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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING ______ B. WING ______	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES** **JOLIET, IL 60435**

(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 Complaint Investigation 1173478/IL55190 - F 156 was cited. 1173337/IL55049- F 203 was cited. 1173532/IL55260- F 329 was cited 1173604/IL55340- no deficiency.	F 000		
F 156 SS=G	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		12/2/11

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Surveyor: Lilibeth Lazaro-Camp Based on interview and record review the facility failed to honor resident's (R 1) wish for Do Not Resuscitate (DNR). (2) Failed to follow facility policy and procedure to document the DNR order/status on the physician order sheet. This was for five (R 1, R4, R5, R6 and R 7) of	F 156		

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F 156	Continued From page 3 five residents with DNR status. These failures resulted in R 1 being resuscitated against her wishes in the hospital on 11-08-11 and expired on the same day. Findings include: (1) R1's Uniform Do- Not- Resuscitate (DNR) Advance Directive form, signed by the Health Care Power of Attorney and R 1's attending physician dated 08-24-11 was found in R 1's clinical record. This form showed: in an event of: (1) FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop): Do Not Attempt Cardiopulmonary Resuscitation (CPR) (2) PRE- ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating): Do Not Attempt Cardiopulmonary Resuscitation (CPR). The facility Do Not Resuscitate policy and procedure reads: #2 A valid DNR order shall be written on the POS (Physician Order Sheet) and reviewed every 30 days by the attending physician. #4. When faced with the possible DNR situation: (e) attach a copy of the DNR order to the transfer order, should the physician order a transfer. # 7. Facility personnel will be oriented to the provisions of this policy upon hire and at least annually. R 1's code status (DNR) was not written on R 1's POS and this was confirmed by the DON (Director of Nursing)/E2 on 11-18-11 at 11:05 AM. E 2 also stated, " the nurse didn't copy the	F 156		

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F 156	Continued From page 4 DNR form, so it was not sent during the transfer. She was disciplined with that. " Review of the nurse (E 4) employee report dated 11-14-11 reads: staff nurse failed to send copy of current DNR with resident (R 1) to the hospital ... On 11-23-11 at 9:50 AM via phone interview with Z1 disclosed " her (R 1's) family was very upset and said they put her mother in so much more suffering because the most important documentation was not sent with her during the transfer (to the hospital). " Z1 stated R 1 expired the same day at night time. Review of senior services documentation from the hospital dated 11-10-11 showed: R 1 -has a trach (tracheostomy tube) that was almost completely clogged and was admitted into the hospital because she was unable to breathe. Although the facility had copy of her (R 1) DNR, they (facility) had neglected to send it along with her in the hospital, so they (hospital staff) were forced to resuscitate her (R 1) ... (2) A DNR list was presented on 11-18-11. The list include R 4, R 5, R 6 and R 7. Review of their clinical records showed R 4, R 5, R 6 and R 7 have Uniform Do- Not- Resuscitate (DNR) Advance Directive form signed by the Health Care Power of Attorney and their attending doctors, but this information was not documented in the physician order sheets. These finding were confirmed by the Director of Nursing (DON)/E 2 on 11-18-11 at 11:00 AM. On 11-18-11 at 1:45 PM, the nurses/ E 5 and E 6 stated "we are not aware that we need to write it on the POS."	F 156		
F 203	483.12(a)(4)-(6) NOTICE REQUIREMENTS	F 203		12/2/11

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F 203 SS=G	Continued From page 5 BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for	F 203		

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F 203	Continued From page 6 nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a written notice of transfer or discharge to a resident for which the facility feels they could no longer meet her needs. This is for one (R 3) of four residents in the sample. This failure resulted in R3's emotional and psychosocial harm. R3's started to exhibit behavioral changes as evidenced by being very upset, unable to sleep at night and crying. R 3 was admitted to the hospital on 11-18-11 for suicidal ideation. Findings include: R3's resident information sheet showed R3 was admitted to the facility on 09-23-05 and was discharged on 11-02-11 to another nursing home. On 11-17-11 at 10:00 AM, the Administrator/E 1 stated R 3 " was discharged to our sister facility. We cannot meet her needs here. There's no	F 203		

