STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	**27 AUERBACH PLACE GLEN CARBON, IL 62034**

(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	F 000		
F 225 SS=D	Annual Licensure and Certification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse immediately to the Department and failed to complete an abuse investigation for 1 of 6 residents (R6) reviewed for abuse in the sample of 15. Findings include: The Incident Details Report for R6, dated 09/05/2015 at 6:05 AM, documents, in part, "(R6) stated, 'They were trying to get me dressed and changed and to get me out of bed and staff (E15, Certified Nursing Assistant, CNA) hit me in the left arm, so I hit her in the stomach.'" On 10/29/2015 at 8:47 AM, E1, Administrator stated, "I did not report this incident to the State or perform a full investigation. There were two CNAs in the room (E14, CNA and E15) and statements were taken from staff. No staff was suspended but (E15), who was accused of hitting (R6) and did not return to work until two days later. By then the statement had been retracted by the resident (R6)." On 10/29/2015 at 9:40 AM, E2, Director of Nursing (DON) stated no statement was taken from E15 regarding the accusation. Only E14's statement was on file for review.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 226	Continued From page 2 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 record review, the facility failed to follow operationalize their Abuse policy for reporting allegations of abuse immediately to the Department, and failed to do a complete abuse investigation for 1 of 6 residents (R6) reviewed for abuse in the sample of 15. Findings include: The facility's Policy on Abuse,revised on 05/04/2013,documents in part, "Investigation: any allegation of abuse or neglect involves an employee, that individual will be suspended from duty until an investigation is completed. An allegation of abuse, neglect, or misappropriation of funds will be reported by the Administrator or designee of the community to the Illinois Department of Public Health (IDPH) immediately once becoming aware of the incident. The Administration will make a determination regarding the outcome of the investigation and actions (S) if any to be taken. This report will be sent to IDPH in the follow-up to the initial report." The Incident Details Report for R6 dated 09/05/2015 at 6:05 AM, documents R6 stated, " They were trying to get me dressed and changed, and to get me out of bed and staff (E15, Certified Nursing Assistant, CNA) hit me in the left arm. So, I hit her in the stomach."	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 226	Continued From page 3 On 10/29/2015 at 8:47 AM, E1, Administrator stated she did not report R6's allegation to the Department. E1 stated that no staff were suspended regarding this allegation. On 10/29/2015 at 9:40 AM, E2, Director of Nurse's (DON) stated no statement was taken from E15 and only E14's, CNA, statement was on file.	F 226		
F 280 SS=E	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 interview and record review, the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 280	Continued From page 4 Facility failed to review and revise Care Plans for 6 of 15 residents (R1, R6, R7, R10, R11, R12) reviewed for Care Plans in the sample of 15. Findings include: 1. R6's October 2015 Physician Order Sheets (POS) document, in part, diagnosis of unspecified psychosis disorder, not substantiated and the following antipsychotic medication: Quetiapine Fumurate 25 milligram (mg) two times a day, Haloperidol 0.5 mg one time a day, Haloperidol Lactate 5 mg/milliliter (ml) inject 1 mg intramuscularly once daily, as needed for agitation. The Behavior/Intervention Monthly Flow Sheet for October 2015 documents, "Yelling, Anxiety, for the use of Haloperidol," and "continuous yelling and fidgeting for the use of Seroquel and Haloperidol." R6's Care Plan for October 2015 documents behaviors, in part, "1) episodes of being restless at night, 2) Incidents of anxiety and fearfulness, and 3) remain calm and not have outbursts." R6's Care Plan fails to address any psychotic symptoms, specific behaviors or tracking of psychotic behaviors. R6's Minimum Data Set (MDS), dated 05/17/2015, documents R6 has severe impairment with cognition and decision making. The Incident Reports for R6 documents on 05/09/2015 at 9:09 PM, Certified Nursing Assistant (CNA) "called nurse into room where resident was found on the floor laying on his back, when asked what happened resident said	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 280	Continued From page 5	F 280		

he was trying to get into his roommates bed. Intervention, Resident told importance of safety measures of waiting for assistance."

