DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. BUILDING ______ B. WING ______	01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PATRICK'S RESIDENCE	**1400 BROOKDALE ROAD NAPERVILLE, IL 60563**

(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 Annual Licensure and Certification Survey.	F 000		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, evaluate, develop and implement a plan of care for the use of a footrest to promote comfort and safety for R19; and palm protectors to maintain or promote existing physical functional ability (R18). This applies to two of 29 residents (R19 and R18) reviewed for restorative concerns. The findings include: On 01-27-15 at 9:52 AM, R 19 was sitting on a wheelchair leaning on the left side and her feet were dragging on the floor while being transported by E 7 (Certified Nursing Assistant) from the third floor main dining room to the small lounge/activity room. R19's feet were swollen. E 7 said R 19 cannot propel her wheelchair. Staff push her and she does not use the foot rest. There was no footrest noted in R 19's room. On 01-29-15 at 10:45 AM, E 6 (Restorative RN) explained R19 has lower extremity edema and should have a foot rest. E 6 said there was no assessment or evaluation that was done for her	F 311		

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 311	Continued From page 1 but definitely she needed the footrest. 2. On 1/29/15 at 1:30 pm R18 was in her high back chair recliner and stationed in the unit hallway. R18's upper extremities had contractures, had limited range motion, she could not open her fist and her right index finger was extended. There were no devices to keep R18's palms open. On 1/29/15 E6 stated R18 should have clean bilateral palm protectors or rolled wash cloths at all times while awake and remove for hygiene and bath. On 1/29/15 at 3:00 pm E6 presented an activities of daily living function plan of care that showed R18 should be wearing bilateral palm protectors.	F 311		
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 provide complete perineal care promptly after residents were	F 315		

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F 315	Continued From page 2	F 315		

incontinent of bowel and bladder; also failed to follow incontinence care policy and procedure for R11 and R 19 and assess and evaluate appropriate toileting program for R 19 to improve and maintain her bowel and bladder functioning.

The findings include:

This applies to (2) of (16) residents (R11 and R19) reviewed for incontinence care in the sample of 29 residents.

The findings include:

On 1/27/15 at 10:50 am E8 and E9 (both Certified Nurse Aides - CNAs) and a private sitter for R11 walked him to his bath room in the room. While the sitter held R11 standing near the toilet E8 pulled his pants down and removed his incontinent brief. R11 was incontinent of bowel, bladder and there was large bowel movement in the diaper. E8 wiped R11's buttocks with incontinent wipes twice. E8 changed her gloves and wiped R11's perineal area and medial thigh area with wipes, but did not clean his penile area. E8 applied a clean diaper on R11. There was fecal stains left on his gluteal area and medial thighs. E8 did not wash hands after providing incontinence care. E9 was not involved in providing care, but held an empty garbage bag for E8 to dispose the waste in the garbage.

R11's admission record showed he was admitted to the facility on 12/16/14, his 12/30/14 Minimum Data Set (MDS) showed he is always incontinent of bowel and bladder.

R11's 12/31/14 incontinence care plan

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interventions are not specific to cleaning after each incontinence episode.

The facility perineal care procedure dated 2/12/10 updated on 1/28/15 showed to use soap and water or use four in one spray and had details to clean male genital area. E8 did not follow the facility policy when providing incontinence care for R11 on 1/27/15.

On 01-28-15 at 9:40 AM, R 19 requested to be toileted. E 4 transferred R 19 from her wheelchair to the toilet. R 19 had diarrhea. R 19 told E 4 she has finished and tried to clean herself with the toilet paper. E 4 grabbed the toilet paper out of of R 19's hand and said, " no I will clean you up. " E 4 grabbed toilet paper and wiped R 19's buttocks twice with the dry toilet paper. " E 4 pulled up R 19's adult disposable incontinence brief pants, and transferred R19 back to her wheelchair. R 19 remained with a strong BM odor.

E 4 said she (R 19) is alert and can verbalize her needs, especially toileting. She needs assistance with transferring. Once she is in the bathroom she can grab the toilet bar and assist with her transfer.

