

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145728	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2009
NAME OF PROVIDER OR SUPPLIER MARYVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2133 VADALABENE DRIVE MARYVILLE, IL 62062		
(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 157 SS=G	<p>Complaint Investigation - # 0940469 (IL 39508)</p> <p>This was not an extended survey.</p> <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157			
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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to consult with 1 (R2) of 5 residents physician's with a significant change in condition that included a deterioration in health, a need to alter treatment significantly, and of adverse reactions noted with a medication increase in a timely manner. The facility also failed to notified the physician of a decline of ADL's. This failure resulted in delayed treatment for R2 who was exhibiting an increase in behaviors that included head banging and also distress behaviors including screaming. On 1/28/09, R2 was transferred to the emergency room for a psychiatric evaluation and was admitted to the hospital for UTI (urinary tract infection), Dehydration and possible Sepsis along with extreme excoriation of the perineal area..</p> <p>Findings include:</p> <p>1. Review of the Admission documentation identifies R2 as an 89 year old female admitted to the facility from home on 12/16/08 with diagnoses of Senile Psychoses, Hypertension, Osteoarthritis, Anemia and Edema among others. The nurses notes written at 3:45pm on 12/26/08 (on admission) state "res (resident ambulatory) with walker and 2 assist. Gait unsteady. Res noted pleasantly confused on admission..." Review of the POS (Physician's Order Sheet) indicates R2 was receiving no medications, including antipsychotics, for behavioral purposes on admission except Exelon 9.5mg Transdermal Patch daily and Namenda 10mg BID (Twice daily) for Dementia and Remeron 15mg at HS (Bedtime) for depression. The care plan indicates staff are to monitor for increased</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>behaviors, increased lethargy, and notify the MD of any concerns/questions.</p> <p>On 12/29/08 at 10:43am, the notes indicate the nurses called the physician (Z1) regarding R2's behaviors, "resident swinging, trying to hit staff, trying to bite staff, yelling out and cursing at staff, awaiting response from MD (Medical Doctor)." There is no documentation of the physician returning their call and no further followup evident. In addition, there is no further documentation of R2's behaviors.</p> <p>On 12/31/08, R2 saw the physician (Z1). Z1 writes "no c/o (complaints) voiced.. Eats well. Incontinent... Dementia (severe) are all stable... meds reviewed. Continue care." There is no mention of the facility's call to his office on 12/29/08 regarding R2's aggressive/combatative behaviors. The next entry into the nurses notes doesn't occur until 1/5/09 at 9:43am and states "call out to MD office again R/T resident behaviors of trying to bite, throwing water at people, kicking and swinging, and grabbing at people, request order for psych consult, awaiting return call." There is no return call from the physician documented and on 1/6/09 at 10am, the nurses notes indicate the facility is sending R2 to the hospital for a psych eval "per nursing judgement".</p> <p>On 2/10/09 at 10:15am, the DON (E2) was asked about Z1's response time and stated the office is very busy and usually requires the nurses to call a second time. E2 indicated Z1 did not return the nurses call therefore, R2 was sent on nursing judgement.</p> <p>R2 was taken to the hospital on 1/6/09 for a psychiatric evaluation and returned at 4pm with no new orders. Review of the hospital records indicate the family member refused all laboratory testing along with any medication changes during</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>the visit and left the hospital after telling the staff she would be taking R2 home. There is no further charting towards R2's behaviors and/or hospital visit.</p> <p>On 1/12/09, the nurses notes indicate R2 was seen at Z1's office and return to the facility with orders for Lorazepam (Ativan) .5mg PRN (as needed) daily, Citalopram 20mg at HS, and Trileptal 150mg every 12 hours. On 1/14/09 at 3:15pm, the nurses writes "res continues to be very fidgety attempting to amb (ambulate) with out asisst and transferring self from couch to w/c (wheelchair) and back. when assist attempts to amb res, res becomes aggressive and scratches at them." On 1/15/09 at 9:51pm, the nurses notes state "Dr. (Z1) returned call with new orders rec'd to increase ativan (lorazepam) and Trileptal to BID and Ativan PRN q (every) 6 hours."