R6's current Care Plan fails to address the intervention decided by the IDT (Interdisciplinary Treatment) Committee notes documented after this fall of, "Will monitor to see if there is connection between behavior and when wife leaves."

On 10/30/2015 at 9:20 AM, E1, Administrator, stated, "The Committee meets once a month and has reviewed (R6's) falls. Some of the interventions implemented were not reflected in the Care Plans and should have been."

2. R11's October 2015 POS documents the diagnosis, in part, Dementia without Behavioral Disturbances and an order for the antipsychotic medication: Seroquel 50 mg two times a day, daily.

R11's Care Plan, dated 10/14/2015, documents behaviors as anxiety and fearfulness. R11's Care Plan fails to address the use of the antipsychotic medication Seroquel.

On 10/30/2015 at 8:45 AM, E2, Director of Nursing (DON), stated "I expect all Care Plans to be completed every shift and be complete."

3. R1's POS, dated 10/01/2015, documents R1 has diagnoses, in part, Unspecified Psychosis and Major Depression.

R1's POS, dated 10/01/2015, documents R1's medications are (in part) Seroquel 25 mg 1/2 tablet daily, Ativan 1 mg three times daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	**27 AUERBACH PLACE GLEN CARBON, IL 62034**

(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 280	Continued From page 6 whenever needed, and Lexapro 5 mg daily. R1's Behavior/Intervention Monthly Flow Record, dated 10/2015, documents R1 is being tracked for the behaviors of anxiety and continuous crying. R1's Care Plan, dated 08/20/15, documents R1 will have decreased anxious behaviors through the next review period as evidenced through behavior tracking. R1's Care Plan, dated 08/20/15, also documents R1's Patient Health Questionnaire-9 (PHQ-9) depression will remain at zero (no depression at all). R1's Care Plan does not document any interventions or goals concerning R1's diagnosis of Unspecified Psychosis. R1's Care Plan does not document any interventions concerning R1's Seroquel. 4. R10's POS, dated 10/01/15, documents R10's diagnoses as Unspecified Psychosis, and Depression. R10's POS, dated 10/01/15, documents R10's medications are (in part) Effexor 25 mg and Clozapine 25 mg give 0.75 tablet daily. The Pharmacy Consultant Report, dated 08/11/15, documents the facility's behavior management committee reviewed R10's medications. The form further documents that R10 has medication orders for Effexor 25 mg daily and Clozapine 25 mg give 0.75 tablet daily for hallucinations related to Parkinson's disease. R10's Care Plan, dated 07/07/15, documents R10 has depression and anxiety, and will have no complications to his psychotropic medications. R10's Care Plan also documents R10 will have a	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 280	Continued From page 7	F 280		

decrease in his PHQ-9 score of 5, which represents mild depression. R10's Care Plan dated 07/07/15 does not have any documentation concerning R10's hallucinations related to his diagnosis of Parkinson's Disease, or his diagnosis of Unspecified Psychosis.

On 10/28/15 at 1:45 PM, E4, Long Term Care Clinical Nurse Leader, stated, "I'll have to look at the Care Plans. I don't know why it's not in the Care Plan."

5. R7's Face Sheet, dated 9/15/15, has no psychiatric diagnosis documented.

R7's Electronic Medical Record (EMR), dated 10/16/15, documents physician's orders (PO) for Buspirone HCL (Hydrochloride) 10 mg take 1 tablet per gastrostomy tube twice daily, Fluoxetine HCL capsule 20 mg take 1 capsule per gastrostomy tube once daily, Alprazolam tablet 0.25 mg as needed every six hours, Quetiapine Fumarate (Seroquel) 25 mg 1 tablet by mouth 1 time per day.

R7's Care Plan, dated 9/15/15, documents, "I (R7) have had incidences of anxiety and fearfulness. I will have decreased anxious behavior through the review period."