The facility policy and procedure for providing perineal care/incontinence care showed to use soap and water to provide incontinence care.

On 01-20-15 at 2:20 PM, E 16 (Assistant Director of Nursing/Bowel and Bladder Nurse) said R19 is not in any program (toileting) because she's always sleeping. The only time she is awake is when you put food in front of her. E16 said she

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F 315	Continued From page 4 did not assess her for any program.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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 by:
Based on record review and interview facility failed to utilize appropriate equipment to safely transfer one resident (R6); failed to supervise a high fall risk resident (R22); failed to evaluate/analyze hazards and risk factors resulting in fall incidents and failed to develop and implement individualized interventions to prevent recurrent fall incidents (R15 and R21).

This applies to 4 of 15 residents (R6, R15, R21 and R22) reviewed for falls in the sample of 29.

The findings include:

1. Review of Summary of Accident/Incident Occurrence dated 11/18/14 states R6 is 69 years old, alert and oriented to all spheres. This report states on 11/13/14 at about 5:30pm, two aides were transferring R6 with a mechanical lift when she fell out of the lift and was sent to the ER. R6 was diagnosed with acute T12 compression fracture and left 3rd rib fracture.

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F 323	Continued From page 5 MDS (minimum data set) dated 12/27/14 shows R6 has diagnosis including Epilepsy, hemiplegia, hypertension. R6 requires extensive assistance with one to two staff for all activities of daily living. MDS dated 1/10/15 shows R6 is 62" and weighs 201 lbs. On 1/30/14 at 10:10am R6 was observed to be sitting in her high back wheelchair, alert and oriented. R6 stated that she (R6) was being transferred from the bed to her wheelchair by two nurse's aides she did not recognize. R6 said she did not know that an incorrect size sling had been placed on her until she was mid air. R6 stated "the sling they were using was about the size of my thigh. I felt it was too small and tried telling them I was going to fall but they didn't listen. Then I did. I fell out and onto the hard floor, hitting my head very badly." E1 (administrator) stated on 1/30/15 at 11:00am R6 had been transferred via a full body mechanical lift with an incorrect sling size (small), resulting in R6 falling out of the sling and onto the floor. E1 stated an extra large size should have been utilized based on R6's weight/girth and manufacturer's guidelines, and facility policy and procedure. 2. Review of Summary of Accident/Incident Occurrence dated 12/24/14 states R22 is 87 years old with diagnosis including Alzheimer's, Pseudobulbar affect, major recurrent episode of agitated depression. The incident/accident report dated 12/20/14 shows R22 was observed on the floor inside her room at 5:10am.on 12/20/14, in front of the highback wheel chair she had been placed in. R22 was bleeding from a laceration to her forehead. Page 4 states this laceration	F 323		

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F 323	Continued From page 6 required 15 sutures to close. Review of R22's Fall Care Plan dated 11/05/14 (prior to the above fall) shows R22 is at risk for falls related to dementia with impaired cognition and balance/strength. The goal is for R22 to be free from falls/injury related to falls. Some listed approaches are "Do not put (R22) in her room unattended unless in bed. Keep resident in vicinity of TV room when up in chair for supervision and diversional activity." These interventions were not followed with the care of R22. As indicated in E14's (LPN) witness statement, R22 was left sitting alone in her room, without supervision. On 1/29/15 at 11:15am E15 (R22's nurse's aide) said R22 gets agitated with transfers and can become anxious at times. E15 stated R22 has been a high fall risk for at least a couple years and should not be left alone in her room while in the chair. E1 stated on 1/29/15 at 2:45pm that R22 should not have been left in the room alone at 5:10am in the morning. R22 requires supervision due to being a high fall risk. R21 has diagnosis to include Alzheimer disease, dementia and over active bladder. R21's nursing progress notes and 01/29/15 family interview state R21 has long term frequent, recurrent urinary tract infections (UTI). R21's 2014 incident reports include 2 fall incidents within a month with head injuries requiring hospital medical intervention : 1) 5/17/14 at 11:35PM, found on the floor next to	F 323		

