STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145910	A. BUILDING _____ B. WING _____	06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALHOUN NURSING & REHAB CENTER	#1 MYRTLE LANE HARDIN, IL 62047

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F 000	INITIAL COMMENTS	F 000		
F 329 SS=D	Annual Licensure and Certification Survey 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 by: Based on interviews, observations and record review, the facility failed to ensure that residents do not receive Antipsychotic medications until signs and symptoms of other possible underlying conditions are ruled out, and failed to ensure	F 329		

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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residents are not given these drugs unless other non-pharmaceutical interventions are attempted prior to the use of Antipsychotics for 2 of 5 residents (R10, R11) reviewed for Antipsychotic medication use in a sample of 15.

Findings include:

1) The Admission Sheet for R10 documents diagnoses to include Schizo-affective Disorder and Anxiety among others. The Minimum Data Set (MDS), dated 2/27/15, documents R10 has no delirium, identified behaviors or psychosis, but has moderate cognitive impairment. The June 2015 Physician Order Sheet (POS) documents R10 to currently receive Abilify 5 milligram (mg) at bedtime (HS), Cymbalta and Ativan 0.5 mg three times daily. The current Care Plan documents R10 have tearfulness at times, attentions seeking behaviors and gets easily agitated.

R10's Urinalysis, dated 3/16/15, identifies a urinary tract infection (UTI) with Levaquin 250 mg daily started for three days. The March 2015 POS documents that R10's Abilify was originally ordered for 2 mg on 3/24/15 with the physician documenting Schizo-affective Disorder as the diagnosis. R10's Departmental Notes, dated 3/21/15 at 11:20 PM document R10 continues on antibiotic for a UTI with no adverse effects noted. The Departmental Notes for 3/21/15 through 3/24/15 fail to document any behaviors. R10's Departmental Notes also fail to document any attempts at non-pharmacological or less restrictive interventions prior to the use of Abilify. There is also no documentation that staff assessed R10's behaviors in light of the UTI she currently had to determine if it had an effect. The Departmental Notes following the initiation of the

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Abilify fails to document its effectiveness or affect on R10. The consent to use the Abilify for R10 was signed on 3/27/15. A physician note, dated 3/31/15, documents R10 "Was started on Abilify 1 week ago for memory issues and depression." There is no documentation that the facility assessed R10's behavior to determine if any other factors, environmental/physical, etc attributed to an increase in R10's behaviors.

R10's Departmental Notes, dated 4/5/15, fail to document any behaviors. R10's Note, dated 4/6/15 at 3:15 PM, documents "Resident stopped SSD (Social Services Director), calling SSD by name. Resident appeared to be somewhat agitated. SSD spoke with resident. She states that she needs to get to the store. SSD did ask resident what she needed from the store and she said she just needed to get there. Resident switched topics and started talking about daughter. SSD did visit for a while with resident. Resident was calm when SSD left." R10's Departmental Notes on 4/7/15 at 12:20 AM and 10:32 AM fail to document identified any adverse behaviors. R10's Note, dated 4/7/15 at 2:21 PM, documents that Z1, Physician, saw R10 and increased her Abilify to 5 mg at HS. There is no documentation of what warranted the increase. The Physician Note, dated 4/7/15, documents "Was started on Abilify 1 week ago for memory issues and depression. Nurse Note continued outbursts of yelling and violent behavior." There are no entries into the Departmental Notes by nurses that document violent behavior. A Departmental Note, dated 4/8/15, documents R10 "Was fairly cooperative with staff with care. No real crying out except when incont (incontinent) care was being done."

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R10's Behavior/Intervention Monthly Flow Record for April 2015 tracks worrying, anxiousness, tearfulness, and needy behaviors with things she can do on her own. There are no violent behaviors tracked and/or documented in R10's Departmental Notes for March or April 2015. There is no documentation that the facility comprehensively assessed R10 to determine what behaviors she exhibits, how often and how severe the behaviors are and what, if any, environmental or physical concerns may attribute to R10's behaviors, such as UTI's. R10's current Care Plan has no documentation of a reduction plan.