</p> <p>There is only one entry on 1/16/09 at 1:43am and states "no behaviors this night so far..."</p> <p>On 1/17/09 at 12pm the nurses writes "resident lethargic at lunch d/t (due to) increase in medication, resident laid back down d/t being unable to sit up." There is no evidence the facility notified the physician of the possible adverse effect of the medication increase as indicated they should in the care plan. There is no further entry or follow up evident in the nurses notes regarding R2's behaviors and/or lethargy until 1/19/09 at 10am when the nurses writes "resident alarm sounding and staff went to assess, noted resident on floor on left side with legs crossed and hands up to mouth,... resident had recent increase in medication, writer called MD and notified him resident's fall, and asked for a decrease in medication d/t lethagy, order received to change Ativan to just PRN..."</p> <p>On 2/10/09 at 10:15am, E2, DON, stated the</p>	F 157			

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F 157	Continued From page 4 nurses notified the physician of the lethargy on 1/17/09 but failed to document it. However, the the clinical record fails to support this. Interview with E2 indicates she feels the facility's obligations are met when the physician's office is called and they assume if no callback is done, the physician chooses to have no changes. R2 continued to exhibit increased behaviors including head banging and screaming and had a decline in activities of daily living. On 1/27/09, following R2's head banging behavior, the physician was called and ordered received to transfer her to the emergency room for a behavioral admit to the hospital. On 1/28/09, R2 was transferred where she was admitted with dehydration, UTI with possible sepsis and excoriation of the perineal area. The facility's policy on CHANGE IN A RESIDENT'S CONDITION states the nurse will notify the resident's attending physician when "there is significant change in the resident's physical, mental or psychosocial status" and when "there is a need to alter the resident's treatment significantly". The facility failed to implement their policy on physician's notification when a change in R2's condition was evident and in need of a treatment change. Z1 failed to return phone calls for interview.	F 157			
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide necessary care and services to attain, or maintain the highest practicable, mental, and psychosocial well-being in accordance with her plan of care and identified need. This failure resulted in lack of identification/treatment for extreme excoriation of R2's perineal area and lack of identification/monitoring for extensive bruising from falls and head banging behaviors. According to an interview with Z2, attending physician at the emergency room, R2 was experiencing extreme pain from the excoriation upon presenting to the emergency room on 1/28/09.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the Admission documentation identifies R2 as an 89 year old female admitted to the facility from home on 12/16/08 with diagnoses of Senile Psychoses, Hypertension, Osteoarthritis, Anemia and Edema among others. The nurses notes written at 3:45pm on 12/26/08 (on admission) state "res (resident ambulatory) with walker and 2 assist. Gait unsteady. Res noted pleasantly confused on admission..." Review of the POS (Physician's Order Sheet) indicates R2 was receiving no medications, including antipsychotics, for behavioral purposes on admission except Exelon 9.5mg Transdermal Patch daily and Namenda 10mg BID (Twice daily) for Dementia and Remeron 15mg at HS (Bedtime) for depression. Review of the Care Plan dated 12/26/08 identifies R2 to have a history of combative & aggressive behaviors usually secondary to resisting care R/t (due to 	F 309			

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F 309	<p>Continued From page 6</p> <p>her fear of water and modesty. It also states she has a history of using hands and fingers to remove feces from anus.</p> <p>On 1/19/09, an EVENT REPORT indicates R2 sustained a hematoma to the left side of her forehead following a fall from her wheelchair. On 1/24/09, R2 had another fall from her wheelchair. The EVENT REPORT indicates R2's head did hit floor upon falling, bump to right side of head noted. There is no documentation as to the extent of these injuries. The nurses notes dated 1/25/09 at 12:11 am and 9:10am both state "bump to right side of head noted" but don't include any descriptive information as to the extent of the bump/bruising/injury. The nurses notes do note neuro checks being done following the second fall only but fail to include any assessment/documentation of the actual bruises.