R7's Care Plan, updated 9/23/15, documents, "I (R7) receives psychotropic meds (medications) daily for anxiety and depression. I will feel comfortable and relaxed in these surroundings, with minimal outward signs of anxiety or agitation." R7's Care Plan does not document any interventions related to the use of Seroquel. R7's Care Plan fails to identify the type of psychotropic medications that R7 is receiving.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 280	Continued From page 8 6. R12's EMR, dated 10/01/15, documents a diagnosis of Major Depression Disorder. R12's EMR, dated 10/01/15, documents PO's for Quetiapine Fumarate (Seroquel) 50 mg, 2 times daily, and Lorazepam (Ativan) 1 mg every four hours. R12's Care Plan, dated 10/15/15, documents, in part, "Psychotropic Drug. My goal is to have no side effects and to have my depression agitation managed with medication during my stay here." The Care Plan fails to document what psychotropic medication R12 is receiving daily. R12's Care Plan, dated 9/29/15, documents, in part, "I have had incidences of anxiety and fearfulness. I will have decreased anxious behavior through the review period. I have expressed feelings of helplessness due to my depression. I will have decreased evidence of depression through the next review." R12's Care Plan fails to document to monitor the adverse side effects concerning the use of anti-psychotic medication, Seroquel.	F 280		
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	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 315	Continued From page 9 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide an effective antibiotic to treat a urinary tract infection (UTI) for 1 of 2 residents (R5) reviewed for UTI's in the sample of 15. Findings include: The current Face Sheet for R5 documents diagnoses, in part, as UTI, Sepsis, Urinary Retention and Chronic Indwelling (Urinary) Catheter. The Minimum Data Set (MDS), dated 8/20/2015, documents R5 has an indwelling urinary catheter. On 10/27/2015 at 9:50 AM, R5 reported he recently was treated for a UTI. R5 reported he knows to drink plenty of fluids. R5 had an indwelling urinary catheter that was draining clear yellow urine. The Urine Culture and Sensitivity Report (C&S), dated as reported 10/02/2015, documents R5's urine contained over 100,000 CFU/mL (colony forming units per milliliter) of the bacteria Escherichia coli and over 100,000 CFU/mL of the bacteria Pseudomonas aeruginosa. The Physician's Orders Daily Signing Sheet for R5 of 10/2015 documents an order for the oral antibiotic, Augmentin 875/125 mg (milligrams) by mouth BID (twice daily) for 7 days. The urine C&S Report, dated 10/02/2015, documents Escherichia coli is sensitive to Augmentin, but is resistive to kill the bacteria, Pseudomonas	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 315	Continued From page 10	F 315		

aeruginosa. The EMAR (Electronic Medication Record) Monthly Report for 10/2015 documents R5 was administered Augmentin (Amoxicillin/Potassium Clavulanate) 875/125 mg from 10/02 at 2:00 PM, until 10/08/2015 at 6:00 PM.

A Physician's Progress Note for R5, dated 10/07/2015, from Z2, Nurse Practitioner (NP) documents, in part, "Patient (R5) started on ABX (antibiotic) for UTI and needed another. Patient was started on Augmentin which only covered E-coli (Escherichia coli) not Pseudomonas. Start Cefepime every 12 hours for 7 days."

The Urine C&S Report, dated as reported 10/02/2015, documents E-coli and Pseudomonas are both sensitive to the antibiotic Cefepime, which could have been ordered on 10/02/2015. The Physician's Order (PO), dated 10/07/2015 documents, in part, "Trimethoprim 100 mg by mouth every HS, (bedtime) diagnosis-UTI/prophylaxis and Cefepime 1 gm (gram) IM (intramuscular) every 12 hours for 7 days-diagnosis, UTI."

The EMAR for 10/2015 documents R5 did not receive the antibiotic Trimethoprim 100 mg at 8:00 PM on 10/15/2015, and Cefepime 1 gm IM on 10/08/2015. This is a 6 day delay in treatment for the bacteria, Pseudomonas aeruginosa for R5.

