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
	145840	A. BUILDING ______ B. WING ______	04/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABOR HILLS HEALTH CARE FAC	**1347 CRYSTAL COURT** **NAPERVILLE, IL 60563**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Validation survey for Tabor Hillis Healthcare for Subpart U: Alzheimer's Unit	F 000		
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 interview and review of the facility's policy and procedure for abuse the facility failed to develop a policy and procedure for reporting reasonable suspicion of a crime under the Elder Justice Act. The findings include: During the evening of 3/24/14, E1 (administrator/abuse coordinator) presented a copy of the facility's abuse policy and procedure for review. This policy and procedure did not include how the facility would handle a reasonable suspicion of a crime under the Elder Abuse Act. A tour of the facility showed there were no postings regarding the Elder Abuse Act. E1 was asked about postings 3/27/14 at 11 a.m. E1 stated there were none. E1 presented a second copy of the abuse policy and procedure for review on 3/27/14 at 11:a.m.	F 226		4/11/14

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 226	Continued From page 1 There was no mention of the Elder Justice Act or inclusion of the components of the Elder Justice Act into the facility's abuse policy or procedure. Missing were references to when employees reasonably suspects a crime has occurred and must report that suspicion to the Police and the State Survey agency within two hours of a crime occurring. Also, each employee has the right to make a complaint without retaliation or punishment Interviews with E8 (nurse) and E9 (certified nursing assistant) on 3/24/14, E4 (activity director), E5 (Alzheimer's director) and E6 (nurse) on 3/25/14, E7 (nurse) on 3/26/14. All of the staff interviewed were unable to define what the Elder Justice Act meant. All staff responded only it was regarding abuse to an elder an older person.	F 226		
F 253 SS=E	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 maintain 5 of 10 wheel chairs checked in safe working order. This deficient practice affected one (R28) of 20 residents in the sample and four residents in the supplemental sample (R32, R34, R35 and R36). Findings include; During the environmental tour of the facility on	F 253		4/18/14

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F 253	Continued From page 2 3/24 and 3/25/14, R28, R32 and R35's wheel chair brakes did not work R28 said, "That's not safe. Who will fix it?" R35 said, "Look at my arm rest." The arm rest was missing a screw and was loose. It did not provide a secure grip when getting in and out of the chair. R34 said, "I don't like this new wheelchair. It's to hard to put on the brakes. There is no rubber grip. The metal is hard. I would like longer brake levers. My feet dangle. It makes it hard to scoot along." E1 (administrator) during interview stated, "Those will be fixed today."	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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	F 278		4/14/14

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F 278	Continued From page 3 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure information entered for falls on the MDS (minimum data set) for two residents (R19 and R2) was accurate/correct. This is for two residents in the sample of 20. The findings include: 1. Review of R19's care plan and facility incident tracking log showed R19 had seven falls from 6/6/13 to 2/23/14 (6/6, 6/13, 9/5, 9/9, 10/4, 11/14/13 and 2/23/14). Review of R19's quarterly MDS dated 11/4/13 under the section addressing falls showed the coding of one fall with no major injury. Review of the facility Occurrence Report documentation for R19 showed R19 had a fall on 9/5/13 with a major injury with diagnosis of Subdural Hematoma which required R19 to have a three day hospital stay. R19 also had falls on 9/9 and 10/4/13. Review of this quarterly MDS showed the information entered for falls was not accurate due to R19 having a total of three falls during this assessment period, not one. Also the fall coded on this MDS should have been coded as a major injury because R19 spent three days in the hospital with diagnoses including Subdural Hematoma.	F 278		

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F 278	Continued From page 4 2. Review of R2's significant change MDS dated 2/11/14 in the section addressing falls showed documentation/coding that R2 had no falls since the prior MDS assessment (quarterly MDS dated 11/15/13). Review of the facility's incidents and incident tracking log showed R2 had two falls (11/26/13 and 1/5/14) since the last MDS assessment of 11/15/13. With one of the falls R2 had injuries. With the fall on 11/26/13 R2 sustained a laceration to the right ear and bruises to the right upper extremity and both lower extremities. The information coded on the significant change MDS of 2/11/14 was not correct due to R2 having two falls; not zero falls and R2 sustaining injuries with the fall on 11/26/13, which was not coded on the 2/11/14 MDS. On 3/27/14 at 3:45 p.m., during interview E1 (Administrator) was asked why the MDS's were noted coded incorrectly regarding the falls of R19 and R2. No answer was given.	F 278		
F 323 SS=D	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 by: Based on observation, record review, and	F 323		4/28/14

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interview the facility failed to provide supervision to one resident (R19) with multiple falls and who had been assessed at high risk for falls.

