visual checks. There were no further notations in the nursing notes after 8/18/14 to the day of review on 8/24/14. R3's care plan of 05/07/14 ,was reviewed on 8/24/14 and found notations for Mood and Psychosocial problems that indicate R3 "likes to self isolate, has little socialization and prefers to stay in his room the majority of the day. The care plan had no reference to suicide or observation of R3 for potential suicide. The lack of care planning for this issue was brought to the attention of E1(Administrator) on 8/25/14 and a care plan was created on 8/26/14. The new care plan included the facility Suicide Precautions policy dated 10/06. The Care Plan did note R3 needs assistance to transfer from the bed to the wheel chair and requires staff assistance to move the wheel chair long distances. The Care Plan also notes R3 has a diagnosis of Chronic Obstructive Pulmonary Disease and has difficulty breathing. The policy indicates that a number of actions take place including: #2 states, Interview the resident by using clear,	F 250		

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F 250	Continued From page 2	F 250		

direct questions using the Suicidal Potential Assessment form. E6 (Social Service Director) stated on 8/28/14 at 2:15pm that R3 had not been interviewed with the assessment form until 08/26/14.

#8 states, Initiate resident checks every 15 minutes or 1-1 as IDT deems necessary.
A review of the visual check log book found R3 was monitored from 8/12/14 to 8/13/14 at 6:00am. From the 13th to the 24th the only entries in the record were for the time from midnight to 6:00am indicating that R3 was in bed.

Social service notes on 8/12/14 found a note indicating the following: "RN let me know that R3 made the statement that if they didn't get him some medicine he was going to run out the front door and jump on the interstate". The note also stated : E1 and the doctor were notified, R3 was offered someone to talk to and refused and 15 minute visual checks were put in place. A report dated 08/12/14 notes E6 and E2 checked R3's room on 08/12/14 for possible harmful items. They removed the call light cord and replaced it with a bell so R3 could ring it to summon assistance if needed. Daily notes from E6 on 08/12/14 - 08/19/14 indicate R3 did not voice any further suicidal ideation's.

R3 was in the dining room eating lunch on 08/26/14 at 12:45 PM, R3 stated "They can't get my meds right" in response to the question, "How are you?". R3 stated "I feel like suicide" when further questioned. R3 indicated he had a new doctor because the old doctor would not work with the psych doctor at the Veterans Hospital. R3 stated he was hoping the new doctor would work well with the doctors at the Veterans Hospital. R3

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F 250	Continued From page 3 stated after lunch he was going to wash his face and take a nap. A review of R3's medical record on 8/24/14 found R3's new physician had increased R3's dose of Zoloft on 8/12/14, made a face to face visit on 08/19/14 and plans to see R3 on 09/18/14 to evaluate the effectiveness of the medication. On 08/26/14 at 12:45 PM, R3 was sitting at the dining room table feeding himself. R3 ate 75% of his meal. At 1:00 PM a staff member assisted R3 out to the fenced in patio for a supervised smoke break. R3 was calm and clean. R3 was talking with other residents during the meal and while smoking on the patio. E2 stated on 8-24-14 at 10:30 a.m. that R3 sleeps in his room most of the day however he does come to the dining room for all three meals, supervised smoke breaks and family visits. E2 stated R3 's family visits a couple of times a week and includes the grand children.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		

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F 280	Continued From page 4 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update the Care Plan of residents to reflect their current care needs for 1 of 1 resident (R3), reviewed for care planning in the sample of 10. Findings include: 1. A review of R3's nursing notes on 8/24/14 find that R3 had vocalized thoughts of suicide and increased depression. The note 8/12/14 at 11:30 states, "states he wants to run out of the front doors and onto the interstate in front of a big truck"...The note indicates that the physician, and Social Service Designee were notified and 15 minute visual checks were initiated. The care plan for R3 was reviewed on 8/24/14 and no reference to self harm or suicide verbalizations were located. E16 (Care Plan Coordinator) stated on 8/27/14 at approximately 10:00am that a care plan for Behavior ; Resident at risk for self harm was created on 8/26/14 and added to the existing care plan.	F 280		
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 5 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 follow the physicians orders and/or the care plan interventions for 1 of 10 residents (R6) reviewed for care planning in the sample of 10. Findings include: 1. R6 was admitted to the facility on 5/16/14, according to the current Physician's Order sheet dated 8/01/14 - 8/31/14, and has the following diagnoses: Status Post Right Distal Femur Fracture with Open Reduction Internal Fixation, (ORIF), Obesity, Chronic Grand Mal Seizures, Osteoporosis secondary to chronic antiepileptic medication, History of Gastric Bypass, and Learning Difficulties. R6's Care Plan was initiated on 5/27/14 and includes Enabler/Physical Restraint; Bilateral Padded Side Rails - Used because (R6) has a diagnosis of chronic Grand Mal Seizures. R6's current Physician's Order sheet dated 8/01/14 - 8/31/14 reads Full Padded Side Rails while in bed. (Seizure Disorder). The Care Plan was reviewed on 5/30/14, 6/13/14, 7/11/14, and 8/13/14 and no changes noted. A Restraint Progress Note dated 5/27/14 and reviewed on 8/20/14 documents that R6 requires the use of full padded side rails to promote safety and prevent injury. The note reads; Staff assist R6 to complete turning and repositioning every 2	F 282		

