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	IL6015648	A. BUILDING: _____ B. WING _____	09/06/2018

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CITADEL ESTATES-HAZEL CREST	3701 WEST 183RD STREET HAZEL CREST, IL 60429

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S 000	Initial Comments Annual Sheltered Care Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.790 330.710 330.1510 330.1155 Section 330.790 Infection Control c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Center for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 330.340): 1) Guideline for Hand Hygiene in Health-Care Settings This requirement is not met as evidence by: Based on observation, Interview, and record review the facility failed to maintain infection control practices with hand washing and gloves use for three of three employees reviewed for hand hygiene. This deficient practice has the potential to affect all 50 residents current living in the facility. Findings Include: On 9/5/18 at 10:16 am V6 CG (Care Giver) is leaving the laundry room with folded clothing and wearing gloves. V6 is delivering clothing's to residents rooms with gloves on without changing	S9999	**Attachment A** **Statement of Licensure Violations**	

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or using hand hygiene in between resident rooms. V6 is asked if its the practice of the facility to wear gloves in the hall and from room to room? V6 states, "I'm new, but no I shouldn't have the gloves on." V5 CNA (Certified Nursing Assistant) states, "No she (V6) shouldn't be in the hall with gloves on."

On 9/4/18 at 10:00am surveyor observed V4 CNA is walking in the hall from room to room with gloves on and without changing gloves or performing hand hygiene in between rooms.

At 12:15pm surveyor observed V8 (Care Giver) is serving plates during dining with gloved hands. V8 is observed touching V8's face, answering the phone, going into the cabinet, and return to plate and serve food without changing gloves or performing hand hygiene.

Facility Personal Protective Equipment page 16 guidelines for glove use is stating that gloves should be changed after each patient contact, an hands are to be washed after glove removal, or a waterless hand sanitizer used.

(C)

Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

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b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public.

c) The written policies shall include, but are not limited to, the following provisions:

1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers.

2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services.

This requirement is not met as evidenced by:

Based of on observation, interview, and record review the facility failed to create a care plan for psychotropic medications administration and management for three (R1,R2,R4) of three residents in a total sample of 5 reviewed for psychotropic medications management.

Findings Include:

Review of R1's POS (Physicians Order Sheet) is with R1 having the following order for psychotropic medications; Prozac Capsule 10mg (milligram) by mouth one time daily(ordered

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S9999	Continued From page 3 6/20/18), Risperdal 1mg, one tablet by mouth every 12 hours as needed for agitation (ordered 11/9/17). R2 has the following medication Prozac 20mg by mouth in the morning related to restlessness and agitation, Resperdal 1mg tablet by mouth one time daily related to restlessness and agitation (Ordered 3/14/18). R4 has an order for Quetiapine Fumarate 25mg by mouth 1 tablet at bedtime for hallucination (ordered 8/23/17). Review of R1, R2, and R4's service plan/careplan is without any documentation regarding psychotropic medication administration and education. Surveyors interview with V2 DON (Director of Nursing) on 9/5/18 at 3:03pm didn't address staff updating or documenting the psychotropic medications on the service plans. Facility service plan policy/ Procedure number 1. The Administrator, or a designated representative, develops a service plan for each resident prior to admission 2. d. is as follows; A registered or licensed nurse, if the resident is receiving nursing services, medication assistance , or is unable to direct self care. 3. The service plan should address, but is not limited to, the following; b. Medication management and/or assistance required. (AW) Section 330.1510 Medication Policies	S9999		

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a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility.
1) Medication policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written program of care and services.
2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy.

This requirement is not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow physician orders for 2 of 4 residents (R6,R7) observed during medication administration.

Findings include:

On 9/5/18 at 9:09am, during medication pass observation with V3 LPN (Licensed Practical Nurse), V3 administered R6's scheduled 9:00am medications. V3 administered Vitamin B12 2500mcg (micrograms) to R6 during this pass.

Review of R6's Order Summary Report (print

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date 9/5/18) documents an active order (start date 11/1/16) for Vitamin B12 1000mcg tablet. R6's Order Summary Report does not include an order for Vitamin B12 2500mcg.

