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
	145993	A. BUILDING ______ B. WING ______	08/19/2016

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COULTERVILLE REHAB & HCC	**13138 STATE ROUTE 13** **COULTERVILLE, IL 62237**

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F 000	INITIAL COMMENTS Annual Certification Survey Complaint #1644465/IL87575 - F280(E) cited	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Facility failed to ensure physical restraints were not used for convenience for 1 of 4 residents (R4) reviewed for restraints in the sample of 15. Findings include: R4's July 2016 Physican Order Sheet (POS) documents in part, R4 has a diagnosis of anxiety disorder, age related cognitive decline, and Alzheimer disease. R4's Minimum Data Set (MDS), dated July 2016, document R4 has severe cognitive impairment. R4's Progress Note, dated 07/17/2016 at 7:26 PM, documents "Resident was combative with when this nurse was trying to give Risperdone, staff helped by holding her hands during administration, but then resident just spit it back out." On 08/17/2016 at 9:35 AM, E4, Licensed	F 221		

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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Practical Nurse (LPN), stated "(R3) gets upset frequently and is easily agitated and when she gets like that, just give her space and then reapproach. She usually only needs 2 minutes then she is good." E4 identified E13, LPN, as the nurse who wrote the Progress Note on 07/16/2016 at 7:26 PM regarding holding (R4's) hands while giving medication.

On 08/18/2016 at 10:32 AM, E5, Licensed Practical Nurse (LPN), stated "(R4) gets agitated really easy. Sometimes during medication, she (R4) gets upset, but if you just redirect her and then try again later, she always does better."

On 08/18/2016 at 9:58 AM, E2, Director of Nursing (DON), stated "If a resident is not cooperating with medication and not wanting to take their medication, I expect staff to try and redirect the resident. Wait and then try again."

On 08/19/2016 at 11:50 AM, E13 stated "I was the nurse passing out the meds back in July and (E14, Certified Nursing Assistant, CNA) held (R4's) hands as I gave her the medicine. She (R4) was really agitated and then she just spit them back out."

Three attempts on 08/19/2016 to contact E14 for interview were unsuccessful.

The Facility's Use of Restraint Policy, revised 2/2014, documents in part, "Restraints shall only be used for the safety and well-being of the resident (s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls."

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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 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 observation, interview, and record review, the facility failed to review and revise Care Plan for 4 of 15 residents (R4, R9, R10, R11) reviewed for care planning in the sample of 15.

Findings Includes:

1. R9's Physician Order Sheet (POS), dated 08/01/16, documents R9 has diagnoses of Altered Mental Status, Dementia with Behavioral Disturbances, Alzheimer's, and Depression with Psychosis. R9's POS also documents R9 is on

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Seroquel (an antipsychotic medication) 25 milligrams (mg) once daily at 8:00 AM and Seroquel 50 mg once daily at 4:00 PM.

R9's Care Plan, dated 08/16/16, documents R9 uses psychotropic medications, but does not list the name of the medication. R9's Care Plan also documents the intervention to monitor and record the target behaviors of violence and aggression. The intervention does not address R9's psychotic behavior. R9's Care Plan, dated 08/12/16, documents on 06/02/16 R9 was found lying on the floor, after ambulating with bare feet to chase the cats out of his room.

On 08/18/16 at 1:40 PM, E10, Care Plan Coordinator, stated " our Point Click Care System deletes some information, when the resident returns from the hospital, and I have been in the process of fixing the Care Plans."

2. R4's July 2016 POS documents in part, R4 has an diagnosis of anxiety disorder, age related cognitive decline, and Alzheimer disease.

R4's Psychiatric Evaluation, dated 02/21/2016 at 12:00 PM, documents R4 has a diagnosis in part, of senile dementia of Alzheimer's type with psychosis.

R4's July 2016 Minimum Data Set (MDS) documents R4 has severe cognitive impairment. The MDS also documents R4 is taking Seroquel 25 mg two times a day and Risperidone 1.5 mg.

On 08/16/2016, R4 was sitting at the dining room table attempting to feed herself and talking to someone who is not there. Her words were mumbled and she was talking about watching out

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for the children. No children were present in the dining room.

On 08/17/2016 at 9:35 AM, E4, LPN, stated "(R4) has psychotic behaviors like seeing things that are not there and talking to people that are not there. She sees animals, children and just stares into space sometimes."

On 08/18/2016 at 10:33 AM, E5, Registered Nurse (RN), stated "(R4) sees things that are not there and talks to people who are not there she has psychotic hallucinations."