</p> <p>On 1/27/09, an EVENT REPORT indicates R2 had fallen out of bed. The evaluation note states "resident has been exhibiting behaviors of placing self on floor and being harmful to self by banging head and arms on tables and walls..." The note indicates R2 was admitted to the hospital for behavioral assessment. Review of the nurses notes dated 1/27/09 at 12:30pm, indicates R2 was noted to be yelling out loudly, and screaming, hitting her head on the table and saying she was going to die..." There is no indication of any injury noted from this behavior in the facility's documentation.</p> <p>On 1/28/09 at 9am, the nurse noted R2 to have a "rash covering resident's body,... no s/s (signs/symptoms) of discomfort noted." The note continues to state the physician was already aware of R2's increase behaviors and an order was received to send R2 to the hospital for behavioral assessment.</p> <p>Review of the hospital notes indicate R2 was</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>admitted to the hospital with UTI (urinary tract infection) and dehydration, possible sepsis. In addition, the notes indicate R2 had obvious pain in addition to "a rash to genitourinary areas and perianal areas as well in a satellite distribution". The History and Physical states R2 had "multiple excoriations and also lesions and skin breakdown to lower extremities and right upper extremity.</p> <p>On 2/11/09 at 9:15am, interview with Z2, the attending physician at the emergency room, stated R2 had extensive bruising over her forehead which was old and new and looked as if it was traumatic. Z2 stated she knew R2 had been head banging as the ambulance attendants had said so. Z2 stated the bruising would be consistent with head banging and also a result of falling. Z2 also stated she had bruises and injuries to her elbow. Z2 also stated R2 had extensive excoriation which included erythema to her upper thighs, inguinal area, and perineal area that looked like a yeast infection. Z2 stated she couldn't believe how extensive it was and how uncomfortable it must have been for her. Z2 stated she thought the facility should have assessed R2 more carefully for physical concerns which probably contributed to her discomfort and caused an increase in her behaviors. Z2 stated basic medical care should have been provided such as comfort measures if aggressive treatment wasn't an option. Z2 stated R2 presented to the emergency room in a fetal position, crying/moaning.</p> <p>Interview with E4, LPN (Licensed Practical Nurse) on 2/5/09 at 2:05pm indicates R2 did have head banging behavior mainly in the dining room on the table and she did sustain bruising from it. E4 did not recall any open areas or skin issues on her. However, E7, CNA (Certified</p>	F 309			

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F 309	Continued From page 8 Nurses Aide) stated on 2/5/09 at 2:23pm that R2 did have a rash in the periarea and would insert fingers in the vagina and rectum. E7 stated R2's behaviors had increased quite a bit the last week she was in the facility. E7 also added that R2 was "gaulded, red, scratches" in the vaginal area. Both staff stated they felt sorry for R2 as she was definitely uncomfortable. There is no indication the nurses were aware of R2's excoriation as the clinical record fails to record any concerns even though the direct care staff recalled R2 having a "gaulded area". In addition, there is no indication the facility continued to monitor R2's injuries following her falls and no evidence they identified injuries sustained during her head banging/elbow hitting behaviors. On 2/10/09, a policy on condition change was requested from E1, Administrator who stated they did not have one. E1 referred to the facility's policy on CHANGE IN A RESIDENT'S CONDITION, and noted that 4. states "the nurse will record in the resident's medical record any changes in the resident's medical condition or status." The facility failed to follow this policy to ensure that R2's sustained injuries were identified and monitored and that her skin excoriation was also identified, monitored and treated in a timely manner.	F 309			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION 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.	F 323			