On 10/28/2015 at 4:00 PM, E2, Director of Nursing (DON) reported that it is the nurses responsibility to make sure the physician orders the correct effective antibiotic to treat a specific bacteria.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 315	Continued From page 11 The facility policy and procedure for Nurse Notification of Physician, dated 4/01/2008, documents, in part, "Licensed nurses are responsible for reporting to the resident's physician any time they believe a resident has a clinical issue that requires physician notification and/or intervention. The licensed nurse contacting the physician will perform and assessment and have the following information available as appropriate: Relevant laboratory/diagnostic studies. Anticipate questions the physician may ask and have appropriate information available."	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 322	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to check placement of a gastrostomy feeding tube (G-tube) prior to administration, ensure accurate amounts of enteral feeding solution was administered as ordered by the physician, and failed to document accurate intake measurements for 1 of 1 residents (R7) reviewed for gastrostomy tube feedings in the sample of 15. Findings include: R7's Physicians Orders (PO), dated 10/19/15, documents, in part, "Glucerna 1.2 cal (calorie) enteral tube feeding four times per day at 0800 (8:00 AM), 1200 (12:00 PM), 1700 (5:00 PM), 2100 (9:00 PM), give one can after each meal. if intake less than 50% (per cent), and 1 can HS (at bed time) regardless of intake." On 10/28/15, at 9:07 AM, E11, Registered Nurse (RN) stated, "(R7) ate less than fifty percent for breakfast. She will need her tubing feeding this morning." On 10/28/15, at 9:08 AM, E11 took R7 in her wheel chair from the dining room to her room. E11 washed her hands and applied gloves. E11 connected the 60 cubic centimeter (cc) syringe to R7's G- tube feeding port and filled the syringe with enteral feeding formula (Glucerna 1.2 cal). The G-tube feeding formula remained in the syringe and failed to infuse into the G-tube tube. E11 stated, "That's not going in." E11 removed the 60 cc syringe full of feeding formula from R7's G -tube feeding port and poured it into the container of water at the bedside. E11 then	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	**27 AUERBACH PLACE GLEN CARBON, IL 62034**

(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 322	Continued From page 13	F 322		

discarded the 60 cc's contained in the syringe into the bathroom sink. E11 washed her hands and donned clean gloves. E11 reconnected the 60 cc syringe to R7's G- tube feeding portal with the plunger administered 30 cc's of water through the syringe into R7's Gastrostomy feeding tube while E11 listened with her stethoscope. E11 stated, "It's in the right place." E11 filled the syringe with 55 cc's of Glucerna formula. R7 began gagging and stated, "Oh, I'm getting sick." E11 clamped the G-tube to stop the instillation of Glucerna into the feeding tube. E11 then handed R7 the trash can from the floor in case she needed to vomit. At that time, R7 stopped gagging and E11 placed the trash can on the floor. E11 resumed administering 125 cc's Glucerna feeding formula. R7 began gagging again and stated, "Oh," and reached again for the trash can. E11 continued administering the tube feeding and handed the trash can to R7. R7 placed trash can on the floor. R7 began loudly burping, multiple times and breathing hard, while grimacing. R7 stated, "I want to go to bed." E11 continued administering the tube feeding. E11 stated, "Just a little bit more." When all the gastrostomy tube feeding formula had been administered, E11 administered 30 cc's of water. E11 disconnected the syringe from the G- tube port. E11 removed her gloves and washed her hands.

The Electronic Monthly Report for October 2015, inaccurately documents on 10/28/2015 at 8:00 AM 1 can (240 cc's) Glucerna 1.2 cal was administered via G-tube not the actual amount of 180 cc's Glucerna administered.

The facility's Enteral Feeding via Gastrostomy Tube procedure, dated 2/22/2013, documents (in part), "1. Greet the resident by name and explain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 322	Continued From page 14 what you plan to do in a manner the resident can understand. 3. Auscultate for bowel sounds. 4. Verify placement using the following methods: i. Instill approximately 30 cc of air into the Gastrostomy tube using a large syringe while auscultating the abdomen. A 'swishing' sound indicates proper placement. ii. Verify placement through aspiration of stomach contents by gently withdrawing stomach contents by pulling back gently using a 30 cc or larger syringe. 5. Check for gastric residual - done in step above. a. If gastric contents exceed 100 ml (milliliter) hold feeding for one hour and re-check. If residual still exceeds 100 ml, continue to hold feeding and contact the resident's physician (or follow previously provided instructions). Gastric content can be re-instilled following evaluation. 10. Record the feeding and amount of residual in the clinical record."	F 322		
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	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 15 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, observation and interview, the facility failed to conduct resident specific behavior tracking and document the medical diagnosis to justify the use of antipsychotic medications for 5 of 6 residents (R1, R6, R7, R10, R12) reviewed for antipsychotic medications in the sample of 15. Findings Include: 1. R1's Physician Order Sheet (POS), dated 10/01/15, documents R1's diagnoses, in part, as Unspecified Psychosis and Major Depression. R1's POS, dated 10/01/2015, documents the orders (in part) Seroquel (an antipsychotic medication) 25 milligrams (mg) 1/2 tablet daily, Ativan (an antianxiety medication)1 mg three times daily whenever needed, and Lexapro (an antidepressant medication) 5 mg daily. R1's POS, dated 08/27/15, documents a Psychiatric Consult was ordered with Z1, Psychiatrist. There was no consult from Z1 in R1's clinical record as of 10/30/15. The Pharmacy Consultation Report dated	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 16	F 329		