On 9/5/18 at 9:15am, during medication pass observation, V3 continued and administered R7's scheduled 9:00am medications. V3 administered Prednisone 7.5 milligrams (three 2.5mg tablets) to R7.

Review of R7's Order Summary Report (print date 9/5/18) documents an active order for Prednisone 5mg (take 2.5mg 2 tabs) by mouth in the morning related to Chronic Obstructive Pulmonary Disease. R7's Order Summary Report denotes Prednisone 7.5mg dose was discontinued. R7's Order Summary report also includes an order for Citalopram 20mg. V3 did not administer Citalopram to R7 during the medication pass observation. Following the administration pass and after medication reconciliation, V3 assessed R7's current medications in the nurse's cart and acknowledged that R7's Citalopram was not available.

On 9/5/18 at 11:15am, V3 stated, in regards to R6's medications, I thought that R6's order for the Vitamin B12 was changed to a different dose.

Review of the facility's Medication Orders policy (Rev. date 12/15), documents: 1. No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness. 9. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than 3 days prior to the last dosage being administered to ensure that refills are readily available.

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S9999	Continued From page 6 (C) Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug used: 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use b) Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106.1(b) of the Act). d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, in an effort to discontinue these drugs in accordance with Section 330.Appendix E unless clinically contraindicated. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify, monitor, and document a resident's adverse behaviors prior to administering a psychotropic medication; failed to obtain informed consent for psychotropic medication administration, failed to document any behavior interventions prior to administering a psychotropic medication, and failed to document	S9999		

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a gradual dose reduction plan for psychotropic medication use for two of five residents (R1, R4) reviewed for unnecessary drugs.

Findings include:

1.) R1 is a 58 year old resident admitted on 11/9/17 with the following diagnoses that include: Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Undifferentiated Schizophrenia, Alcohol Abuse with Alcohol-Induced Psychotic Disorder, Unspecified, Alcohol Dependence with Alcohol-Induced Persisting Dementia, and Altered Mental Status, Unspecified.

On 9/4/18 at 10:12am, observed R1 seated on the bed. R1 was dressed appropriately, appearing calm with no signs of distress. R1 would make eye contact, but appeared disinterested in conversing. Asked if R1 liked the bedroom, R1 replied "yes" and turned away (from further conversation). R1 then stood up, made eye contact and nodded, walked out of the bedroom into the hall. R1 continued to walk to the Living Room area, sat down and looked toward the TV (television). Approached R1 again in the Living Room area at 10:50am, where he continued to make very little eye contact during conversation, answering "good" to inquiries if R1 liked the food, accommodations and services. At 12:05pm, R1 stood up and walked to the dining area, easily seating self at a table with two other residents. R1 did not converse with the other residents, but sat quietly at the table watching staff serving the lunch meal.

On 9/4/18 at 2:00pm, per the POS (Physician Order Sheet) and MAR (Medication Administration Record) for R1, current medication

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orders include two psychotropic medications; Prozac (Fluoxetine Hcl) 10mg (milligram) by mouth once daily for Depression related to Alcohol Abuse with Alcohol-Induced Psychotic Disorder (ordered 6/20/18), and Risperdal (Risperidone) 1mg by mouth every twelve hours as needed for Agitation related to Dementia in other diseases classified elsewhere with Behavioral Disturbance (ordered at admission on 11/9/17). R1's MAR for Risperdal administration documents zero administrations in June 2018, two administrations in July 2018 (7/12, 7/25), seven administrations in August (8/1, 8/2, 8/6, 8/11, 8/20, 8/23, 8/27) and one administration in September 2018 (9/3 to date).

On 9/5/18 at 9:55am, V3 (LPN, Licensed Practical Nurse) stated that whenever a PRN (as needed) psychotropic medication is to be administered to a resident, the nurse will call the physician and notify him of a resident status change, will call the family to let them know the resident needs the PRN medication, and then will document in the resident's nursing notes why the resident needs the PRN, of notifying the physician and family, and then will document on the MAR (medication administration record) in PCC (PointClickCare electronic medical record system) when they administer the medication.