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that one (R2) of 5 residents on the sample remains as free of accident hazards as is possible and receives adequate supervision to prevent falls. This failure resulted in R2 falling from her wheelchair on 1/19/09 during a time when staff assessed her to be lethargic from an increase in medications. R2 had body alarm on which staff were unable to respond to quick enough to prevent her fall. R2 had another fall from her wheelchair on 1/24/09 after the alarm was sounding. On 1/26/09, staff documented R2 head banging which resulted in extensive bruising to her forehead. The facility failed to implement interventions to prevent her from harming herself as evident in bruising across her forehead. Findings include: 1. Review of the Admission documentation identifies R2 as an 89 year old female admitted to the facility from home on 12/16/08 with diagnoses of Senile Psychoses, Hypertension, Osteoarthritis, Anemia and Edema among others. The nurses notes written at 3:45pm on 12/26/08 (on admission) state "res (resident ambulatory) with walker and 2 assist. Gait unsteady. Res noted pleasantly confused on admission..." Review of the POS (Physician's Order Sheet) indicates R2 was receiving no medications, including antipsychotics, for behavioral purposes on admission except Exelon 9.5mg Transdermal Patch daily and Namenda 10mg BID (Twice daily) for Dementia and Remeron 15mg at HS (Bedtime) for depression. Review of the Care	F 323			

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F 323	<p>Continued From page 10</p> <p>Plan dated 12/26/08 identifies R2 to have a history of combative & aggressive behaviors usually secondary to resisting care R/t (due to) her fear of water and modesty. It also states she has a history of using hands and fingers to remove feces from anus. Review of the care plan indicates R2 is at risk for falls due to weakness and diagnoses of Alzheimer's Disease and urge incontinence. The care plan also indicates she has balance deficits and impaired safety awareness. Interventions include wheelchair alarm among others.</p> <p>On 1/12/09, the nurses notes indicate R2 was seen at Z1's office and return to the facility with orders for Lorazepam (Ativan) .5mg PRN (as needed) daily, Citalopram 20mg at HS, and Trileptal 150mg every 12 hours for increased behaviors. On 1/14/09 at 3:15pm, the nurses writes "res continues to be very fidgety attempting to amb (ambulate) with out assist and transferring self from couch to w/c (wheelchair) and back. when assist attempts to amb res, res becomes aggressive and scratches at them." On 1/15/09 at 9:51pm, the nurses notes state "Dr. (Z1) returned call with new orders rec'd to increase ativan (lorazepam) and Trileptal to BID and Ativan PRN q (every) 6 hours." There is no documentation toward R2's response to the implementation of these medications and the subsequent increase on 1/15/09.</p> <p>On 1/17/09 at 12pm the nurses writes "resident lethargic at lunch d/t (due to) increase in medication, resident laid back down d/t being unable to sit up." There in no further entry or follow up evident in the nurses notes regarding R2's behaviors and/or lethargy until 1/19/09 at 10am when the nurses writes "resident alarm sounding and staff went to assess, noted resident on floor on left side with legs crossed and hands</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>up to mouth,... resident had recent increase in medication, writer called MD and notified him resident's fall, and asked for a decrease in medication d/t lethagy, order received to change Ativan to just PRN...." The facility failed to provide adequate supervision of R2 in an effort to prevent her fall. Review of the EVENT REPORT dated 1/19/09 indicates R2 sustained a hematoma to the left side of her forehead. Under "level of consciousness", it states R2 was "lethargic/drowsy - does not perceive the environment fully" and under "contributing factors, it states "recent change in medications". There is no indication/documentation the facility reassessed R2's present needs following the nurses note of 1/17/09 identifying the lethargy in an effort to maintain R2's safety. On 1/19/09, the nurses notified the physician and a drug reduction changing the Ativan to PRN only.</p> <p>On 1/24/09, R2 had another fall from her wheelchair. The EVENT REPORT indicates R2 attempted to get up out of wheelchair unattended and the nurse could not reach her in time to prevent her from falling. Again, the facility failed to provide adequate supervision and appropriate assistive devices in an effort to maintain R2's safety. The report states "residents head did hit floor upon falling, bump to right side of head noted." The facility then placed a lap buddy on R2.</p> <p>Interview with E2, DON, on 2/10/09 at 10:15am indicates the facility had placed a body alarm on R2 when she was first admitted. Following the fall on 1/24/09, the facility implemented a lap buddy in the wheelchair. E2 stated on 2/11/09 at 1:15pm that the nurses did assess R2 immediately following the fall on 1/19/09 and determined the medication increase contributed to her lethargy, therefore a</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>medication reduction was requested. There is no indication the facility took R2's increased fall risk into consideration when looking at the lethargy caused from what the nurse described as due to "increase in medication." on 1/19/09.