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F 203	Continued From page 7 programming we can provide and get for her. No, we didn't give her a written 30 days notice. " At 1:45 PM, the Social Service Director/E 3 confirmed the facility had not issued R 3 a written notice for transfer or discharge. E 3 stated " I talked with her (R 3) and explained to her we can't keep her here. We can't get any programming for her. No one wants to accept her. She wanted to move to a nursing home where she was before but they would not accept her back. " This nursing home was called and I spoke with the Admission Director (Z 5 claimed " the facility didn't call me. It's the patient's family from Florida that called me inquiring if we can take her back. " On 11-23-11 at 12:05 PM, R 3's sister/Z 2 stated, " she was very- very shocked with the transfer. She doesn't want to be transferred. She had been in that nursing home for a long time (2005). They transferred her to another nursing home she didn't like to go. She was doing so well in that nursing home, no behavior problem. She was very- very good for a long time until now. She was very upset, unable to sleep at night and crying on the phone all the time. They transferred her again to another nursing home closer to us on 11-10-11 but she remains upset. She had a breakdown. The transfer just rattled her and she tried to commit suicide. She is now in the hospital." The ADON (assistant Director of Nursing) at R3's current nursing home stated on 11-23-11 at 1:30 PM R 3 was discharged to the hospital for suicidal ideation, asking staff for their gait belt so she can hang herself. At 1:45 PM, the hospital social worker (Z 4) stated the patient (R 3) was in	F 203		

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F 203	Continued From page 8 the hospital's Psych Unit for behavior monitoring/ suicidal ideation. On 11-18-11 at 10:30 AM, E 1 stated " we ' re trying to be SMI (serious mental illness) free we got five to six more residents left. "	F 203		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		12/2/11

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F 329	Continued From page 9 Based on interview and record review the facility failed to obtain a consent prior to administration of antipsychotic medication for one (R 2) of four residents in the sample. The facility also failed to provide a medical justification or indication for the use of this medication, monitor for presence of adverse consequences /side effect and to develop a plan for gradual dose reduction. These failures resulted in R 2's admission to the hospital on 11-07-11 with diagnosis of altered mental status. Findings Include: R 2's nurse's notes for the month of October 2011 (Oct 2, 4, 5, 6, 9, 10, 17 and 19) showed R 2's alert and oriented, cooperative and quiet until 10-21-11. The facility preliminary 24 hour incident investigation report reads: 10-21-11 approximately 6-6:30 PM, Ist floor dining room R 2 became physically aggressive with another resident and put the resident in a " head lock. " On 11-17-11 at 2:20 PM, the ADON (Assistant Director of Nursing)/E 7 said " there were two residents who were having a verbal altercation. R 2 didn't like what the other patient said to the other guy. R 2 went to the other resident and put the resident in head lock. " When E 7 was asked what was the facility intervention that was implemented E 7 stated " we separated them. The two patients having the altercation were sent back to second floor. We sent R 2 to the hospital but was sent back right away. " E 7 confirmed there were no orders from	F 329		

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F 329	Continued From page 10 the hospital so the facility staff called R 2's attending physician and obtained an order for psychotropic medication. E 7 also stated there's no other behavioral problem after the incident on 10-21-11. E 7 claimed "he's (R 2) always been quiet, will not give you any problem, pleasant and cooperative." R 2 ' s October 2011 MAR (Medication Administration Record) showed R 2 was given an antipsychotic medication, Risperdal 0.5 mg, twice a day, from 10-21-11 thru 10-30-11(10 days). There was no indication for the use of this medication, no consent, no monitoring for the possible adverse side effects and no plan of care developed for the use of the antipsychotic medication or plan for gradual dose reduction. These findings were confirmed by the DON (Director of Nursing) on 11-17-11 at 1:00 PM. Hospital transfer form (page 2 of 2) showed: reason for admission- altered mental status, allergies Risperdal. Page 4 of 73 pages from the hospital record with note date of 11-02-11, under altered mental status: showed: - may have originally been contributed to by Risperdal. Review of Risperidone indication and side effects thru Midline Plus (U.S. National Library of Medicine thru the Internet) reads: (1) Background Risperidone (Risperdal) is an antipsychotic medication used to treat mental illnesses including schizophrenia, bipolar disorder, and irritability associated with autistic disorder. (2) IMPORTANT WARNING: Studies have shown that older adults with Dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and	F 329		

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F 329	Continued From page 11 that may cause changes in mood and personality) who take antipsychotics such as risperidone have increased risk for death during treatment. R 2 has a diagnosis including dementia. (3) What side effects can this medications cause? Drowsiness, dizziness, diarrhea, stomach pain, vision problem. Some side effects can be serious. If you experience any of the following symptoms or those listed call your doctor immediately.	F 329		
F9999	FINAL OBSERVATIONS Surveyor: Lilibeth Lazaro-Camp LICENSURE VIOLATIONS 300.610a) 300.1035a)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a	F9999		

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F9999	Continued From page 12	F9999		

meeting.