This is for one resident in the sample of 20. (R19)

The findings include:

Review of R19's admission face sheet and diagnoses sheet showed R19 was admitted to the the facility on 5/6/13 with diagnoses including Vascular Dementia, Hypertension, and Cerebellar Atrophy.

Observation of R19 on 3/25/14 at 11:30 a.m. and 3/26/14 at 11:45 a.m., showed R19 to be sitting quietly in the dining room at a dining room table. R19 was noted to be hard of hearing. On 3/25/14 at 11:30 a.m. during interview with R19, R19 stated, "Can you speak closer to my ear? I don't hear well. I can't hear you."

Review of R19's fall assessments from 6/9/13 through 2/23/14 showed R19 was assessed at high risk for falls. Review of R19's plan of care and facility fall tracking log showed R19 had seven falls from 6/6/13 to 2/23/14 (6/6, 6/16, 9/5, 9/9, 10/4, 11/14/13, and 2/23/14). R19's care plan showed for the fall on 6/16/13, R19 was found on the floor. An intervention included after this fall was "closer monitoring every 30 minutes x 7 days (6/16 to 6/23/13)."

Review of an incident for R19 dated 9/5/13 at 11:00 a.m. showed R19 was sitting in the dining room, the nurse heard R19's alarm, turned, and saw R19 on the floor. R19 complained of neck pain with redness noted, and a bump on the head behind R19's right ear was observed.

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F 323	Continued From page 6 R19 was sent to a nearby hospital for evaluation. Per facility Occurrence Report dated 9/5/13, showed a CT (computerized tomography) scan was performed at the hospital which indicated "an interval appearance of a left-sided subdural fluid collection with bland and acute hemorrhagic components measuring 2.5 cm in maximum thickness with a 6 mm left to right midline shift." Also noted was a "suspect hemorrhage above the right ear likely within the right sternocleidomastoid muscle." Further Occurrence Report documentation showed no invasive treatments/surgery was done due to resident/POA (power of attorney) refusal. R19 was hospitalized for three days due to this injury (9/5 to 9/8/13). Even though R19 had fallen twice since her admission on 5/6/13, R19's close supervision/monitoring of every 30 minutes had been discontinued as of 6/23/13. Other interventions noted included adding a talking alarm. There was no mention of R19 being hard of hearing and/or whether R19 could hear the talking alarm.	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.	F 329		4/28/14

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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, interview and record review, the facility failed to identify specific and accurate target behavior symptoms for the use of anti psychotic medications, attempt to initiate non pharmacological interventions prior to use of antipsychotic medications, accurately monitor the effectiveness of the medication on resident behaviors and develop resident specific plans for drug reduction.
This applies to two of eight residents (R17 and R26,) evaluated for the use of antipsychotic medications in the sample of 20 residents.
The findings include:
According to the medical record R26 is a 79 year old female originally admitted to the facility on 08/03/10. R10's current diagnoses include dementia with behavioral disturbance and psychosis and depression. R26's current POS (physician's order sheet) reviewed on 03/26/14 lists the following psychoactive medications:

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F 329	Continued From page 8 Seroquel 50 mg (milligrams) at 6am and 25 mg. at 12 pm, daily. R26 also receives Citalapram 10 mg daily. R26 ' s current MDS (minimum data set) dated 03/06/14 does not list hallucinations or delusions as identified behaviors. R26's current Antipsychotic Assessment dated 03/05/14 lists R26's targeted behaviors as anxiousness and agitation, calling out/screaming. However, behavioral monitoring sheets found in the record list crying, yelling, screaming, hallucinations and refusing care as R26's targeted behaviors. Review of the behavioral documentation does not show any of the listed behaviors occurring. R26 was observed throughout the survey. R26 was quiet and appeared to be in no distress. Further documentation in the record describes non pharmacological interventions which have been attempted for R26 and noted to be effective. However, there is no evidence in the record that these interventions were employed prior to the initiation of anti-psychotic medications. The care plan also does not include a resident specific plan to reduce R26's Seroquel. The facility's designee to oversee their psychotropic medication program, E10 stated during interview on 03/26/14, the facility is attempting to reduce and discontinue unnecessary psychotropic medication use. Upon admission new residents are assessed immediately and a plan is put into place but residents who are already here need to have their psychotropic medications reduced gradually. E10 further stated the facility is in the middle of this process with current residents. R17 is an 89 year-old male originally admitted to	F 329		

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the facility on 7/19/06. R17's Accumulative diagnoses record reflects a 9/23/13 diagnosis of Dementia with delusions and behavior disturbances.

Physician's order sheet (POS-telephone orders) for R17 reflects on 9/23/13, Risperdal 0.25mg BID (2 times a day) was ordered, for a diagnosis of dementia with delusions and behavior disturbances. POS also reflects R17's Risperdal dose was increased (POS states decreased) to 0.5mg every morning and 1 mg every evening, with the order dated 11/4/13. The next dosage adjustment was ordered 12/2/13, with Risperdal decreased to 0.5mg BID, per POS.