</p> <p>On 1/26/09 at 10:52pm, the nurses notes indicate R2 fell "x 2" and a new event was created for rolling out of bed. The facility placed mats on her floor. On 1/26/09, an EVENT REPORT indicates R2 was exhibiting behaviors of placing self on floor and being harmful to self by banging head and arms on tables and walls. There is no indication of bruising or injury with this behavior.</p> <p>On 1/27/09, the facility received an order to send R2 to the hospital for a psychiatric evaluation. According to an interview with Z2, the attending physician at the emergency room, R2 had extensive bruising over her forehead which was old and new and looked as if it was traumatic. Z2 stated she knew R2 had been head banging as the ambulance attendants had said so. Z2 stated the bruising would be consistent with head banging and also a result of falling but didn't believe it was the result of one fall. The hospital records also indicate trauma/bruising to her elbow.</p> <p>Review of the nurses notes for this time frame fail to reflect R2 banging/hitting her elbows. However, interview with the DON on 2/10/09 indicates she observed her banging her elbow on the pillars and walls in the dining room during mealtime on 1/27/09. There is no indication the facility implemented interventions to prevent this behavior from occurring and prevent R2 from injuring herself. In addition, there was no INCIDENT REPORT completed identifying this injury.</p> <p>Interview with E4, LPN (Licensed Practical</p>	F 323			

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F 323	Continued From page 13 Nurse) on 2/5/09 at 2:05pm indicates R2 did have head banging behavior mainly in the dining room on the table Interview with E2, DON on 2/10/09 at 3:30pm indicated she witnessed R2's head banging behavior and also hitting her elbows on the walls and pillars behind her. E2 stated the nurses are to chart by "exemption" which means they would only chart problems or concerns" when asked about the lack of documentation of the extent of bruising and/or injuries sustained in her falls with her banging/hitting behaviors. Review of the facility's policy and procedure entitled "ACCIDENT/INCIDENT PREVENTION, "When a resident has been identified as a high risk for accident/incidents, interventions will be put in place per the individual resident assessment and care plan. Interventions may include "maintain close supervision of confused resident", "assess effects of medication given that would place resident at risk for falling", "assess for adaptive equipment", among others. The facility failed to identify R2's increased fall risk following the initial increase of medications and implement interventions toward maintaining her safety, failed to provide adequate supervision, and failed to assess R2 for appropriate adaptive equipment to prevent falls from occurring and failed to assess her head banging behaviors and implement interventions to prevent injury.	F 323			
F 329 SS=G	483.25(l) 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	F 329			

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F 329	<p>Continued From page 14</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that one (R2) of 5 residents on the sample was free from unnecessary drugs, had adequate monitoring, and had behavioral interventions implemented. This failure resulted in R2 having lethargy from the medication and then increased behaviors which included head banging without monitoring of the effectiveness or lack of, the medication. On 1/28/09, R2 was transferred to the hospital for behavioral assessment and admitted with dehydration and UTI (Urinary Tract Infections), possible sepsis to the medical unit of the hospital.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the Admission documentation 	F 329			

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F 329	<p>Continued From page 15</p> <p>identifies R2 as an 89 year old female admitted to the facility from home on 12/16/08 with diagnoses of Senile Psychoses, Hypertension, Osteoarthritis, Anemia and Edema among others. The nurses notes written at 3:45pm on 12/26/08 (on admission) state "res (resident ambulatory) with walker and 2 assist. Gait unsteady. Res noted pleasantly confused on admission..." Review of the POS (Physician's Order Sheet) indicates R2 was receiving no medications, including antipsychotics, for behavioral purposes on admission except Exelon 9.5mg Transdermal Patch daily and Namenda 10mg BID (Twice daily) for Dementia and Remeron 15mg at HS (Bedtime) for depression. Review of the Care Plan dated 12/26/08 identifies R2 to have a history of combative & aggressive behaviors usually secondary to resisting care R/t (due to) her fear of water and modesty. It also states she has a history of using hands and fingers to remove feces from anus. The care plan also indicates staff are to monitor for side effects/adverse effects of the medication. Interventions indicate staff are to monitor for increased behaviors, increased lethargy, and notify the MD of any concerns/questions.