Section 300.1035 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:
2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to honor resident's (R 1) wish for Do Not Resuscitate (DNR). (2) Failed to follow facility policy and procedure to document the DNR order/status on the physician order sheet. This was for five (R 1, R4, R5, R6 and R 7) of five

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F9999	Continued From page 13 residents with DNR status. These failures resulted in R 1 being resuscitated against her wishes in the hospital on 11-08-11 and expired on the same day. Findings include: (1) R1's Uniform Do- Not- Resuscitate (DNR) Advance Directive form, signed by the Health Care Power of Attorney and R 1's attending physician dated 08-24-11 was found in R 1's clinical record. This form showed: in an event of: (1) FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop): Do Not Attempt Cardiopulmonary Resuscitation (CPR) (2) PRE- ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating): Do Not Attempt Cardiopulmonary Resuscitation (CPR). The facility Do Not Resuscitate policy and procedure reads: #2 A valid DNR order shall be written on the POS (Physician Order Sheet) and reviewed every 30 days by the attending physician. #4. When faced with the possible DNR situation: (e) attach a copy of the DNR order to the transfer order, should the physician order a transfer. # 7. Facility personnel will be oriented to the provisions of this policy upon hire and at least annually. R 1's code status (DNR) was not written on R 1's POS and this was confirmed by the DON (Director of Nursing)/E2 on 11-18-11 at 11:05 AM. E 2 also stated, " the nurse didn't copy the DNR form, so it was not sent during the transfer.	F9999		

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She was disciplined with that. " Review of the nurse (E 4) employee report dated 11-14-11 reads: staff nurse failed to send copy of current DNR with resident (R 1) to the hospital ...

On 11-23-11 at 9:50 AM via phone interview with Z1 disclosed " her (R 1's) family was very upset and said they put her mother in so much more suffering because the most important documentation was not sent with her during the transfer (to the hospital). " Z1 stated R 1 expired the same day at night time.

Review of senior services documentation from the hospital dated 11-10-11 showed: R 1 -has a trach (tracheostomy tube) that was almost completely clogged and was admitted into the hospital because she was unable to breathe. Although the facility had copy of her (R 1) DNR, they (facility) had neglected to send it along with her in the hospital, so they (hospital staff) were forced to resuscitate her (R 1) ...

(2) A DNR list was presented on 11-18-11. The list include R 4, R 5, R 6 and R 7. Review of their clinical records showed R 4, R 5, R 6 and R 7 have Uniform Do- Not- Resuscitate (DNR) Advance Directive form signed by the Health Care Power of Attorney and their attending doctors, but this information was not documented in the physician order sheets. These finding were confirmed by the Director of Nursing (DON)/E 2 on 11-18-11 at 11:00 AM. On 11-18-11 at 1:45 PM, the nurses/ E 5 and E 6 stated "we are not aware that we need to write it on the POS."

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(B)

300.3240a)

300.3300d)1)2)3)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Section 300.3300 Transfer or Discharge

d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances:
1) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs;
2) When the transfer or discharge is mandated by the physical safety of other residents, the facility staff, or facility visitors, as documented in the clinical record. The Department shall be notified prior to any such involuntary transfer or discharge. The Department will immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged under this

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subsection (d), and the Department may place relocation teams as provided in Section 3-419 of the Act;
3) When an identified offender is within the provisional admission period defined in Section 1-120.3 of the Act and Section 300.330 of this Part. If the Identified Offender Report and Recommendation prepared under Section 2-201.6 of the Act shows that the identified offender poses a serious threat or danger to the physical safety of other residents, the facility staff, or facility visitors in the admitting facility, and the facility determines that it is unable to provide a safe environment for the other residents, the facility staff, or facility visitors, the facility shall transfer or discharge the identified offender within 3 days after its receipt of the Identified Offender Report and Recommendation.

Based on interview and record review the facility failed to provide a written notice of transfer or discharge to a resident for which the facility feels they could no longer meet her needs. This is for one (R 3) of four residents in the sample.

This failure resulted in R3's emotional and psychosocial harm. R3's started to exhibit behavioral changes as evidence by being very upset, unable to sleep at night and crying. R 3 was admitted to the hospital on 11-18-11 for suicidal ideation.

Findings include:

R3's resident information sheet showed R3 was

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admitted in the facility on 09-23-05 and was discharged on 11-02-11 to another nursing home.

