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
	146145	A. BUILDING ______ B. WING ______	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATHER, THE	425 DAVIS STREET EVANSTON, IL 60201

(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 Certification Survey	F 000		
F 323 SS=E	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 interview and record review, the facility failed to implement their fall policy governing post fall assessment, updating interventions and modifiying a resident's care plan to prevent further falls for one of four residents (R2), reviewed for falls in a sample of eight. In addition, the facility failed to follow their policy for monitoring hot water temperatures used in a machine that heats and contains heat packs in the physicial therapy room for two of eight sampled residents (R3,R8) and one supplemental resident (R9) reviewed for accident/incidents in a sample of 8. Finding Include R2 is a 93 year old female admitted to the facility on 3/5/13 with diagnoses that included: status post open reduction and internal fixation of right hip fracture, Parkinson ' s disease, dementia, depression, spinal stenosis, and degenerative joint disease. R2's quarterly, Minimum Data Sets (MDS) dated 9/12/13 and 12/13/13, indicates that R2 ' s cognitive skills for daily decision making is	F 323		

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 323	Continued From page 1 severely impaired, R2 had falls since admission/entry or reentry or the prior assessment, and R2 had 2 falls with no injury since admission/entry or reentry or prior assessment. On 3/5/14 at 2:56 PM, E3 (Registered Nurse) stated in part that she could not find documentation regarding updated interventions on R2's fall care plan after R2's falls on 6/26/13, 7/11/13, and 9/10/13. On 3/5/14 at 4:00 PM, E3 stated in part that when a resident has a fall, the nurses should do a fall assessment and update the fall care plan. The facility educated the staff regarding falls in January, 2014. Before that education in January, 2014, the nurses knew to do a post fall assessment but not to update the fall care plan. On 3/6/14 at 9:25 AM, E3 stated in part that the fall documented on R2's care plan dated 1/21/13, really occurred on 1/21/14. R2's fall care plan interventions were updated on 1/24/14 and included interventions for a physician therapy and occupational therapy evaluation for wheel chair safety and a wheel chair cushion. R2's fall care plan was not updated consistently after R2's falls and should have been updated after each fall. The facility doesn ' t use wheel chair alarms. The facility uses infrared alarms that detect movement in the area that the sensor covers. The alarm sensor has about a 90 degree radius. The facility uses the alarm for residents when they are in bed or in a wheel chair while in their room. On 3/6/14 at 8:53 AM, E3 stated in part that she could not locate the incident report for R2's fall on 6/7/13. Nurse note dated 6/7/13 at 4:30 PM indicates that R2 was found on the floor beside her bed in a kneeling position, facing her bed. Incident reports indicate the following: On	F 323		

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F 323	Continued From page 2 6/14/13 at 10 AM, R2 stood up from a chair and fell onto her left side, while in a common area and visible to all staff; On 6/26/14 at 9:00 AM, R2 was found on the floor in a common area, lying on her right side and incurred a skin tear on the right elbow; On 7/11/13 at 8:21 AM, R2 was found with half of her lower body off the bed while her right hand was holding the grab bar; On 9/10/13 at 11:00 AM, R2 was found sitting on the floor in her room with her back propped up by the bed and the air mattress was totally deflated; On 12/6/13 at 5:19 PM, R2 stood up from her wheel chair and fell backward when the certified nurse assistant (CNA) who was sitting next to her, stood up to help another resident; and on 1/21/14 at 5:10 PM, R2 slid out of her wheel chair while in the hallway as a registered nurse walked toward R2. Fall assessments for R2 on 3/6/13, 3/12/13, 3/20/13, 6/14/13, 6/26/13, 9/10/13, 12/23/13, and 1/21/14 indicate that R2 was at a high risk for falls. Fall risk assessments were not completed after each fall indicated on the above mentioned incident reports. On 3/6/14 at 11:28 AM, E3 stated in part and acknowledged that fall assessments were not completed after each of R2's falls. R2 ' s fall care plan initiated 3/12/13 indicates that R2 is at a high risk for falls related to impaired mobility, history of recent fall with right hip fracture, and Parkinson ' s disease with dementia. On R2 ' s fall care plan, initiated on 3/12/13, there is documentation of intervention updates on 6/7/13. On R2's fall care plans, with review start dates of 6/4/13 and 12/10/13, there is no documentation of intervention updates. On 3/6/14, at 8:55 AM, E1 (Administrator) stated that the Fall Precaution Protocol Draft, dated February, 2013, that she presented on 3/6/14 is the policy that the facility is following.	F 323		

