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S 000	Initial Comments Complaint investigation 1891245/IL100574 Statement of Licensure Violations:	S 000		
S9999	Final Observations 300.610a) 300.1210b) d) 3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observations, interview and record review, the facility failed to provide documentation to support the use of the anti-psychotic medications in dementia residents, failed to have documentation on targeted behaviors being treated and failed to provide documentation of non-pharmacological interventions prior and during the use of the anti-psychotic medications for 3 (R1, R2 and R3) of 3 residents reviewed for anti-psychotic medication in the sample of 3 residents. This failures have resulted in R2 exhibiting Tardive Dyskinesia (side affects)	S9999		

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S9999	Continued From page 2 symptoms and R3 exhibiting excessive sleepiness. The findings include: On 3/8/18 between 9:45 AM to 10:45 AM accompanied by V3 (Director of Nursing), tour of the main nursing unit was conducted. R3 was sound asleep in the bed. V3 stated that R3 has dementia and is a fall risk. V3 stated that R3 has an (anti-slipping pad) in wheelchair along with a chair alarm. In the main dining room, R1 and R2, were participating (mostly observing) in an activity. V3 stated that R1 and R2 are both fall risks with dementia diagnoses. On 3/8/18 at 11:30 AM in the Main Dining Room, R1 is seated at the same table as R3. R2 is seated at another table. R3 was sound asleep in wheelchair at the dining room table. R3 did not touch his food. R3 stated not to be hungry when he was aroused by staff to eat something. R1 and R2 are both slow eaters but consumed a fair portion of their meals. At 12:05 PM, R3 was taken from the main dining room to the resident lounge where he continues to be lethargic and sleepy. On 3/13/18 at 10:20 AM, both R1 and R2 are in the main dining room for an activity. R2 is noticed to make an uncontrolled "rabbit-like" mouth movement. R1 is very quiet and calm and moves very little. At 4:10 PM, R1 was in bed and eyes closed but easily aroused by opening her eyes. R2 is a 89 year old, non-ambulating female who was admitted to the facility on 11/6/14 with diagnoses that include Non-Alzheimer's Dementia, depression, Psychotic disorder and Psuedobulbar Affect (PDA) disorder per the quarterly MDS dated 3/3/18. R2 is cognitively	S9999		

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impaired with a BIMS of "4" and requires extensive assistance with transfers, dressing, hygiene and bathing. R2 is also incontinent of bowel and bladder.

R2's March 2018 P.O.S. and November 2017 through March 2018 M.A.R. document Nuedextra 20/10 mg daily for PBA. The Nuedextra was started 10/31/17 and discontinued on 12/6/17. On 12/7/17 the Nuedextra 20/10 mg is increased to twice a day. Risperdal (psychotropic medication) 0.25 mg is started 3/16/17 for Psychosis.

V5's 1/29/18 psychiatric progress note documents that Nuedextra was increased to twice a day due to R2 saying disrespectful things and that the Risperdal will be kept since R2 exhibits mild Tardive Dyskinesia (T.D.) and no clear Extrapyramidal Symptoms.

Per the V5's (psychiatrist) progress notes 4/24/17 documents R2 not taking the Nuedextra but restarting it on 12/6/17 progress note. There is no supporting documentation that R2 was experiencing PDA symptoms prior to initiation, during the discontinuation phase and the resuming of the Nuedextra medication.

On 3/14/18 at 9:23 AM, V5 stated that he understood that R2 was seeing and hearing things that are not there and would be loud and say inappropriate things. V5 added that the criteria for PBA has widen to include people saying inappropriate things. V5 stated that he could discontinue the Risperdal because it is just a low dose. V5 stated that R2 does exhibit "rabbit-like" movement of her mouth which may be TD.

On 3/15/18 at 9:17 AM, V6 (C.N.A.) stated that

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R2 does not exhibit any behaviors. At 9:19 AM, V7 (Licensed Practical Nurse/L.P.N.) stated she has been employed one month and she has not seen R2 exhibit any behaviors. At 9:22 AM, V8 (L.P.N.) stated she has been employed since June 2017 and has seen R2 exhibit forgetfulness and is hard of hearing and will yell out to go to the bathroom but once she is attended to she is okay. At 9:25 AM, V9 (C.N.A.) who has worked in the facility for 4 years, stated she has witnessed R2 saying she needs to use the bathroom.

There is no documentation to support R2 having any psychosis nor is there any documentation on the targeted behavior being addressed nor any documentation of non-pharmacological interventions prior to and during the use of the Risperdal and Nuedextra medications. No staff member voiced any psychosis for R2.

On 3/14/18 at 9:41 AM and 11:48 AM, R3 was sound asleep on his bed. At 9:50 AM, V4 (R3's assigned certified nurse aide) stated that R3 ate very little for breakfast this morning and was very sleepy so he was laid down. V4 (C.N.A) stated she has been employed in the facility for one month and during this time, R3 has been very lethargic, hard to motivate, doesn't want to eat and at times hard to wake up. At 12:45 PM, in front of the nurses' station, R3 was alert, calm and pleasant.

On 3/15/18 at 9:25 AM in the resident lounge, R3 was in wheelchair with head down but easily aroused. V9 (C.N.A.) stated that R3 does not have any harmful behaviors except that R3 wants to stand up from wheelchair.

R3 is a 88 year old male who has recently started needing a wheel-chair for mobility. R3 was

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admitted to the facility on 4/19/07 with diagnoses that include Non-Alzheimer's Dementia, Depression, Psychotic Disorder, absolute Glaucoma, diabetes mellitus, peripheral vascular disease, coronary heart disease and hypertension per the annual minimum data set (MDS) dated 2/21/18. R3 has a brief interview mental score (BIMS) of "8" which indicates cognitive impairment, has no behaviors that interfere with care, requires extensive assist of 2 staff members for ambulation and transfers, and extensive assistance with bathing and hygiene and is incontinent of bowel and bladder per the MDS.