On 08/18/2016 at 1:21 PM, E6, Certified Nursing Assistant (CNA), stated "(R4) has psychotic behaviors. She stares out into space not making eye contact. She sees things that are not there and has conversation with people that are not there too."

R4's Progress Note, dated 07/22/2016 at 4:13 PM, documents in part, "Resident sitting in wheelchair at nurses station, talking nonsensically to people who are not there. She grabbed the fingers of one hand with her other hand she twisted them yelling 'quit that! Let go of my hand!' when I speak to resident it is as if she does not see or hear me, she's in a whole other world. We have to get right in from of her face in order to talk to her."

R4's Care Plan, dated 06/25/2016, documents R4 fell forward out of her wheelchair and hit her head. The Care Plan documents R4 said She was fishing and the lure got caught up and she was trying to get her lure out of the seaweed. The Care Plan lists Behavior Problems, but does not

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list a heading for antipsychotic medications. Under the Behaviors dated 02/04/2016 document in part, "Administer antipsychotic medications as ordered (Risperdal)." The use of Seroquel is not listed on the Current Care Plan. The Care Plan does not address hallucinations.

The Care Plan Policy, revised 10/2010, documents in part, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." It also documents under Care Plan Interventions "5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes, When possible interventions, address the underlying source (s) of the problem area (s), rather than addressing only symptoms or triggers, It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident."

3. R10's Progress Note, dated 7/29/2016 at 2:33 PM, documents in part, "Administrator and Social Service director delivered the 30 day involuntary discharge notice to (R10). We explained the process, the cause behind the notice and the efforts his son was making to find of alternative placement and pay his outstanding balance."

R10's Care Plan, revised 6/15/2016, documents the resident wishes to be discharged home. "Goal: Resident will be discharged to home safely." The Care Plan had no documentation of the involuntary discharge or alternative placement.

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F 280	Continued From page 6 On 8/19/2016 at 11:32 AM, E10, Registered Nurse (RN)/ Care Plan Coordinator, stated R10's Care Plan had not been updated to reflect the involuntary discharge. 4. R11's Progress Note, dated 5/25/2016 at 8:26 AM, documents in part, "(R11) was issued a 30 day notice of involuntary discharge. Admin (Administrator) and SSD (Social Services Director) met with (R11), privately in her room. We explained the reason for the notice being failure to pay her bill. A copy of the paperwork was given to her, which she placed in the top dresser drawer in an envelope." R11's Care Plan, revised 9/22/15, does not document discharge plan. The Care Plan had no documentation of the involuntary discharge. On 8/19/2016 at 11:32 AM, E10 stated R11's Care Plan had not been updated to reflect the involuntary discharge.	F 280		
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		

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interview, the facility failed to prevent falls and provide safe transfers for one of 7 residents (R7) reviewed for falls and transfers in the sample of 15.

Findings include:

R7's Physician's Order Sheet (POS) for 8/2016 documents diagnoses, in part, as General Muscle Weakness, Hemiplegia, Aphasia and Alzheimer's Disease.

The Minimum Data Set (MDS), dated 2/19/2016 and 5/21/2016, documents R7 is severely impaired with cognition, has unsteady sitting balance and requires extensive assistance with bed mobility, transfers and all activities of daily living (ADL's).

R7's Fall Risk Assessment, dated 2/12/2016, documents R7 is at risk for falls.

On 8/16/2016 at 11:42 AM, R7 was in bed on a alternating low air loss mattress. There were no siderails on the bed. R7 had right sided hemiplegia and was nonverbal. Z3, family member, was visiting at that time. Z3 stated, "One time they (staff) caught his (R7's) right middle toenail and tore it off. The rest of it had to be removed." Z3 reported R7 is transferred with a mechanical lift. The toenail was missing from R7's right second toe. Z3 reported R7 had one fall from bed.

The Resident Fall Report/Investigation for R7, dated 7/09/2016 at 3:50 AM, documents R7 rolled out of bed and was found on the floor on his right side, between the bed and the window. The Fall Report documents, in part, "Resident (R7) is

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nonverbal." The Fall Report documents R7 was sent to the local hospital, but had "no apparent injury." The intervention after R7's fall is documented on the Fall Report of 7/09/2016 as, "Educate staff on making sure resident is placed in the middle of the bed, and check mattress setting."