</p> <p>According to the nurses notes dated 12/26/08 at 8:09pm, R2 refused to have a skin check done. At 4:57am on 12/27/08, the nurse writes "resting quietly with eyes closed. Stayed in bed all night. Incont (incontinent) of B&B (bowel and bladder). Gets combative at times and tries to kick and hit." At 10:39am, later in the morning, the nurse writes R2 is confused but pleasant this am and "walked to and from dining room with walker and 1 assist."</p> <p>The nurses notes written on 12/28/08 identify R2 has trying to get up without assist and confusion. At 9:37am, the nurses writes that R2</p>	F 329			

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F 329	<p>Continued From page 16</p> <p>"bit the spoon when given medication and then cursed at the writer." Later in evening at 9:08pm, the nurse writes that R2 continues to be combative and resists care. On 12/29/08 at 10:43am, the notes indicate the nurses called the physician (Z1) regarding R2's behaviors, "resident swinging, trying to hit staff, trying to bite staff, yelling out and cursing at staff, awaiting response from MD (Medical Doctor)." There is no documentation of the physician returning their call and no further followup evident. In addition, there is no further documentation of R2's behaviors.</p> <p>On 12/31/08, R2 saw the physician (Z1). Z1 writes "no c/o (complaints) voiced.. Eats well. Incontinent... Dementia (severe) are all stable... meds reviewed. Continue care." There is no mention of R2's aggressive/combative behaviors identified on 1/29.</p> <p>The next entry into the nurses notes doesn't occur until 1/5/09 at 9:43am and states "call out to MD office again R/T resident behaviors of trying to bite, throwing water at people, kicking and swinging, and grabbing at people, request order for psych consult, awaiting return call." Review of the BEHAVIORAL OBSERVATION FORM shows two entries on 1/5/09 and identifies "Combative during care" duration 15 minutes and "throwing silverware." duration 20 minutes. The OBSERVATION DETAILS sheet indicates R2 is totally disoriented, physically abusive, socially inappropriate and verbally abusive. There is no return call from the physician documented and on 1/6/09 at 10am, the nurses notes indicate the facility is sending R2 to the hospital for a psych eval "per nursing judgement". There are no behaviors documented on the BEHAVIORAL OBSERVATION FORM FOR 1/6/09.</p> <p>On 2/10/09 at 10:15am, the DON (E2) was</p>	F 329			

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F 329	<p>Continued From page 17</p> <p>asked about Z1's response time and stated the office is very busy and usually requires the nurses to call a second time. E2 indicated Z1 did not return the nurses call therefore, R2 was sent on nursing judgement.</p> <p>R2 was taken to the hospital on 1/6/09 for a psychiatric evaluation and returned at 4pm with no new orders. Review of the hospital records indicate the family member refused all laboratory testing along with any medication changes during the visit and left the hospital after telling the staff she would be taking R2 home. There is no further charting towards R2's behaviors and/or hospital visit.</p> <p>According to the BEHAVIORAL OBSERVATION FORM, R2 was screaming in the dining room and swatting at 9am, duration 30 minutes. There is no nurses notes entries for this occurrence.</p> <p>On 1/12/09, the nurses notes indicate R2 was seen at Z1's office and return to the facility with orders for Lorazepam (Ativan) .5mg PRN (as needed) daily, Citalopram 20mg at HS, and Trileptal 150mg every 12 hours. There is no documentation toward R2's response to these new medications. On 1/14/09 at 3:15pm, the nurses writes "res continues to be very fidgety attempting to amb (ambulate) with out assist and transferring self from couch to w/c (wheelchair) and back. when assist attempts to amb res, res becomes aggressive and scratches at them." On 1/15/09 at 9:01pm, the nurses notes state "Dr. (Z1) returned call with new orders rec'd to increase Ativan (lorazepam) and Trileptal to BID and Ativan PRN q (every) 6 hours." There is no entry as to when Z1 was called and what information was provided to him regarding R2's behaviors that resulted in an increase in medications. Interview with E2, DON, on</p>	F 329			