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F 323	Continued From page 3 The facility's Fall Precautions Protocol Draft dated February, 2013 depicts the following: Assessment and re-assessment of fall risk should occur after a fall; evaluation and re-evaluation of fall risk should occur after a fall; fall reduction interventions are specific to the individual and arise from age-related changes in the structure and function of the body, and/or chronic diseases associated with aging and these interventions can be utilized as needed to assist in developing an individualized plan of care for all precautions for residents and any interventions that are selected for a resident ' s plan of care/service plan should be documented in the care plan/service plan. On 3/5/14 at 11:05am, during the Environmental Tour, a hydrocollator was noted in Therapy Room. Z2 (Rehabilitative Manager) indicated that the heating unit was not plugged in because they did not anticipate using it. Z2 stated, " The hydrocollator warms up moist heated packs. They are used on the residents mainly for pain management. We use the hot packs maybe two to three times a week. We don't check the temperatures of the water. No, we don't have a log for water temperatures." Z2 continued to state, " We never place (the hot packs) on a resident that cannot provide cognitive feedback." Z2 was asked how quickly a burn can take place if a hot pack is placed on the elderly with fragile skin, cognitively intact or not. Z2 replied, " Fairly quickly." On 3/6/14 at 10:18am, Z2 further clarified, " Hot packs are used on anybody that complains of pain or to loosen up joints and muscles. Anyone going to Physical Therapy could potentially use the hot packs. There does not need to be a doctor's order for the use of hot packs. It can be used on anyone who comes to therapy and can	F 323		

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F 323	Continued From page 4 report pain." The user manual for the hydrocollator was submitted by the facility on 3/5/14. The manual was undated and titled, " Hydrocollator Heating Units User Manual." The Safety Precautions portion of the user manual documents: Never adjust the thermostat too high. The thermostat is extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 degrees Fahrenheit to 165 degrees Fahrenheit (71-74 degrees Celsius). The temperature of the water should be checked with a thermometer after every adjustment, before using the hot pack. Always allow sufficient time for the water temperature to stabilize. On 3/6/14, E1 (Administrator) submitted a policy titled " Hydrocollator Policies and Procedures " documents: 1.) Always check temperature of water prior to patient use. Log temperature in temperature log. Temperature should not exceed 165 degrees Fahrenheit. R3, R8 and R9 are identified for residents for potential use of the hot packs.	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. Based on a comprehensive assessment of a	F 329		

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F 329	Continued From page 5 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 interview and record review, the facility failed to have evidence for the initial and continued use of psychoactive medications, attempts for a psychoactive medication gradual dose reductions, monitor and evaluate the ongoing need for psychoactive medications and to follow their psychotropic medication management policy for one of four residents (R2), reviewed for psychoactive medications in the sample of 8. Findings Include: R2 is a 93 year old female admitted to the facility on 3/5/13 with diagnoses that included: status post Open Reduction and Internal Fixation of right hip fracture, Parkinson's disease, Dementia, Depression, Spinal Stenosis, and degenerative Joint Disease. R2 ' s physician order sheets from 3/5/13 to 3/1/14 indicate prescription orders for Lexapro 10 milligrams by mouth daily and Klonipin 0.25 milligrams by mouth at bedtime. On 3/5/14 at 3:00 PM, E2 (Assistant Director of	F 329		

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Nursing) acknowledged a physician order dated 4/17/13 to discontinue the Lexapro, physician progress note dated 4/17/13 which indicates documentation to discontinue the Lexapro - no indication for routine using, and the physician order dated 5/22/13 to restart Lexapro 10 milligrams by mouth daily. E2 stated, in part, that Z1 (Medical Physician) reordered the Lexapro on 5/22/13 at the family's request and presented a nurses note dated 5/22/13 at 1:15 PM, which indicates that R2's family member voiced concerns over R2 ' s increased sleeping throughout the day. At which time, Z1 was notified and ordered Lexapro 10 milligrams daily.

On 3/5/14 at 4:00 PM, E3 (Registered Nurse) stated, in part the resident's primary care physician is responsible for managing the resident's psychiatric diagnosis and treatment. The physicians see the residents about once a month and will come and evaluate the residents at the facility's request.

On 3/6/14 at 12:40 PM, Z1 stated, in part, that he is aware of R2 having a prescription order for Lexapro 10 milligrams by mouth daily and Klonipin 0.25 milligrams by mouth at bedtime.; Z1 ordered both of medications for R2; the Lexapro is for R2's diagnosis of depression and the Klonipin is a sleeping aid for R2. R2 ' s underlying diagnosis is dementia; Z1 sees R2 every 1 to 2 months; Z1 is responsible for evaluation and follow up care for R2 ' s psychiatric diagnosis and treatment; initially Z1 felt that the Lexapro wasn't having an effect on R2, one way or the other; Z1 restarted the Lexapro at the family ' s request because they thought R2 was less active and alert; Z1 hasn't considered reducing the dose of Lexapro; R2 is seemingly doing well with Lexapro and hasn't had any adverse effects from the Lexapro; there was