06/10/15 through 07/17/15 documents R1 had a fall on 07/08/15, and R1 was switched from Risperidol to Seroquel in late June.

The Pharmacy Consultation Report, dated 08/14/15, documents R1 was discussed at the facility Behavioral Management Committee Meeting, and according, to the information presented at the meeting, R1 was not having any hallucinations related to dementia. The Behavior Committee also recommended a gradual dose reduction to Seroquel 12.5 mg daily. The Pharmacy Consultation Report documents the recommendation was accepted, and R1's medication was reduced from Seroquel 25 mg daily to Seroquel 12.5 mg daily.

R1's Behavior/Intervention Monthly Flow Record, dated 10/2015, documents R1 is being behavior tracked for anxiety and continuous crying. The Flow Record does not document any crying or anxious behavior for 10/01 through 10/28/2015. The Flow record does not track or document any psychotic behaviors for R1.

On 10/28/15 at 11:10 AM, R1 was sitting in high back wheelchair looking around at other residents, and no psychotic behavior was observed.

On 10/28/15 at 11:30 AM, E8, Certified Nurses Assistant (CNA), stated, "I have never seen her (R1) have any psychotic behaviors."

On 10/28/15 at 11:30 AM E9, CNA stated, "(R1) is not psychotic, but she does ask over and over again to go home."

2. R10's POS, dated 10/01/15, documents R10's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 17 diagnoses are (in part) Unspecified Psychosis and Major Depression. The Pharmacy Consultant Report, dated 08/11/15, documents the facility's Behavior Management Committee reviewed R10's medications. The form further documents that R10 has medication orders for Effexor 25 mg daily and Clozapine (an antipsychotic medication) 25 mg, give 0.75 tablet daily for hallucinations related to Parkinson's disease. R10's Behavior/Intervention Monthly Flow Sheet, dated 10/05/15, documents R1 is behavior tracked for "panic and withdrawn behavior." R10's Behavior/Intervention Monthly Flow Record does not document any panic and withdrawn behaviors from October 1-29 2015. The Flow Record does not document or track any psychotic behaviors. On 10/28/15 at 2:45 PM, R10 was sitting in the day area in the wheelchair watching staff members. No psychotic behaviors were observed. On 10/29/15 at 1:30 PM, E12 Licensed Practical Nurse (LPN) stated," I haven't seen any psychotic behaviors for (R10)." On 10/29/15 at 1:30 PM, E13 CNA, stated, " (R10) talks about the Navy a lot, but he doesn't act psychotic." 3. R6's October 2015 POS documents the diagnosis, in part, as Unspecified Psychosis Disorder, not Substantiated. R6's POS for October 2015 also documents the following antipsychotic medications: Quetiapine Fumurate (Seroquel) 25 mg two times a day, Haloperidol	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 18 0.5 mg, one time a day, Haloperidol Lactate 5 mg/ml (milliliter), inject 1 mg intramuscular once daily as needed for agitation. R6's Behavior Tracking for October 2015 documents the behavior tracking for the use of Haloperidol as; "1) Yelling." The Behavior Tracking Form is incomplete for October 2, 3, 4 and zeros for the rest of the month except 10/08/15. "2) Anxiety" The Behavior Tracking Form is incomplete with blanks for October 2-5th. Zeros are documented for the rest of the month of October. The Behavior Tracking for the use of Haloperidol Injections and Seroquel are documented as, "1) Continuous yelling and 2) Fidgeting." There is no documentation for the days of October 1-4 and zeros for the rest of the month. During observations on 10/27/2015 from 8:42 AM to 9:22 AM, from 10:35 AM to 11:39 AM, from 3:10 PM to 3:30 PM, and on 10/29/2015 at 9:40 AM to 10:00 AM, R6 was calm and did not display any signs of psychotic behavior. On 10/28/2015 at 9:32 AM, Z4, R6's wife, stated, "(R6) is easily confused and at times can be aggressive, but he does not have any psychotic behaviors." On 10/28/2015 at 12:31 PM, E13, CNA stated, "(R6) has psychotic behaviors like talking to staff weird and hitting staff. However, he has not had these behaviors for some time. It has been months now. (R6) does not see things or is not talking to people that are not there." On 10/28/2015 at 12:32, E12, LPN stated, "(R6) does display psychotic behaviors as he is easily	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 19	F 329		

