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F 441	Continued From page 38 items to clean items".	F 441		
F9999	FINAL OBSERVATIONS	F9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1210b)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

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F9999	Continued From page 39	F9999		

care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to immediately report three (3) acquired Stage II Pressure Ulcers to the Nurse, failed to follow the policy for initial treatment, the staff failed to assure the pressure relieving cushion was properly placed in R3's chair, failed to follow the Care Plan for repositioning at least every two hours, failed to follow Physician Orders for daily dressing changes and failed to provide incontinence care following an incontinence episode for two of three residents (R3, R4) reviewed for pressure ulcers on the sample of fourteen. These collective

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F9999	Continued From page 40 failures led to the development of new stage II pressure ulcers, unknown by the facility, and worsening of existing pressure ulcers for R3 and R4. Findings include: 1. The Physician's Order Sheet dated December 2013 documents that R3 was admitted 12/21/12 and diagnosed with Alzheimers, Dementia, and Dementia with Psychotic Episodes and R3 receives the following antipsychotic medications: Risperidone 1 milligram (mg) take 1 1/2 tablets by mouth twice a day, Olanzapine 5 mg take one tablet under the tongue at bedtime, and Olanzapine injection 10 mg, inject 5 mg every 8 hours as needed. The Minimum Data Set (MDS) dated 11/18/13 indicates that R3 requires extensive assistance with bed mobility, transfers, Activities of Daily Living, and toileting. The Skin Assessment dated 11/18/13 indicates R3 is at moderate risk for skin breakdown. The Quality Care Reporting Form dated 8/10/13 documented an unstageable skin tear and described the location as "coccyx-red area with minimal drainage, 4.0 centimeters (cm) x 3.0 cm x 0.1 cm". The Weekly Wound Tracking Report dated 8/10/13 documented a facility-acquired Stage II pressure ulcer on R3's coccyx measuring 1.2 cm x 2.2 cm x 0.1 cm. Another Weekly Wound Tracking Report dated 11/20/13 documented a facility-acquired, unstageable excoriation on left posterior scrotal sac measuring .05 cm x 0.6 cm x 0.1 cm. The Physician Communication and Progress Note dated 8/10/13 documented "coccyx-red area 4.0 cm x 3.0 cm x 0.1 cm, resident (R3) and adds "spends more time in	F9999		

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F9999	Continued From page 41 recliner. Needs reminded to lay down after meals and at HS (hours of sleep)." On 12/2/13 at 8:10 am E6 and E22 CNAs (Certified Nursing Assistants) provided incontinence care for R3 and stated that R3 had three open areas on this coccyx that were not there the last time R3 was checked. E6 stated that the areas on R3's coccyx were "open and bleeding." On 12/2/13 at 10:00 am R3 was seated in a recliner chair. Consistent observations (every 15 minutes) of R3 reflect that R3 remained seated in the same recliner chair in the same relative position from 10:00 am to 12:00 pm without being repositioned. At 12:00 noon R3 received his lunch tray while seated in the same chair and remained seated in the same relative seated position in this this chair until 2:00 pm, for a total of four hours. On 12/4/13 at 3:05 pm E7 (MDS/Care Plan Coordinator) stated that staff are to reposition or walk R3 every two hours. On 12/3/13 at 11:50 am E2 (Director of Nursing) stated that she was only aware of the excoriation area on R3's scrotum which is healing and not aware of any open areas on R3's coccyx. E2 stated that CNA's are supposed to report open areas to the nurse immediately. The nurse will complete the assessment and measurements and contact the doctor, family and dietary. According to E2 this was not done. E2 stated that R3 should be repositioned a minimum of every two hours. E2 stated, "(R3) has a gel pad in his soft chair."	F9999		

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On 12/3/13 at 2:35 pm E21 (Nursing Assistant) lifted the incontinence pad off the chair cushion and stated "the gray side is up. This is how I put the cushion in the chair."

On 12/3/13 at 2:40 pm E2 referenced the cushion in R3's chair and stated that the cushion was placed in R3's chair upside down and that the gray section is to be on the bottom.

On 12/5/13 at 9:45 am E1 (Administrator) stated that E2 is educating the staff since 12/2/13 to place the cushion in resident's chairs with the gray section on the bottom.

On 12/2/13 at 12:05 pm E10 (Licensed Practical Nurse, LPN) stated she was not informed of R3's newly discovered pressure ulcers found by E6 and E22 that morning. E10 stated, "CNA's did not report to me about bleeding areas on the resident's (R3) buttocks today."