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F 329	Continued From page 7 no reason to make a notation in R2's chart because Z1 didn't see a change in R2' s behavior or mental status and Z1 wasn' t going to change the doses; and potentially there is harm if residents are on psychoactive medications and there is no ongoing evaluation and follow up care performed. Medication administration records from April, 2013 to March, 2014 indicate documentation of R2 receiving Lexapro 10 milligrams by mouth daily and Klonipin 0.25 milligrams by mouth at bedtime. R2's care plans dated 3/12/13 and 6/8/13 (with 11/24/14 revision date) for the use of a psychoactive medication -an antidepressant and Klonipin for restlessness indicate the following interventions: monitor resident's mental status functioning on ongoing basis and physician to evaluate the effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Physician progress notes from 3/7/13 to 2/8/14 only indicate documentation of R2' s psychoactive medications on 4/17/13. There is no other documentation of ongoing evaluation of R2's psychiatric diagnosis and treatment in the progress notes from 3/7/13 to 2/8/14. The facility's Psychotropic Medication Management Policy dated April 1, 2013 documents the following: - Residents are not given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident 's comprehensive assessment, to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the aforementioned conditions. Targeted behavioral expressions, for which the medication has been prescribed, are documented in the care	F 329		

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F 329	Continued From page 8 plan and the behavior monitoring record - Residents who use antipsychotic drugs receive attempts to gradual dose reductions, unless clinically contraindicated.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		

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Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to have a system in place for monitoring and tracking infections within the facility according to the facility's infection control policy. This failure has the potential to affect 18 of 18 residents residing in the facility.

Findings include:

On 3/3/14, E1 (Administrator) submitted the Resident Census and Conditions of Residents sheet that documented a census of 18 residents.

On 3/3/14 at 3:15pm, E1 stated, "I would be the person in charge of the infection control program at this time. Previously, it was the DON (Director of Nursing) but she left in December."

During the Infection Control interview, on 3/3/14 at 3:25pm, E1 was asked if she had a process for tracking of infections, types of organisms and antibiotic usage/effectiveness of antibiotics. E1 stated, "The nurses document in the Nurse's Notes and we pull the information from there. We do not have a tracking tool." Regarding antibiotic usage, E1 stated, "Monthly we get a report from the pharmacy. We do not have a daily tracking form for antibiotics. If it is an active infection, then we generate a 24 hour report from (our electronic system)." E1 was asked about reliability of the Nurse's Notes if nurses do not chart on the

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F 441	Continued From page 10 resident's infections. E1 stated, "That is where we pull the information for infections right now." On 3/3/14 at 4:00pm, E1 presented a tracking tool and stated, "This is what we will be using. As of right now, we do not have a tracking tool. We just have the nurses daily charting. We've been looking at this and we realize we need a more formal log in place." On 3/5/14 at 1:50pm, E2 (Assistant Director of Nursing-ADON) indicated that she was currently the Interim Director of Nursing. E2 was asked how infections were tracked under the previous Director of Nursing. E2 stated, "There was no formal infection tracking process. She did not pass any information down to me. We are aware that we need to put a process in place. Our attention was focused on rebuilding our processes. She never told us how she was tracking infections. We had QA (Quality Assurance) meetings where we discussed infection control. But, no formal tracking log." On 3/6/14 at 11:20am, E3 (Minimum Data Set (MDS) Coordinator) was asked to submit a list of the infections that were treated in the last six months. E3 presented monthly reports titled; "Therapeutic Type Reports" which she indicated came from the pharmacy. These reports were dated from September 1, 2013 to February 28, 2014. These reports documented antibiotics that were used for residents. E3 was asked what the indications were for the use of antibiotics. E3 stated, "Well, I can find that out for you but it would take about 40 minutes." E3 indicated that she would have to go into the system to find all the information. When E3 was asked if this is the process by which they track antibiotic usage, E3	F 441		

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F 441	Continued From page 11 stated, "I can't answer that." When E3 was asked how they are tracking antibiotic use on a daily basis, E3 stated, "That's part of the problem. We weren't tracking." A facility policy dated 4/1/13 and titled, "Surveillance System - Infection Control" documents: Purpose: This policy guides the creation of accurate statistics of infection rates in the care venue. Process: A surveillance system is used throughout the care venue. This system is both resident based and laboratory based. 4. Collection of data includes: 4.2 Clinical information about infection signs and symptoms specific to infection and the date(s) of onset. 4.5 Interventions/Outcomes-Antibiotics, other treatment initiated, devices removed, results of treatment (recovery, no improvement, worsening of infection, death). 5. This information is collected on an ongoing basis and tracked and trended for pattern identification. A facility policy dated April 1, 2013 and titled, "Infection Prevention Program" documents: Scope of The Infection Prevention Program 1. The Infection Prevention Program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. 2. Components of the program included but are not limited to: There is ongoing monitoring for infections among residents and personnel and subsequent documentation of infections that occur. Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks.	F 441		