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F 282	Continued From page 6 hours and as needed while in bed at which time they lower the full padded side rails and provide R6 with both auditory and visual stimulation during care. On 8/28/14 at 10:05 AM,when E1 (Administrator) was notified that R6 currently was using a bed without full padded side rails, E1 indicated that R6 changed rooms, "About two weeks ago". E1 further indicated that the care plan was reviewed on 8/20/14, yet no changes were made. Observation of R6's bed on 8/28/14 at 1:50 PM demonstrates that there are no padded, full side rails. There are half rails without padding. Observation of R6 on 8/24/14 at 3:00 PM notes that R6 is sitting up in bed and has 2 metal, half length side rails, positioned upward, and without padding. R6 is observed to frequently use the side rails for repositioning while sitting up in bed. During an interview on 8/25/14 at 3:00 PM, R6 states that "It wouldn't make sense to put pads on the side rails, because then I couldn't use the side rails to reposition myself". In addition, R6 states that, "I haven't had a seizure for at least the past ten years".	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	F 329		

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F 329	Continued From page 7 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide adequate monitoring and indications for use of psychotropic medications for 2 of 5 residents (R3 and R8) reviewed for the use of psychotropic medications in the sample of 10. The findings include: 1. R3's medical record indicates an admission date of 5/12/10 and diagnoses including: Anxiety, Depression, Psychosis with Depression and Dementia. The current physician's orders for August 2014 include: Depakote ER 500 mg 2 tabs daily at bedtime for Psychosis and Zyprexa 2.5mg daily for Depression with psychotic features, Zoloft 200mg daily for Depression with psychotic features. A review of the facility's	F 329		

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F 329	Continued From page 8 Behavior Monitoring Record for the past six months , March 2014 through August 2014, finds the target behaviors for tracking to be: "Signs and Symptoms of Anxiety/Depression: saddened facial expression, agitation, yelling out, lack of motivation, self isolation. A review of the last 6 months of tracking included: 8/5 Making a sexual comment toward a staff member. July 2014 - none, June 2014 - 6/28 Calling out to leave him the hell alone. May 2014 - 5/28 Yelling at another resident to shut the F-- up. April 2014 - 4/5 Yelling at Aides. March 2014 - 3/5 2:30am Yelling at roommate to turn off the radio. Review of R3's current nurses notes from 8/12/14 at 11:30am finds R3 had verbalized thoughts of suicide and increased depression and that R3's Zoloft had been increased to the current 200mg daily. None of these issues were tracked on the behavior monitoring records. 2. The face sheet in the medical record for R8 indicates they are a 56 year old who was originally admitted to the facility on 9-24-12. The diagnosis list includes Schizophrenia, Anxiety, Psychiatric Issues, and Alzheimer's Disease. R8's August 2014 Physician's Order Sheet lists the following medication orders (after readmitted 7-18-14 from a hospital stay): Alprazolam .5 milligrams (mg) two times a day and .5mg at bed time ordered 7-21-14, Hydroxyzine Pamote 25mg three times daily ordered 7-19-14, and Sertraline 50mg at bed time ordered 7-19-14. The facility lacks tracking to ensure adequate monitoring of behaviors to justify the use of psychotropic medications and lacks any planned non pharmacological interventions for any	F 329		

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F 329	Continued From page 9 inappropriate behavior. The facility's pharmacy form titled Gradual Dose Reduction Tracking Report created 8-18-14 notes a Therapy Start Date, the Last Gradual Dose Reduction (GDR) Attempt, the Next GDR Evaluation Date and a Date if Clinical Contraindication (C/I) was noted. The Therapy Start Date for Alprazolam was 1-24-14, Hydroxyzine Pamoate was 9-30-12, and Sertraline was 10-12-12. A Clinical Contraindication date for the Alprazolam, Hydroxyzine Pamoate, and Sertraline was noted to be 7-18-14. E2, (Director of Nursing), stated at 1:30PM on 8-26-14, she did not know where the Clinical Contraindication was documented because this information/date was completed by E7, (Consulting Pharmacist). E2, (Director of Nursing), stated at 2:10PM on 8-26-14, the facility lacks interdisciplinary monitoring/tracking of undesirable behaviors on residents who are receiving psychotropic medications.	F 329		
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368		

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F 368	Continued From page 10 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to offer snacks at bedtime. This has the potential to affect all 39 residents residing at the facility. The findings include: The facility's Resident Census and Conditions of Residents form, dated, 8/24 /14 documented the facility had a census of 39 residents. 1. During the resident group meeting held on 8/26/14 the 7 residents in attendance R7, R11 - R16 were interviewed about snacks in the evening before bed. All 7 residents were in agreement that the facility does not offer a bedtime snack and the 7 indicated that they would be interested in a snack before retiring for the night. R12 further stated she has Diabetes Mellitus and if she wants an evening snack she has to come up front and get it herself. 2. E10 (Certified Nurses Aide, CNA) on 8/26/14 at 3:10pm stated she usually works 1 -9pm. E10 further stated "Not that I know of." when asked if the residents are offered snacks in the evening.	F 368		

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F 368	Continued From page 11 3. E11 (CNA) stated at 4:10pm on 8/26/14 "no, not really" when asked if the residents receive an evening snack. 4. E12 (Cook) and E13 (Dietary Aide) stated at 4:15pm on 8/26/14 that a basket of snacks and beverages are refilled in the Hydration area by the nurses station before they leave the building in the evening at about 7:00pm. The basket of snacks was observed in the dietary area and E12 stated that a variety of items are added to the basket each day. They did not know if the residents are offered the snacks only that they fill the container.	F 368		