On 12/3/13 at 2:00 pm E6 and E20 removed R3's saturated brief to allow E10 to examine the open areas on R3's coccyx. E10 measured three areas on R3's coccyx and stated the pressure ulcers are Stage II. E10 stated that two areas on the right coccyx measure 0.5 centimeters (cm) x 0.3 cm and 0.9 cm x 0.5 cm, and the area on the left coccyx measures 0.5 cm x 0.2 cm. E10 confirmed the pressure ulcers were acquired in the facility. E10 applied barrier cream to the open areas and then left the room to allow E6 and E20 to complete incontinence care.

On 12/3/13 at 2:10 pm E6 replaced R3's saturated incontinence brief with a dry brief without providing proper hygiene (cleansing).

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F9999	Continued From page 43 On 12/3/13 at 2:30 pm E6 stated, "I forgot to wash him (R3)." E6 referenced the policy for incontinence care and stated, "We will clean them (residents) up with soap and water. Yes. He (R3) should have been cleaned with soap and water. I totally forgot to clean him (R3). (R3) didn't get washed up." R3's Restorative Nursing Scheduled Toileting Program dated 3/15/13 documented "Peri (Perineal) care after each incontinent episode." An undated Perineal (Peri) Care Policy for Male Without Catheter provided on 12/4/13 by E2 includes the following procedure to, "....Wet washcloth and apply cleansing agent chosen. Wash pubic area, including upper inner aspect of both thigh as well as the penis and scrotum...Rinse area in same sequence, if applicable..." On 12/9/13 at 12:30 pm E2 referenced E10's assessment and initial treatment of R3's pressure ulcers and stated, "The facility has protocol sheets for Pressure Ulcer Management Guidelines. R3's open areas should have been cleansed with Normal Saline and Hydrogel or Collagen applied. This protocol should have been implemented until a doctor's order was received to change it." 2. Physician's Orders dated December 2013 lists R4's diagnoses which include Lewybody Disease with Dementia and Delusional Paranoid Disorder. The Wound Tracking Report dated 11/18/13 documents a newly acquired Pressure Ulcer on R4's left heel measuring 1.0 cm x 0.5 cm x 0.2 cm (depth). The Newly Acquired Skin Condition Report dated 11/19/13 identifies a Stage II	F9999		

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Pressure Ulcer on R4's left heel. The Minimum Data Set (MDS) dated 9/9/13 indicates that R4 requires extensive assistance with bed mobility, transfers, Activities of Daily Living, hygiene, bathing, and toileting. The Skin Assessment dated 9/9/13 indicates R4 is at moderate risk for skin breakdown.

On 12/9/13 at 11:00 am E7 (Licensed Practical Nurse, LPN) referenced a pressure ulcer on R4's left heel, which was first diagnosed on 1/26/13. E7 stated that R4's left heel pressure ulcer has "recurred" on 5/24/13, 9/12/13, and 11/18/13. E7 stated that R4 was seen at wound clinic on 11/19/13 and 12/6/13. E7 stated, "Yes, (R4) still has the left heel pressure ulcer."

On 12/2/13 at 12:55 pm E3 (LPN) stated, "I came to measure the ulcer on (R4's) left foot." E3 removed R4's protective boot and stocking and stated that there was no pressure ulcer dressing to remove. E3 stated the measurements of the area were 2.0 cm x 2.0 cm.

On 12/5/13 at 9:20 am E8 Registered Nurse (RN) stated there is no dressing on R4's left heel pressure ulcer. E8 stated, "A dressing should be on to cover the area." E8 cleansed R4's left heel with Normal Saline, applied antibiotic ointment and a gauze sponge then wrapped dressing with Kling (gauze). E4 stated, "I did not apply a Telfa pad. I used a gauze pad."

Physician Protocol Orders dated 11/19/13 state "Treatment for skin tears as follows; cleanse with normal saline, apply TAO (Triple Antibiotic Ointment), Telfa and Kling daily and PRN (as needed) until healed. The Physician Order Sheet dated 11/19/13 documents an order to "Send

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(R4) to Wound Clinic for feet..."

On 12/5/13 at 9:30 am and 12/9/13 at 11:30 am E2 stated that R4's dressing changes on the left heel are documented on the Treatment Administration Record. E2 stated that there is no documentation for R4's dressing being changed on November 27, December 2, 3, or 4, 2013. E2 also stated "The Telfa pad is non-adhering to the wound area. The order calls for Telfa to be used."

Treatment Records dated November 2013 and December 2013 document that R4's pressure ulcer dressing was not changed on 11/27/13, 12/2/13, 12/3/13, and 12/4/13.