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F 329	<p>Continued From page 18</p> <p>2/10/09 indicates the family member called the physician who in turn called the facility with new orders. There is no documentation of this in the clinical record.</p> <p>There is only one entry on 1/16/09 at 1:43am and states "no behaviors this night so far..." On 1/17/09 at 12pm the nurses writes "resident lethargic at lunch d/t (due to) increase in medication, resident laid back down d/t being unable to sit up." There is no further evidence the facility notified the physician as indicated in the care plan. There in no further entry or follow up evident in the nurses notes regarding R2's behaviors and/or lethargy until 1/19/09 at 10am when the nurses writes "resident alarm sounding and staff went to assess, noted resident on floor on left side with legs crossed and hands up to mouth,... resident had recent increase in medication, writer called MD and notified him resident's fall, and asked for a decrease in medication d/t lethargy, order received to change Ativan to just PRN..."</p> <p>On 2/10/09 at 10:15am, E2, DON, stated the nurses notified the physician of the lethargy on 1/17/09 but failed to document it. However, the the clinical record fails to support this.</p> <p>The next entry into the nurses notes that reflect R2's behaviors is dated 1/21/09 at 10:21pm and states "res continues to be combative with staff, spitting food across table at supper..." The facility failed to monitor R2's response to the drug decrease done on 1/19/09. In addition, there is no indication staff assessed R2's behaviors to determine if there was possibly any underlying causes of her behaviors.</p> <p>Again, there is no further documentation on R2's behaviors and on 1/24/09 at 11:52am, R2 had another fall hitting her right side and her head on the floor.</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>Interview with E2, DON, on 2/10/09 at 10:15am indicates the facility had placed a body alarm on R2 when she was first admitted. Following the fall on 1/24/09, the facility implemented a lap buddy in the wheelchair. There is no indication the facility took R2's increased fall risk into consideration when looking at the lethargy caused from what the nurse described as due to "increase in medication."</p> <p>There is no further documentation in the nurses notes regarding R2's behaviors. R2 was documented as rolling out of bed twice on 1/26/09 at 10:52pm and again on 1/27/09 at 2:30am. On 1/27/09 at 10:56am, the nurses notes state "Dr. (Z1) called and gave new orders to decrease AM does of Trileptal to 150mg and to D/C Celexa and start Remeron 15mg at HS to help with mood and appetite..." There is no indication if the facility had first called the physician or if he called himself. At 12:30pm on 1/27/09, the nurses notes state "at lunch table, resident noted to be yelling out loudly and screaming, hitting her head on the table and saying she was going to die, resident removed from DR (dining room) and taken to her room, resident grabbed onto staff clothing and pulled, started to swing at staff, resident covered up and left to calm down." At 2:30pm later that afternoon, the nurses notes indicate orders were rec'd to send R2 to the hospital for direct admit for her behaviors. There is no indication the nurses assessed R2 for any possible underlying cause for this decline in light of this distressed behavior. It also indicates R2's family member refused to have PRN Ativan given but provides no further information.</p> <p>On 1/27/09 at 10:18pm, the nurses notes indicate transfer did not occur due to bad</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>weather. The note indicates R2 continues to yell out most of this PM, and family member refused to allow resident to have PRN ativan. The nurses notes written at 4:25am state "resident has hollered all night long. She has rolled around in bed and every which way." and "gets quiet for about 30-40 min (minutes) then starts again." Again, the clinical record fails to show any physical assessment for underlying causes of this increased behavior. The nurses notes written at 10:56am on 1/27/09 states "Z1 called and gave new orders to decrease AM dose of Trileptal to 150mg and to DC Celexa and start Remeron 15mg at bedtime to help with mood and appetite..."</p> <p>On 1/28/09 at 9am, the nurses notes indicate R2 has a "rash covering residents body, no s/s of discomfort noted, MD notified and aware". At 11:29am, R2 was transferred to the hospital where she was diagnosed with Urinary Tract Infection and Dehydration, possible sepsis. On 2/11/09 at 9:15am, interview with Z2, the attending physician at the emergency room, stated R2 had extensive bruising over her forehead which was old and new and looked as if it was traumatic. Z2 stated she knew R2 had been head banging as the ambulance attendants had said so. Z2 stated the bruising would be consistent with head banging and also a result of falling. Z2 also stated R2 had extensive excoriation which included erythema to her upper thighs, inguinal area, and perineal area that looked like a yeast infection. Z2 stated she couldn't believe how extensive it was and how uncomfortable it must have been for her. Z2 was unaware that the family had refused prior treatment/tests on previous hospitalization. Z2 stated she thought the facility should have assessed R2 more carefully for physical</p>	F 329			