tired, and sometimes he throws things, but he has not had any psychotic behaviors for a long time. When (R6) becomes psychotic, he gets confused, yells and throws things. (R6) does not see people, or talk to imaginary people."

A Consultation Report, dated July 18, 2015 through August 17, 2015, documents, in part, "(R6) was recently reviewed during the facility behavior management committee meeting on 08/14/2015. He has orders for Lorazepam and Haldol injections that he has received, he yells at staff, throws items, and is agitated. His Seroquel has been reduced to 12.5 mg. The committee suggests if behaviors continue, the nursing staff should contact the physician to increase Seroquel to 25 milligrams twice a day."

On 10/30/2015 at 9:35 AM, E2, Director of Nursing (DON), stated, "The Seroquel was increased for R6 back in August 2015 to 25 mg, twice a day. We have been adjusting his Seroquel since December, back and forth with the Seroquel."

The facility policy and procedure entitled, Nursing Observations/Assessments and Documentation, dated 4/23/2013, documents, in part, "Behaviors Related To Use Of Psychotropic Medications-daily observation with prn (as needed) notation of presence/absence of behavioral issues. Quarterly review."

4. R7's Face Sheet, dated 9/15/15, has no psychiatric diagnosis documented.

R7's Electronic Medical Record (EMR), dated 10/16/15, documents physician's orders (PO) for Buspirone HCL (Hydrochloride) (an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 20	F 329		

antidepressant medication) 10 mg, take 1 tablet per (gastrostomy) tube twice daily, Fluoxetine HCL (an antidepressant medication) capsule 20 mg, take 1 capsule per (gastrostomy) tube once daily, Alprazolam (an antianxiety medication) tablet 0.25 mg as needed every six hours, Quetiapine Fumarate (Seroquel) 25 mg 1 tablet by mouth 1 time per day.

R7's Brief Interview for Mental Status (BIMS), dated 9/10/15, documents R7 is cognitively intact with no behaviors or psychotic symptoms.

There is no documentation of behavior tracking for R7 in the EMR. The Behavior Tracking Form for October 2015 documents a behavior as, "anxiety: yelling out." There is no documentation of R7's behaviors on the Form for 10/2015.