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F 323	Continued From page 7 her bed with a 3cm laceration to the back of her head and complaint of right sided pain. R21 required 6 staples to close the head laceration and hospitalization 5/18 through 5/20/14 with diagnosis to include UTI. Facilities incident report documentation and R21's care plan failed to include any follow-up interventions to be initiated after this fall as a means to prevent future fall incidents. 2) 6/16/14 at 7:00PM, R21's wheel chair alarm heard sounding, upon entering the bathroom, R21 observed to fall and hit her head on the floor. R21 sustained a 3cm laceration to the back of her head and right knee swelling. R21 was attempting to toilet self. R21 was sent to the hospital and received 6 staples to close head laceration. Facilities incident report documentation failed to include any follow-up interventions to be initiated after this fall as a means to prevent future fall incidents. On 6/21/14, R21 was diagnosed with a UTI (greater than 100,000 col of E-coli), based on a 6/20/14 urine culture and sensitivity test. R21's 12/27/14 fall care plan include interventions: - not to be left alone and unsupervised in her room - requires one assist with ambulation - provide toileting assistance upon rising, before and after meals and at hs (night time) and as needed. - analyze falls to determine pattern/ trends. R21's frequent / recurrent UTI's is not a part of her fall care plan. On 01/29/15 at 12:15PM, Z3 (R21's family),	F 323		

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F 323	Continued From page 8 stated, {R21} has had a life long problem with recurrent UTI's. Z3 also stated when R21 has a UTI, her behavior changes and she becomes more confused than normal. R21 has progressive vascular dementia and has become increasing more confused. R21's 3/10/14 minimum data set assessment (MDS), include a score of zero (severe cognitive impairment), on the brief interview mental status (BIMS). Requires extensive assistance by staff for toileting and dressing and limited assistance from staff with transfers and ambulation. This MDS also states R21 is frequently incontinent of both bowel and bladder. R21's care plan also documented on 4/22/14, R21 attempted self toileting and fell in the bathroom. R15 admitted to facility 6/26/14 with history of pre-admission falls and fractures. R15 has diagnosis including Senile Psychosis, anxiety and personal falls with dorsal vertebrae fracture. R15's 7/08/14 and 01/06/15 MDS document requires staff assistance with transfers, toileting, dressing and ambulation. R15 was started on anti-psychotic medications (Risperdal 0.25mg daily), 10/29/14 related to paranoid behaviors. On 11/05/14, R15's Risperdal was doubled to 0.5mg daily. R15's 11/24/14 nursing progress notes include: at 9:25PM, while the nurse aide was making R15's bed linen, R15 slid out of her wheel chair.	F 323		

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F 323	Continued From page 9 The notes include presence of three pillows, a purse and other personal items being present in R15's wheel chair that prevented R15 from being able to sit all the way back in the chair properly. R15's care plan and medical records failed to document post 11/24/15 fall, interventions initiated to prevent further incidents.	F 323		
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	F 329		

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by:
Based on observation, record review and interview the facility failed to identify specific target behaviors, non pharmalogical interventions and medication reduction programs for the use psychotropic medication).

This applies to (4) of (9) residents evaluated for the use of psychotropic medication in the sample of 29 residents, R11, R3, R17 and R4. The facility also failed to assess and monitor the possible side effect of the increased dose of antidepressant medication and failed to notify the physician regarding a change of condition (sleeping all day and no verbal response) for about two weeks duration for 1 of 1 resident in the supplemental sample, R30.

The findings include:

On 1/27/15 at 11:00 am R11 had a blank stare in his look. His extremities were stiff when seated in his chair in the room.

R11's current physician orders showed he is receiving multiple psychotropic medications including: Clonazepam 0.25 mg twice daily; Valproic Acid 500 mg twice daily; and Trazadone 50 mg daily. On 1/3/15 antipsychotic medication Haloperidol 1 mg twice daily added to the psychotropic medications. There is no assessment to show what are the behaviors that are being treated with haloperidol.

R11's 1/28/15 psychotropic drug assessment showed he has delusions, pacing, combative and resistive with care, wandering, and physically aggressive towards others. There is no documentation to show why R11 is demonstrating

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these behaviors.