R3's March 2018 physician order sheet (P.O.S.) and the October 2017 through March 2018 medication administration records (MAR) documents that R3 has been receiving 0.5 milligrams (mg) of Risperdal (pyschotropic medication) daily since 1/21/2017. The Risperdal is being used for major depression, single episode per the MARs and POS. R3 is also receiving Lexapro (psychotropic medication) 20 mg for the depression since 10/23/15.

On 3/13/18 at 1:30 PM, V3 stated that the behavioral documentation and non-pharmacological interventions would be in the nurses' notes and care plan. There was nothing documented except that R3 has no behaviors. R3's clinical record lacked documentation of any non-pharmacological interventions. R3's psychotic disorder could not be explained when asked nor was there documentation to support the diagnoses.

R3's care plan documents the psychotropic medication is used to manage and alleviate aggression and agitation. The interventions are to

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document behavioral symptoms and offer diversional activities. No documentation provided that the interventions were implemented.

On 3/14/18 at V5 (psychiatrist) stated that he has known R3 for the last 7 years and when he first met R3, V5 stated R3 would say he "just wants to die". V5 stated that R3 suffered from severe depression which why R3 is on Lexapro and that staff would tell him that R3 would make inappropriate comments as to why R3 is on Risperdal. V5 stated that he would re-assess the Risperdal and see if it can be discontinued.

There is no documentation on the targeted behavior being addressed nor any documentation of non-pharmacological interventions prior to and during the use of the Risperdal. The Lexapro was never increased and has remained at the same dose since 10/23/15.

R1 is a 75 year old, non-ambulatory female who was admitted to the facility on 5/11/13 with diagnoses that includes Non-Alzheimer's dementia, Anxiety and Psychotic disorder per the significant MDS 11/18/17 and the quarterly MDS dated 2/24/18. R1 requires extensive assistance with activities of daily living except eating which requires set up only. R1 is cognitively impaired with a BIMS of "5".

R1's March 2018 P.O.S. and November 2017 through March 2018 M.A.R. document R1 receiving 200 mg of Seroquel (pyschotropic medication) at bedtime until 11/21/17 when it was decreased to 100 mg of Seroquel at bedtime. The documented diagnosis for the use of the Seroquel is psychosis but there was only one documented entry 5/12/16 (psychiatric note) of

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R1 screaming she had maggots on her face and they were going to eat her brain. R1 was started on 50 mg of Seroquel with little benefit. The "little benefit" is not explained or documented in the psychiatric note. There were no other documented entries of any targeted behavior warranting the use of the Seroquel. The documented diagnoses for the Seroquel per the 2/19/18 physician order documents dementia without behavioral disturbances.

On 3/13/18 at 2:05 PM, V5 (psychiatrist) stated that R1 did not have dementia when he first started treating her. V5 stated that R1 was started on the Seroquel due to psychotic issues. V5 stated that per nursing staff he was told that R1 was talking in her sleep and disturbing her roommates, possible auditory hallucinations. V5 stated that different staff members would tell him different things. V5 stated that he R1 use to have a lot of psychosis but could not elaborate on the psychosis. V5 states he usually comes in at 7 AM to do his assessments and usually talks to the night shift. When V5 was asked about the non-pharmacological interventions, V5 stated he would not know.

On 3/13/18 at 2:15 PM, V3 stated that R1 has not been exhibiting any behaviors since she started her employment in August 2017. V3 added that she wants to get all her dementia residents off the anti-psychotics medications.

On 3/14/18 at 9:23 AM, V5 came in person to evaluate the residents and stated that R1 was having sleep issues about a year ago and if it is only sleep issues, the Seroquel would not be good choice.

On 3/15/18 at 9:17 AM, V6 (C.N.A.) stated that

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R1 does exhibit talking out loud to self but does not voice any harm to self or others. At 9:19 AM, V7 (Licensed Practical Nurse/L.P.N.) stated she has been employed one month and she has seen R1 express verbal aggression which is difficult to re-direct but that R1 never voices any harmful verbiage. At 9:22 AM, V8 (L.P.N.) stated she has been employed since June 2017 and has seen R1 exhibit verbal aggression but nothing harmful. At 9:25 AM, V9 (C.N.A.) who has worked in the facility for 4 years, stated she has not witnessed any behaviors from R1.

R1's care plan for the psychotropic document it is used for behavior management. The intervention is to monitor and record targeted behavior symptoms.

There is no documentation on the targeted behavior being addressed nor any documentation of non-pharmacological interventions prior to and during the use of the Seroquel. No staff member voiced any psychosis for R1.

The manufacturer's guidelines for Seroquel document that it is not recommended for residents with dementia related psychosis.

The facility's policy labeled Psychotropic Drugs Usage documents when clinically appropriate, the facility staff will initiate non-medication approaches to assist in the treatment or alteration of the resident's behavior as behavioral redirection and environmental alterations. Each resident receiving any anti-psychotic medication for dementia will be observed for episodes of the behavioral symptoms being treated and/or manifestation of the disorder thought process, adverse reactions and side effects and the appropriateness of drug selection and dosage.

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S9999	Continued From page 9 Dementia with associated psychotic and/or agitated behaviors will be documented quantitatively and objectively to assist in assessing whether the behavior symptoms are transitory or permanent or not easily altered, relating the behavior symptoms to other events in resident's life, ruling out environmental symptoms and medical causes such as, fever, dehydration or infections. Anti-psychotics are not to be used if one or more of the following are the only indications, such as, insomnia, unsociability, uncooperativeness and agitated behaviors which do not present a danger to resident or others. (B)	S9999		