The Pharmacy Consultation Report, dated 8/18/15 through 9/13/15, documents, "(R7) was recently admitted with an order for an antipsychotic medication Seroquel. She does not have a diagnosis for this medication. CMS regulations require a re-evaluation of this medication at the time of admission and/or within 2 weeks of admission (at the time of the initial MDS assessment) to consider whether or not the medication can be reduced or discontinued. Recommendation: Please re-evaluate the need for the continued use of Seroquel perhaps considering a gradual dosage reduction with the end goal of discontinuation of therapy if possible. Rationale for Recommendation: The state operations manual, updated in May 2013, requires specific criteria for the indication and target behavior in order for antipsychotic use to be deemed acceptable. If therapy is to continue, please provide detailed documentation of: 1) the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 21 specific diagnosis/indication requiring treatment; 2) the symptom criteria/target behaviors; AND 3) the Facility Interdisciplinary Team should ensure ongoing monitoring of specific target behaviors; documentation of a) DANGER to self or others b) desired outcome(s) c) the efficacy of individualized, nonpharmacological approaches and d) potential adverse consequences. Update and adapt the care plan as needed to provide person-centered care." There is no documentation on the Pharmacy Consultation Report, dated 9/11/2015 that Z3, Physician, was ever aware of this recommendation to justify the use of the antipsychotic medication, Seroquel. 5. R12's EMR, dated 10/01/15, documents a diagnosis, in part, as Major Depression Disorder. R12's EMR documents PO's for Quetiapine Fumarate (Seroquel) 50 mg, 2 times daily, and Lorazepam (Ativan) 1 mg every four hours. R12's Minimum Data Set (MDS), dated 10/6/15 documents R12 has severe cognitive impairment, no behaviors, hallucinations or delusions. The Mood & Behavior-Incident Based form for 10/2015 documents behavioral observations, but fails to document any interventions used for R12 related to those behaviors. On 10/29/15 at 2:35 PM, E25, Registered Nurse (RN), stated "(R12) has behaviors of anxiety." The Pharmacy Consultation Report, dated 9/12/15 through 10/18/15, documents (in part), "(R12) receives Seroquel 25 mg twice daily. Federal Nursing Facility Regulations require the antipsychotic agents be used for one or more of	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 22	F 329		

the following conditions, conditions other than dementia, if current therapy is to continue please indicate specific diagnosis and symptom behavior." The Consultation Report documents Z3 eventually gave R12 specific diagnoses as severe bipolar disorder and psychosis on 10/22/2015.

Pharmacy Consultation Report Comment and Recommendation, dated 9/12/15 through 10/18/15, documents (R12) was admitted (9/25/2015) with an order for an antipsychotic medication, Seroquel 50 mg twice daily. Please re-evaluate the need for the continued use of Seroquel, perhaps considering a gradual dosage reduction to 25 mg twice daily, with the end goal of discontinuation of therapy if possible. Rationale for recommendation: the state operations manual, updated in May 2013, requires specific criteria for the indication and target behavior in order for antipsychotic use to be deemed acceptable. If therapy is to continue, please provide detailed documentation of 1) specific diagnosis/indication requiring treatment. 2) The symptom criteria/target behaviors, AND 3) the facility Interdisciplinary Team should ensure ongoing monitoring of specific target behaviors; documentation of a) DANGER to self or others b) desired outcome(s) c) the efficacy of individualized, non-pharmacological approaches and d) potential adverse consequences. Update and adapt the care plan as needed to provide person centered care."

On 10/22/15, E3, Assistant Director of Nursing (ADON), documented on the Pharmacy Consultation Report, dated 9/12/15 through 10/18/15, "guest still displays periods of mood fluctuations as well as shouting out repetitively,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 23 'help me.' Recommending not reducing at this time due to possible increased behaviors if reduced."	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to prevent potential contamination of ice by not providing an air gap on the ice machine between the ice storage bin drain and the floor sewage drain for 3 of 15 residents (R5, R11, R13) in the sample of 15 and 11 residents (R16 through R26) in the supplemental sample. Findings include: On 10/27/2015 at 7:40 AM, the drain on the ice machine in the Assisted Living Kitchen extended more than four inches deep into the floor drain. This leaves no air gap with the potential for back flow of sewage into the ice machine storage bin, contaminating the ice served to residents. On 10/27/15 at 7:55 AM, E6, Certified Dietary	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

(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 371	Continued From page 24 Manager stated, "This ice machine is used for assisted living residents, and at this time, the ice machine is also used for the residents on Maple Lane, while their ice machine is broken. The (commercial kitchen equipment repair company) comes quarterly to clean out the ice machine." On 10/29/15 at 12:05 PM, E10, Certified Dietary Manager, stated, "That drain tube goes all the way down into the drain. I can't tell how far." The facility's Daily Census of Rooms Report, dated 10/27/2015, documents R5, R11, R13 and R16 through R26 reside on Maple Lane.	F 371		