(B)

300.1210b)
300.1210d)6)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to supervise R2, resulting in R2 sustaining a fractured wrist when he tipped over in his wheel chair. R2 was one of five residents reviewed for falls in the sample of 14.

Findings Include:

1. R2's Minimum Data Set dated 8/19/13 documents he is moderately cognitively impaired and requires extensive to total assist with bed mobility, transfers, wheelchair locomotion and activities of daily living. The Physical Restraint Assessment dated 8/9/13 documents a soft cushion restraint was implemented for R2 on that date due to a history of multiple falls, forward leaning upper body, cognitive impairment and unawareness of safety needs.

The fall investigation dated 10/15/13 documents

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R2 was found in his room, in his wheelchair with his wheelchair tipped over on its left side with a soft cushion restraint in place with his left arm behind him on that date. The same investigation report documents that R2's roommate, R24, reported that R2 stood up from his wheelchair and the wheelchair tipped over sideways. Nurses Notes dated 10/15/13 10:30 AM document that at that time R2's left arm was pinned under his body. Nurses Notes dated 10/15/13 document R2 was sent to the local hospital Emergency Room at that time. The X-Ray report dated 10/15/13 documents R2 was diagnosed with an acute fracture of his left wrist.

The Fall Analysis Log dated January 2013 through October 2013 documents R2 experienced 16 falls prior to the 10/15/13 fall including a fall on 6/5/13 when R2 flipped over backwards while he was seated in his wheelchair.

On 12/4/13 at 2:20 PM E2 Director of Nurses confirmed that R2 was in his room seated in his wheelchair with a soft cushion restraint in place across his lap unsupervised when he fell on 10/15/13. At that time E2 stated that R2 should not be left in his wheelchair unsupervised and that during her investigation she was unable to determine why R2 was left unsupervised in his in his wheelchair on 10/15/13.

On 12/4/13 at 1:35 pm E19 Certified Nurses Aide (CNA) stated R2 frequently leaned over his soft cushion restraint while he was seated in his wheelchair and frequently tried to stand up while he was seated in his wheel chair with the soft cushion restraint in place before he fell {on 10/15/13}. At that time E19 further stated that when she began working at the facility in August

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she was instructed not to leave R2 unsupervised while he was seated in his wheelchair. On 12/4/13 at 1:40 PM E23 CNA stated that {prior to the 10/15/13 fall} R2 was not be left unsupervised in his wheelchair with the soft cushion restraint in place because he had a tendency to try to stand up.

(B)

300.610a)
300.1210b)
300.1220b)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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest

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practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 are not met as evidenced by:

Based on interview, record review and observation the facility failed to provide justification for the use of duplicative antipsychotic medication therapy and failed to attempt gradual dose reductions for antipsychotic medications for one of four residents, R2 reviewed for psychoactive medications in the

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sample of 14. These failures resulted in somnolence for R2 in addition to functional declines with ambulation, transfers and all activities of daily living.

Findings Include:

1.) The Behavioral Center Discharge Summary dated 5/24/13 documents R2 was admitted to the Behavioral Center on 5/11/13 with a chief complaint of increased verbal and physical aggression and that R2 has diagnoses of Dementia with Behavioral Disturbance and Aggressiveness. The same Discharge Summary documents R2 returned to the facility on 5/24/13 with orders for the following medications Olanzapine (antipsychotic) 5 milligrams (mg) in the morning and 10 mg in the evening, Thiothixene (antipsychotic) 10 mg twice daily and Desyrel (antidepressant) 150 mg twice daily.

The Minimum Data Set discharge assessment dated 5/10/13 documents R2 required only limited assistance with transfers, ambulation and activities of daily living when he was transferred to the Behavioral Center on 5/11/13. The Minimum Data Set dated 5/31/13, eight days after readmission to the facility from the Behavioral Center, documents that R2 required extensive assist with transfers, ambulation and all activities of daily living except eating. On 12/9/13 at 2:00 PM the functional decline documented on R2's 5/10/13 and 5/31/13 Minimum Data Sets was reviewed with E7 Minimum Data Set Coordinator at that time she stated she believed R2's decline was caused by his {antipsychotic} medication.

Nurses Notes dated 7/22/13 document Z4 family member requested a medication review for R2

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due to weight loss and multiple falls. Nurses Notes dated 7/25/13 document a new order to decrease R2's Desyrel to 100 mg twice daily with no changes in R2's antipsychotic medication.