The Resident Incident Report for R7, dated 7/22/2016 at 8:45 AM, documents, in part, "Right hand slipped down into shower chair side, and when resident's (R7) hand assisted back to lap, a 2.4 cm (centimeter) ST (skin tear) obtained on chair." This Report documents an intervention to prevent recurrence as, "Staff education on slowing work pace to prevent accidents, and also use extra staff assist when repositioning heavy care resident."

The Resident Incident Report for R7, dated 7/26/2016 at 6:40 AM, documents, in part, "Type of Incident: Removal of toenail. Resident was laying in bed in his room and CNA's (Certified Nurses Aides) were helping shower aide (mechanical sling lift) resident into the shower chair, and most likely caught (R7's) toe on the (sentence remains incomplete). Right foot second toenail removed, blood present. No signs and symptoms of pain. Interventions: staff education provided and toenails trimmed. Staff education to caution when transferring (R7) with a (mechanical sling lift). Watch hands, arms, legs and feel and make sure they are in proper position for transfer to prevent injury."

On 8/18/2016 at 9:57 AM, E2, Director of Nursing (DON), stated, "I don't know what the bed was set on when (R7) fell out of bed. Right now it is set on 'air'. (R7) is a big guy. (R7) is very high acuity. I

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F 323	Continued From page 9 suggested to (Z3) a bariatric bed, but she refused." E2 reported Z3 provided R7's mattress. R7's Care Plan, revised 7/26/2016, documents, in part that R7 has had a "low air loss mattress on bed" since 2/18/2016. An intervention in the Care Plan is documented, "Make sure air mattress not on alternating." The facility's policy and procedure, revised 12/2007 and entitled, "Falls and Fall Risk, Managing" documents, in part, "Based on previous evaluations and current data, the staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling, and to try to minimize complications from falling. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls." The facility's policy and procedure, revised 8/10/2001 and entitled, (Mechanical Sling Lift) documents, in part, "A (mechanical lift) should be used for residents who are too heavy to move by yourself, or who are seriously disabled. A (mechanical sling lift) provides a mechanism to move a resident as safely and as easily as possible. Be sure to support the resident's head and legs while seated in the (mechanical sling lift). Rule: Avoid hazards. Clear your path of obstacles or hazards BEFORE you move the resident."	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	F 329		

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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 record review and interview the facility failed to conduct resident specific behavior tracking for 2 of 3 residents (R4, R9) reviewed for antipsychotic medications in the sample of 15.

Findings Include:

1. R9's Physician Order Sheet (POS), dated 08/01/16, documents R9 has diagnoses of Altered Mental Status, Dementia with Behavioral Disturbances, Alzheimer's, and Depression with Psychosis. R9's POS also documents R9 is on Seroquel (an antipsychotic medication) 25

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milligrams (mg) once daily at 8:00 AM and Seroquel 50 mg once daily at 4:00 PM.

R9's Care Plan, dated 08/16/16, documents R9 uses psychotropic medications, but the name of the medication is not listed. R9's Care Plan also documents R9 has the intervention monitor and record the target behaviors of violence and aggression. The intervention does not address R9's psychotic behavior. R9's Care Plan dated 08/12/16 documents on 06/02/16 R9 was found lying on the floor, after ambulating with bare feet to chase the cats out of his room.

On 08/18/16 at 9:15 AM, E9, Licensed Practical Nurse (LPN), stated "I haven't seen any psychotic behaviors, but he can become verbally abusive."

On 8/18/16 at 9:20 AM, E8, Certified Nursing Assistant (CNA) stated "Yesterday, he (R9) was pretending to drink coffee. He (R9) even put the imaginary cup to his mouth."

On 08/18/16 at 9:21 AM E7, CNA, stated " He (R9) screams that he will kill us. He (R9) tries to pick up stuff from the floor (that is not there)."

R9's Behavior Tracking documents R9 is being tracked from 08/01/16 through 08/17/16 for aggressive behaviors. However, R9 didn't show any Aggressive Behavior from 08/01/16 through 08/16/16.

R9's Behavior Tracking does not document that R9 is being track for any Psychotic behavior.

2. R4's July 2016 Physician Order Sheet documents in part, R4 has an diagnosis of anxiety disorder, age related cognitive decline,

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and Alzheimer disease.

R4's Psychiatric Evaluation, dated 02/21/2016 at 12:00 PM, documents R4's diagnosis in part, of senile dementia of Alzheimer's type with psychosis.