On 1/30/15 at 1:15 PM E16 (Assistant Director of Nurses) stated R11 grabs people, not just staff, but family and others coming off the elevator. R11 is difficult to be redirected. The facility had no documentation to show qualitative, quantitative behavior occurrence analysis.

R11's 12/31/14 psychotropic drug use care plan interventions did not identify any specific target behaviors, non-pharmacological interventions, or any drug reduction plan.
According to the medical record R17 is an 84 year old female with diagnoses including Depression and Dementia. The physician's orders in R17's record include the anti-psychotic medication Seroquel 12.5 milligrams (mg) two times per day and 50 mg and bedtime. However, the only behaviors being tracked in the record are anxiety and agitation. On 12/03/14 R17 was seen by Z2 (psychiatrist). Z2's progress note stated R17 has no agitation or aggression reported. On 12/28/14 Z2 saw R17 and wrote staff reports no behavior changes or any episodes of aggression. On the mental status exam Z2 documented R17 as having no delusions or hallucinations. Further review of the documentation did not indicate a psychiatric medication reduction plan is in place for R17. There was also no assessment in the record for the use of psychotropic medications found (to support the use of Seroquel for R17.)

According to the medical record R4 is an 88 year old female hospice resident with diagnoses including Alzheimer's Dementia with behaviors. R4's medication orders include the anti-psychotic medication risperdal 0.75mg every morning and 0.5mg every evening. R4's record also contained

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F 329	Continued From page 12 behavioral tracking. The tracking for November 2014 lists behaviors of "anxiety/agitation", "withdrawn" and "increased confusion". Tracking for December 2014 included behaviors of "agitation/anxiety", "hallucinations" and "withdrawn". R4 has no psychiatric assessment in the record to support the use of an antipsychotic medication. R4 also has no plan in the record to reduce or eliminate the use of risperdal. Z3 (psychiatrist) documented on 01/21/15 that R4 has intermittent delusional thinking but there is no information of what the delusions are nor is there behavioral tracking in the record for delusional thinking. According to the medical record R3 is an 86 year old female with diagnoses including dementia with behavioral disturbance and senile psychosis. R3 is currently receiving the anti-psychotic medication, Seroquel 25mg two times per day and 50mg at bedtime. R3's record does not include a psychiatric assessment for the use of Seroquel. There are no identified behaviors to support the use of Seroquel but the facility behavior tracking sheet lists increased confusion, resistance to care, screaming/agitation and withdrawn on R3's tracking sheet. R3's record also does not include any interventions that have been employed prior to the use of Seroquel and there is no medication reduction plan in the record. On 01-29-15 at 11:08 AM, R 30 was sitting in his wheelchair asleep. Z 1 (family member) said he's (R 30) has been like this for two weeks now. He sleeps all day now and he cannot even open his eyes. He was in two different antidepressants one	F 329		

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(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 329	Continued From page 13 was discontinued (Zoloft) because it is affecting his appetite then they increased the dose of the other one (Trazadone from 25 mg increased to 150 mg). After the change, he (R 30) has been sleeping all day. R 30's Physician Order Sheet showed an order for two anti-depressant (1) Sertraline HCL (Zoloft) 100 mg one tablet by mouth every morning and (2) Trazadone 25 mg by mouth and prescribed on 08-20-14, this dose (25 mg) was changed to 150 mg on 01-12-15. There was no documentation found in R 30's progress note the doctor was notified about R 30's condition (sleeping all day). On 01-29-15 at 12:25 PM E 3 said (R 30) has been like this (sleeping all day) for about a week and a half now. His doctors change his medications then he became like this. His doctors has not been notified. He's on vacation; he won't be back until about February 6. " E 3 was asked if there is another doctor covering for R 30's attending physician, E 3 said yes but there was no record any doctor was notified about his (R 30) change of condition after the antidepressant (Trazadone) dose was increased from 50 to 150 mg on 01-12-15.	F 329		
F 498 SS=E	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 assessments, and described in the plan of care.	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. BUILDING ______ B. WING ______	01/30/2015

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F 498	Continued From page 14	F 498		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review the facility failed to ensure nurses aides demonstrated competency when, grooming, dressing, transferring, and providing perineal care.