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F 329	<p>Continued From page 21</p> <p>concerns which probably contributed to her discomfort and caused an increase in her behaviors. Z2 stated basic medical care should have been provided such as comfort measures if aggressive treatment wasn't an option. Z2 stated R2 presented to the emergency room in a fetal position, crying/ moaning. Z2 stated she was aware that R2 had had a decline in ADL's (activities of daily living) since her admission to the facility and was told on admission, R2 was ambulating. Z2 stated R2 was totally dependent for all ADL's when presented to the emergency room acknowledging what she thought was a decline in activities of daily living since her admission to the facility.</p> <p>Review of the ASSESSMENT/PLAN from the hospital records dated 1/28/09 state "likely source of patient's agitation, combativeness and confused state would be patient's underlying infection as is with all dementia patients" referring to R2's UTI/excoriation. The report also reports R2 to have suspected Candida, vulvovaginitis. Exam results also indicate R2 had contractures.</p> <p>Interview with E4, LPN (Licensed Practical Nurse) on 2/5/09 at 2:05pm indicates R2 did have head banging behavior mainly in the dining room on the table, and did not recall any open areas or skin issues on her. However, E7, CNA (Certified Nurses Aide) stated on 2/5/09 at 2:23pm that R2 did have a rash in the periarea and would insert fingers in the vagina and rectum. E7 stated R2's behaviors had increased quite a bit the last week she was in the facility. E7 also added that R2 was "gaulded, red, scratches" in the vaginal area. Both staff stated they felt sorry for R2 as she was definitely uncomfortable.</p> <p>Interview with E2, DON on 2/10/09 at 3:30pm indicated she witnessed R2's head banging</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER MARYVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2133 VADALABENE DRIVE MARYVILLE, IL 62062		
(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	<p>Continued From page 22</p> <p>behavior and also hitting her elbows on the walls and pillars behind her. E2 stated the nurses are to chart by "exemption" which means they would only chart problems or concerns" when asked about bruising and or injuries sustained in her falls and/or in her banging/hitting behaviors.</p> <p>Review of the Nursing Pharmacological Handbook indicates Trileptal is an anticonvulsant which can also be given for Bipolar disorder and treatment of neuropathic pain.</p> <p>Warning/Precautions include using with precautions for people with CNS related adverse events, most significant of these were cognitive including ataxia and gait disturbance.</p> <p>Review of the facility's policy PSYCHOPHARMACOLOGIC DRUG USAGE, lists under OBJECTIVES 1) - To provide appropriate monitoring of residents receiving these medications and 2) - To reduce or eliminate the usage of these medications to control mood, mental status, and/or behavior of residents. The facility failed to follow this policy as no consistent monitoring/assessment was done prior to implementation of the medication and with the medication increases/decreases. Under PROCEDURE, it states "6. Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis, as well as medication response." Again, the facility failed to do this consistently. The policy continues to indicate under 7B - Residents using psychopharmacologic drugs must have an initial assessment with quarterly reassessments to provide a data base for the care plan and Dose Reduction program. A behavioral assessment was requested on 2/5/09 and E1, Administrator, stated an assessment is done only if a program is going to be implemented and since she had only</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 329	Continued From page 23 3 days of tracking, no assessment was done. E1 also stated no further tracking was documented. Furthermore, under 7D of the policy, it states "response to medication reduction must be clearly documented on a routine basis. There is clearly no evidence the facility documented R2's response to either increase or decrease of medications as stated in their policy.	F 329			