On 6/3/15 at 1 PM, R10 was not agitated and/or aggressive as she was moved from side to side in bed during a treatment change to a wound on her buttocks. On 6/4/15 at 1:10 PM, R10 was transferred to bed by E8 and E6, Certified Nurses Aide (CNA.) R10 was cooperative and pleasant during the transfer.

On 6/4/15 at 11 AM, E7, Licensed Practical Nurse (LPN), described R10's behaviors as "noisy", thinks her Mom and Dad are here. E7 stated R10's behaviors are not harmful to herself or others, has never struck out at her or anyone else that she knows of. E7 stated R10 is very confused and sometimes thinks she has a motorcycle and needs to go to the Post Office. E7 stated she has taken care of R10 for approximately 7 months. E7 stated she is unaware if R10's UTI's have any impact on her behaviors or not.

On 6/4/15 at 11:23 AM, E8 described R10 as being anxious, yelling, noisy, but has never been harmful to herself or others. E8 stated R10 is

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very confused. E8 also stated R10's behaviors escalate when she has a UTI.

On 6/4/15 at 2:45 PM, E6 described R10 as confused. E6 stated R10 has good days and bad days, some days quiet, some days loud. E6 stated R10 does not use her call light, but hollers out instead. E8 stated she has never known R10 to harm herself or others and knows all the staff by name. E8 stated R10 is confused and often calls her granddaughter her daughter. E8 stated R10 is really loud when she has a UTI.

The facility's policy entitled "Behavioral Management and Psycho-Pharmacological Medication Monitoring Protocol" (no date) documents the purpose as being "Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program. Interventions developed will include the use of medications when the appropriate assessment by the physician and interdisciplinary team have validated that non-chemical interventions alone are not successful, that these behaviors were persistent and were not caused by preventable reasons. The criteria for use of an Antipsychotic medication: Since diagnoses alone do not warrant the use of Antipsychotic medications, the clinical condition must also meet at least one of the following criteria (A, B or C): A. the Symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions (such a paranoia or grandiosity.) or B. The behavioral symptoms present a danger to the resident or others; or C. The symptoms are significant enough that the

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resident is experiencing one or more of the following: inconsolable or persistent distress (e.g. fear, continuously yelling, screaming, distress associated with end of life, or crying); a significant decline in function, and/or substantial difficulty receiving needed care (e.g. not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection.) The procedure includes establishing the length of time."

2) R11's Initial OBRA screening, dated 8/01/13, documents that R11 does not have a diagnosis of developmental disabilities or mental illness. R11's POS, dated 5/30/15, documents that R11 has a diagnosis of Psychosis and Dementia with behavioral disturbances. R11's POS, dated 5/30/15, documents that R11 takes Seroquel 25 mg in the AM and 50 mg in the PM. R11's MDS, dated 3/17/15, documents that R11 has no signs of delirium, hallucinations or delusions.

R11's Behavior/Intervention Monthly Flow Record, dated 1/2015, documents 0 episodes for resistive to care, 1 episode of verbal abuse/combative, and 0 episodes of being rude. The Record for 2/2015 for R11, documents that R11 had 3 episodes of resistive to care, 0 episodes of verbal abuse, and 0 episodes of being rude. The Record for 3/2015 for R11 documents that R11 had 2 episodes for resistance to care, 3 episodes of verbal abuse, and 0 episodes of being rude. The Record for 4/2015 for R11, documents that R11 had 6 episodes for resistance to care, 1 episode of verbal abusive/combative, and 8 episodes of being rude. The Record for 5/2015, documents that R11 had 0 episodes of resistance to care, 0 episodes of verbal abuse/combative, and 2 episodes of being rude.

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F 329	Continued From page 6 On 6/3/15 at 12:10 PM, R11 was eating lunch in the dining room, staff were providing verbal cues during R11's lunch. R11 did not display any behaviors at that time. On 6/5/15 at 10:00 AM, E5, Facility Corporate Nurse, stated that when R11 was admitted she was not on any antipsychotic medication. E5 stated the physician was contacted last night and a reduction had been made in Seroquel. R11's Physician Order, dated 6/4/15, documents Seroquel reduced from 75 mg to 50 mg daily. On 6/5/15 at 10:15 AM, E2, Director of Nursing (DON), stated that R11's behaviors are easily redirected.	F 329		