The Physical Restraint Assessment dated 8/9/13 documents R2 was restrained on that date with a soft cushion lap restraint due to a history of multiple falls, unsteady balance when standing and ambulating, and upper body forward leaning.

Nurses Notes dated 8/11/13 document Z4 family member requested a further reduction in R2's sedating medication on that date stating "It seems like he sleeps all the time." Nurses Notes dated 8/13/13 document the following order from R2's Physician Z2, "continue {medications} at present dose unless the family insists on a decrease."

The September, October, November and December 2013 Behavior Monitoring Records Document R2 has target behaviors of yelling and cussing, kicking and hitting, rolling around on the floor, resistant to care, urinating in inappropriate places, becoming agitated when he sees himself in the mirror, exit attempts and wandering.

The September 2013 Behavioral Monitoring Record documents R2 had six episodes of rolling around on the floor, one episode of resisting care and one episode of cursing and attempting to hit a Certified Nurses Aide (CNA) during the month of September.

The October 2013 Behavior Monitoring Record documents R2 had three episodes of unplugging the bed (10/13/13 and 10/23/13), two episodes of rolling on the floor (10/27/13 and 10/28/13), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146117	A. BUILDING ______ B. WING ______	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	**100 N.E. 15TH CASEY, IL 62420**

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F9999	Continued From page 52	F9999		

one episode of being resistive care (10/27/13).

The November and December 2013 Behavior Monitoring Records through 12-9-13 document that R2 exhibited no behaviors. The Minimum Data Set dated 11/13/13 documents that R2 exhibits no behaviors and no wandering and that R2 has declined to requiring total assistance with transfers, hygiene and bathing and that R2 is unable to ambulate.

On 12/3/13 at 10:50 AM E10 Licensed Practical Nurse stated that R2's behaviors can be easily redirected.

On 12/2/13 at 3:55 PM E9 CNA stated R2's behavior is not aggressive.

On 12/2/13 at 12:25 PM R2 was sitting in his wheel chair with his trunk flexed leaning forward and appeared lethargic. On that same day at 12:45 PM R2 was slumped over in his wheelchair leaning on his soft cushion restraint and the right side of his wheel chair sleeping. At 1:05 PM on that same day R2 required total assistance of E11 CNA and E12 CNA to transfer from his wheelchair to his bed. R2 then slept as E11 and E12 assisted him with incontinence care. On that same day R2 was sleeping at 3:30 PM and 3:50 PM.

On 12/3/13 at 7:25 AM R2 was seated at the assist dining table with his trunk flexed forward leaning to his left side and over his soft cushion restraint. At 7:30 AM E16 CNA sat down at the table with R2, removed the soft cushion restraint and asked R2 if he could sit up. R2 did not sit up and his trunk remained in a flexed position as E16 fed him his breakfast. At that time E16

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F9999	Continued From page 53 stated that {R2} is leaning over because he is tired. On that same day at 8:00 AM E16 and E17 CNA transferred R2 from his wheel chair to his bed. At that same time E16 stated sometimes R2 sleeps through his meals. At 12:05 PM on that day E17 stated R2 has been in his bed since he finished breakfast (at 8:00 AM) and that R2 was sleeping when she came in to reposition him. E17 further stated at that time that R2 looked sleepy. On 12/4/13 at 7:50 AM R2 was seated in his wheelchair at the assist dining table with his trunk flexed forward. On 12/3/13 at 12:25 PM E2 Director of Nurses stated that R2's forward leaning increased after he returned to the facility from the behavioral center (on 5/24/13). E2 explained that the antipsychotic medication may have contributed to R2's increased forward leaning. On 12/3/13 at 2:25 PM Z6 Pharmacist confirmed that R2's forward lean is a possible side effect of antipsychotic medication therapy. The Physician's Order Sheet dated 11/22/13 documents R2 currently has orders for the same antipsychotic medications he was on when he was discharged from the behavioral center on 5/24/13, Olanzapine 5 mg in the morning and 10 mg in the evening and Thiothixene 10 mg twice daily . On 12/3/13 at 11:00 am E2 Director of Nurses was unable to provide justification from Z2, R2's Physician, for the continued use of the duplicative antipsychotic therapy and agreed that based on R2's current assessment his antipsychotic therapy is not appropriate.	F9999		

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F9999	Continued From page 54 The Nursing Lexi-Drug Guide 2013 lists drowsiness as an adverse reaction to Thiothixene and somnolence as an adverse reaction to Olanzapine. The Chemical Restraint Policy dated 3/15/11 states that An unnecessary drug is any drug used in excessive dose, including duplicative therapy. (B)	F9999		