On 11-17-11 at 10:00 AM, the Administrator/E 1 stated R 3 " was discharged to our sister facility. We cannot meet her needs here. There's no programming we can provide and get for her. No, we didn't give her a written notice. " At 1:45 PM, the Social Service Director/E 3 confirmed the facility had not issued R 3 a written notice for transfer or discharge. E 3 stated " I talked with her (R 3) and explained to her we can't keep her here. We can't get any programming for her. No one wants to accept her. She wanted to move to a nursing home where she was before but they will not accept her back. " This nursing home was called and I spoke with the Admission Director (Z 5 claimed " the facility didn't call me. It's the patient's family from Florida that called me inquiring if we can take her back. "

On 11-23-11 at 12:05 PM, R 3's sister/Z 2 stated, " she was very- very shocked with the transfer. She doesn't want to be transferred. She had been in that nursing home for a long time (2005). They transferred her to another nursing home she didn't like to go to. She was doing so well in that nursing, no behavior problem. She was very-very good for a long time until now. She was very upset, unable to sleep at night and crying on the phone all the time. They transferred her again to another nursing home closer to us on 11-10-11 but she remains upset. She had a breakdown. The transfer just rattled her and tried to commit suicide. She is now in the hospital."

The ADON (assistant Director of Nursing) at R3's

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F9999	Continued From page 18 current nursing home stated on 11-23-11 at 1:30 PM R 3 was discharged to the hospital for suicidal ideation, asking staff for their gait belt so she can hang herself. At 1:45 PM, the hospital social worker (Z 4) stated the patient (R 3) was in the hospital's Psych Unit for behavior monitoring/ suicidal ideation. On 11-18-11 at 10:30 AM, E 1 stated " we ' re trying to be SMI (serious mental illness) free we got 5 to 6 more residents left. " (B) 300.686a)3)4) 300.686b) 300.686c) 300.686d) 300.1210a) 300.3240a) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs	F9999		

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a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used:

3) without adequate monitoring;

4) without adequate indications for its use; or

b) Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of the medications shall be described.

c) Residents shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident's comprehensive assessment, to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions in accordance with Section 300.Appendix F.

d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in accordance with Section 300.Appendix F.

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Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview and record review the facility

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failed to obtain a consent prior to administration of antipsychotic medication for one (R 2) of four residents in the sample. The facility also failed to provide a medical justification or indication for the use of this medication, monitor for presence of adverse consequences /side effect and to develop a plan for gradual dose reduction.

These failures resulted in R 2's admission to the hospital on 11-07-11 with diagnosis of altered mental status.

Findings Include:

R 2's nurse's notes for the month of October 2011 (Oct 2, 4, 5, 6, 9, 10, 17 and 19) showed R 2's alert and oriented, cooperative and quiet until 10-21-11. The facility preliminary 24 hour incident investigation report reads: 10-21-11 approximately 6-6:30 PM, Ist floor dining room R 2 became physically aggressive with another resident and put the resident in a " head lock. "

On 11-17-11 at 2:20 PM, the ADON (Assistant Director of Nursing)/E 7 said " there were two residents who were having a verbal altercation. R 2 didn't like what the other patient said to the other guy. R 2 went to the other resident and put the resident in head lock. "
When E 7 was asked what was the facility intervention that was implemented E 7 stated " we separated them. The two patients having the altercation were sent back to second floor. We sent R 2 to the hospital but was sent back right away. " E 7 confirmed there were no orders from the hospital so the facility staff called R 2's

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F9999	Continued From page 22 attending physician and obtained an order for psychotropic medication. E 7 also stated there's no other behavioral problem after the incident on 10-21-11. E 7 claimed "he's (R 2) always been quiet, will not give you any problem, pleasant and cooperative." R 2 ' s October 2011 MAR (Medication Administration Record) showed R 2 was given an antipsychotic medication, Risperdal 0.5 mg, twice a day, from 10-21-11 thru 10-30-11(10 days). There was no indication for the use of this medication, no consent, no monitoring for the possible adverse side effects and no plan of care developed for the use of the antipsychotic medication or plan for gradual dose reduction. These findings were confirmed by the DON (Director of Nursing) on 11-17-11 at 1:00 PM. Hospital transfer form (page 2 of 2) showed: reason for admission- altered mental status, allergies Risperdal. Page 4 of 73 pages from the hospital record with note date of 11-02-11, under altered mental status: showed: - may have originally been contributed to by Risperdal. Review of Risperidone indication and side effects thru Midline Plus (U.S. National Library of Medicine thru the Internet) reads: (1) Background Risperidone (Risperdal) is an antipsychotic medication used to treat mental illnesses including schizophrenia, bipolar disorder, and irritability associated with autistic disorder. (2) IMPORTANT WARNING: Studies have shown that older adults with Dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality)	F9999		

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F9999	Continued From page 23 who take antipsychotics such as risperidone have increased risk for death during treatment. R 2 has a diagnosis including dementia. (3) What side effects can this medications cause? Drowsiness, dizziness, diarrhea, stomach pain, vision problem. Some side effects can be serious. If you experience any of the following symptoms or those listed call your doctor immediately. (B)	F9999		