This applies to four of 29 residents in the sample.

The findings include:

1. R1's face sheet and physicians orders showed the following: R1 was admitted on 10/21/13 with multiple diagnoses including Alzheimer's Disease, Dysphasia, Contusion of eye on 7/31/14, Open wound on forehead with complication (history of laceration eye brow).

The facility assessed R1 on 1/27/14 and 10/24/14 to be moderate risk for safety.

The Minimum Data Set (MDS) comprehensive assessment dated 10/27/14 show R1 requires extensive assistance of one to transfer and toilet.

R1's incident reports on 1/28/15 at 9:30 a.m. indicate E13 (certified nursing assistant - CNA) written statement on 11/28/14 was, R1 was standing / assisted from toilet by E13 and R1 hit face on the wall. R1 sustained a 4 cm X 1 cm laceration to the left upper eyebrow and a 1.5 cm cut on the right eye brow documented in the incident report.

The incident investigation was reviewed with E2 (director of nurses) on 1/29/15 at 10:30 a.m. The

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F 498	Continued From page 15	F 498		

written statements signed by E13 on 11/28/14 stated the gait belt was not used when R1 was being transferred. Further review of the written statements from R1, E17 (nurse) and E18 (nurse) with E2, indicate the resident sustained the injury after falling not bumping her head on the wall. E2 stated nursing staff are trained to use gait belts when transferring residents. Review of the facility policy and procedure for "Gait -Safety Belt" show gait belts are to be used for the safety and security of residents requiring assistance with ambulation or transferring.

2. On 1/29/15 at 1:30 pm R18 was in her high back chair recliner and stationed in the unit hallway. R18's upper extremities had contractures, had limited range motion, she could not open her fist and her right index finger was extended.

The facility had an incident on 8/7/14 involving R18 who sustained subacute non-displaced fracture of right index proximal phalanx base. The investigation of the incident report concluded when CNA (E10) was assisting R18 screamed 'ouch' and observed her right index finger swollen with bluish discoloration and X-Ray report confirmed the fracture.
R18's care guide showed 10/1/13 she needs extensive assistance involving two person assistance.

On 1/29/15 at 2:10 pm E2 stated E10 was the agency CNA who worked night shifts and did not know R18 required assistance of two persons.

3. The facility had an incident report involving R29

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F 498	Continued From page 16 on 5/24/14. The incident report showed, E12, CNA was providing incontinence care while R29 was in bed, E12 rolled R29 from supine position to side lying position away from the staff. In the process R29's lower portion of R29's body went off the side of bed. E12 attempted to hold R29, but the upper portion of her body rolled on to the lounge chair and then slid to floor. At the Hospital it was diagnosed R29 sustained chest wall contusion. R29's closed records (face sheet, physician orders, MDS (11/9/14), Care plan - 11/20/14) showed R29 required extensive assistance. On 1/29/15 at 2:10 pm E2 stated E12 was not supposed to turn R29 away from E12. E2 presented a revised policy and procedure incorporating proper turning. 4. On 1/27/15 at 10:50 am E8 and E9 (both Certified Nurse Aides - CNAs) and a private sitter for R11 walked him to his bath room in the room. While the sitter held R11 standing near the toilet E8 pulled his pants down and removed his incontinent brief. R11 was incontinent of bowel, bladder and there was large bowel movement in the diaper. E8 wiped R11's buttocks with incontinent wipes twice. E8 changed her gloves and wiped R11's perineal area and medial thigh area with wipes, but did not clean his penile area. E8 applied a clean diaper on R11. There was fecal stains left on his gluteal area and medial thighs. E8 did not wash hands after providing incontinence care. The facility perineal care procedure dated 2/12/10 updated on 1/28/15 showed to use soap and water or use four in one spray and had details to clean male genital area. E8 did not follow the	F 498		

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F 498	Continued From page 17 facility policy when providing incontinence care for R11 on 1/27/15. The facility did not ensure the CNAs were proficient in providing perineal care to prevent urinary tract infection.	F 498		