R17' s antipsychotic assessment dated 10/3/13 indicates a diagnosis of Dementia with behavioral disturbance. Targeted behavior section indicate a history of rejecting care. Specifically, this form states R17 was verbally abusive to staff on 8/10/13, making a sexually inappropriate comment to staff. On 8/21/13, R17 refused a blood sugar check and on 9/19/13, R17 was described as awaiting a ride from the President of the Chicago Cubs. R17 was described as looking for an exit. Non -pharmacological interventions indicate that R17 responds well when re-approached at a later time. He also responds well when explained what his medications are for and why they are needed. R17 also was noted to enjoy watching Western movies and responds well when asked about the movies. Staff can enlist help from R17's wife as needed.

There is no evidence staff utilized non-pharmacological interventions proper to the start of the Risperdal, and how long any interventions were attempted.

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Psychiatric progress note of 10/7/13 describes R17 being less paranoid but more agitated, being angry with his wife for not taking him home. R17 reported feeling well but being upset with his wife for not taking him home. At that time, R17's affect was bright, and his mood was neutral. Delusions were still described as paranoia about his wife. No hallucinations were documented. Diagnoses included vascular dementia, depression (stable) persistent delusions, persistent agitation. It was recommended to increase Risperdal.

Psychiatric progress note dated 10/14/13 indicates R17 upset with wife being disloyal to him, because she didn't want him home. Mood was described as neutral and no hallucinations documented. Diagnoses included vascular dementia, depression (stable), persistent delusions and agitation. His psychiatrist recommended an increase of Risperdal. The delusions was described as paranoia (questioning his wife's motives). There is no mention of any harmful affect to R17 because of this delusion.

R17's Quarterly Interdisciplinary Team Review of Psychotropic Medication/Dosage Reduction Program dated 12/30/13 reflects R17 was not delusional at that time. Targeted behavior was described as delusions and behavior disturbances (non-specific). The only therapeutic alternatives to drug therapy indicated were the staffs type of approach and modification of staff's approach. These interventions were deemed not effective at the time tried. There were no other approaches utilized. At that time, R17's Risperdal dose was .5mg BID.

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R17's behavior care plan with an original date of 4/10/13 lists the following behaviors for R17: rejecting care; making sexually inappropriate comments toward staff; being verbally abusive and delusions. The problem documented about the delusion is R17 was noted to have the delusion that he plays ball for the Chicago Cubs. During daily status meeting of 2/25/14 at 3:45 pm E1 (Administrator) stated that at times, R17 attempts to exit the building to go play ball. E1 agreed that Risperdal is not a treatment for elopement.

Behavior Monitoring Record for R17 from March 2013 tracks the following behaviors: wandering/elopement/pacing, socially inappropriate behavior (not specified) and refusing care. In March 2013, R17 had 3 episodes of refusing care, with staff utilizing redirection. There are only two episodes that has a positive result indicated; on the day shift of 3/12/13 and the night shift of 3/2; the evening shift documentation of 3/12/13 does not reflect whether the intervention was successful or not. The rest of the days that contain documentation contain all zeros, indicating no behaviors. February 2013 behavior tracking record reflect that on 2/26/13, R17 had 2 behaviors of refusing care, on the night shift. There is no documentation of any interventions used or any results. The rest of the form contains all zeros, indicating R17 had no other behaviors that were being tracked. Although R17 had been diagnosed with delusions, R17 is not being tracked for this.

Behavior Care Plan with the original date of 4/10/13 and revised date of 12/30/13 lists the following approaches for R17: calm approach, allow to make decisions when able; encourage to

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F 329	Continued From page 12 take meds; explain need for medical procedures, give time to calm down when upset; involve family with care and if needed; if upset, wait until calm to approach; remind resident not to be inappropriate, Risperdal re-started 9/23/13; psychiatric follow-up; ask about his love for Western movies. There is no mention of increased supervision, for R17, nor any mention of attempting to increase R17's participation in an activity, either group activity or 1:1. R17's behavior care plan does not contain a plan for a reduction in R17's psychotropic medication nor any specific criteria for any reduction. Neuropsychological Evaluation of R17 dated 11/29/12 states, in part, "...the patient endorsed visual hallucinations of humans of various sizes. These were not described as particularly distressing...". R17's 12/30/13 MDS (Minimum Data Set) reflects in Section E, which discusses behaviors, reflects no behaviors for R17. There were no hallucinations or delusions noted. and no physical, verbal or other behavioral symptoms. R17's 4/11/13 MDS, section E, also does not reflect any hallucination, delusions or indicators of psychosis. There were also no physical, verbal or behavioral symptoms documented.	F 329		