R4's July 2016 MDS documents R4 is taking Seroquel 25 mg two times a day and Risperidone (an antipsychotic medication) 1.5 mg. R4's MDS also documents R4 has severe cognitive impairment.

On 08/16/2016, R4 was sitting at the dining room table attempting to feed herself and talking to someone who was not there. Her words were mumbled and she was talking about watching out for the children. No children were present in the dining room.

On 08/17/2016 at 9:35 AM, E4, LPN, stated "(R4) has psychotic behaviors like seeing things that are not there and talking to people that are not there. She sees animals, children and just stares into space sometimes."

On 08/18/2016 at 10:33 AM, E5, Registered Nurse (RN), stated "(R4) sees things that are not there and talks to people who are not there. She has psychotic hallucinations."

On 08/18/2016 at 1:21 PM, E6, CNA, stated "(R4) has psychotic behaviors. She stares out into space not making eye contact. She sees things that are not there and has conversations with people that are not there, too."

R4's Progress Note, dated 07/22/2016 at 4:13 PM, documents in part, "Resident sitting in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145993	A. BUILDING ______ B. WING ______	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COULTERVILLE REHAB & HCC	**13138 STATE ROUTE 13 COULTERVILLE, IL 62237**

(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

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wheelchair at nurses station, talking nonsensically to people who are not there. She grabbed the fingers of one hand with her other hand she twisted them yelling 'quit that! Let go of my hand!' When I speak to resident, it is as if she does not see or hear me, she's in a whole other world. We have to get right in from of her face in order to talk to her."

R4's Care Plan, dated 06/25/2016, documents R4 fell forward out of her wheelchair and hit her head. The Care Plan documents R4 said she was fishing and the lure got caught up and she was trying to get her lure out of the seaweed.

R4's Behavior Tracking provided by the Facility documents the following: "(1) Resident hits, claws, scratch and kicks staff during care. (2) Cuss at staff when she is upset (3) Wake up and crawl out of her bed onto the floor mat and sit down." R4's Behavior Tracking did not include tracking of hallucinations, hearing voices or people.

On 08/18/2016 at 2:08 PM, E2, Director of Nursing, stated there was no Behavior Tracking Policy.

F 363 SS=E — F 363

483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

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	145993	A. BUILDING ______ B. WING ______	08/19/2016

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the Facility failed to follow the recipe to ensure all residents receive appropriate nutritive value of food in accordance with their dietary orders for the puree diets for 1 of 5 residents (R1) in the sample of 15 and 4 residents (R18, R20, R21, R22) in the supplemental sample.

Findings include:

On 08/17/2016 at 10:50 AM, E11, Cook, began preparing the Puree Italian Beef Sandwich. E11 took the beef from the pan and put it into the food processor and added 2 cups of the beef broth and blended the ingredients until smooth. The consistency of the mixture achieved was a smooth pudding or soft mashed potato consistency. E11 began to put the mixture into the holding pan when E12, Cook, stated she had other ingredients that needed to be added. E12 then began to follow the recipe which documents add 2 cup of milk and 4 tablespoons of mayonnaise and 2 teaspoons of mayonnaise. The consistency of the beef became very thin and runny with a milk like consistency. E12 stated they would need to now add thickener to achieve the right consistency. The beef puree was now double in size and E12 threw out the remaining puree which would not fit into the holding pan because it had doubled in size.

On 08/17/2016 at 11:01 AM, when asked why she did not follow the recipe and E11 stated "I have only been here for a few weeks and with the other recipes I used broth to puree, so I thought it was the same. I did not look at the recipe."

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F 363	Continued From page 15 The Pureed Italian Beef Sandwich Recipe with the copyright date of 2016 documents in part for 10 servings: "10 each Italian Beef Sandwich, 4 Tablespoon, 2 teaspoon heavy Mayonnaise and 2 cups of whole milk." It also documents "3. Follow any facility/policy /procedures to ensure a correct portion is served." The recipe also documents "It is noted that if product needs to be thinned, the cook can gradually add an appropriate amount of liquid that is not water to obtain pureed consistency." A written statement by E12, dated 08/17/2016 and provided by the facility, documents "I was preparing to make the pureed Italian Beef for our lunch meal but before I could get all the required ingredients (E11) had already started to puree the meat just using broth." A list of residents on puree diets provided by the facility documents R1, R18, R20, R21, and R22 are on puree diets. On 08/17/2016 at 2:50 PM, E2, Director of Nursing, stated there was no Policy for Purees.	F 363		