On 9/5/18 at 11:05am, V1 (Executive Director) stated "the psychotropic medication consents are kept in the resident's medical chart. When they are admitted on psychotropic medication, I keep a copy of the consent that's from admission in my office. If they have a medication ordered after admission, the consent would be in the chart." Asked V1 to locate the psychotropic medication written consents in R1's medical chart. After locating the consent for Risperdal, V1 stated

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S9999	Continued From page 9 "Here it is, the consent for R1's Risperdal." Asked V1 if a psychotropic medication was ordered after a resident was admitted where the consent would be located, V1 stated "Right here, in the medical chart." No written consent form for Prozac administration was observed in R1's medical chart (Prozac was ordered on 6/20/18). During further interview at 2:46pm, V1 stated "Psychotropic consents are obtained when a resident is admitted to the facility, or with any changes in their condition after being admitted. If the Physician or Nurse Practitioner deems it necessary and orders a psychotropic medication, the nurse will call and get a phone consent, write on the consent form "phone consent", and document in the Nursing Notes the received phone consent." V1 also stated "you don't need a consent if the resident is already on the psychotropic medication on admission, you only have to get the consent after being admitted if the Physician orders it (a psychotropic medication)." On 9/5/18 at 3:03pm, V2 (Director of Nursing) stated "after the Physician orders a psychotropic medication, the Nurse will call the family to notify them and get verbal consent for the medication. They (the Nurse) will document in the Nursing Note in PCC whether or not verbal consent was given. If the POA (Power of Attorney) isn't here, then they will sign the consent when they visit. Before a Nurse gives (administers) a psychotropic medication, they will make a Nursing Note in PCC about the resident behavior that is happening, indicate if it's a new behavior or an increased behavior. The Physician will state on the order why the resident is getting the medication, and the Nurse will document in the PCC the behavior prior to administering the medication. Any behavior redirection techniques to be used are reflected in the care plan."	S9999		

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Facility's policy titled "Policy: Psychotropic Medications" (undated) states the procedure as "1. Behavioral and environmental interventions are attempted to avoid over or unnecessary use of psychotropic medications. 2. Caregivers are educated on appropriate interventions for anxiety, agitation, dementia-related behavioral challenges, and potential adverse effects of psychotropic medications." Review of R1's care plan and Nursing Notes documents no description of any adverse behaviors displayed by R1, nor any behavior interventions to be implemented prior to psychotropic medication administration to R1, or of any GDR (Gradual Dose Reduction) plans addressing Risperdal administration.

R1's medical chart documents written consent dated 11/10/17 (on admission) is specified for "Risperdal 1mg by mouth every twelve hours PRN (as needed) for the specific condition of Dementia, Alzheimer's type with Behavioral Disturbance", with the expected beneficial effects noted as "reduced adverse behaviors". No Nursing Note entries document any adverse behaviors, or of any behavior interventions implemented prior to administering PRN Risperdal to R1 on 7/12/18, 7/25/18, 8/1/18, 8/2/18, 8/6/18, 8/11/18, 8/20/18, 8/23/18, 8/27/18 and 9/3/18). Per R1's MAR, has received once daily administration of Prozac 10mg since 7/11/18 with no written documentation for guardian notification, verbal or written consent for Prozac administration observed in R1's medical chart.

2.) On 9/4/18 at 10:35am, R4 was observed in Bistro eating, behavior calm and cooperative. R4 stated "I'm ok, I guess."

On 9/4/18 at 12:10pm, R4 observed in the dining

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S9999	Continued From page 11 area, sitting quietly waiting for plate, R4 ate 100% of his lunch independently. R4 calm and cooperative. Record review of R4's Medication Administration Record dated 6/1/18-9/3/18, documented that R4 has been taking Quetiapine Fumarate Tablet 25mg. 1 tablet at bedtime related to hallucinations. Medication has been administered without consent for psychotropic medication. Psychotropic Medication Consent received on 9/5/18 is dated 9/4/18. On 9/5/18 at 10:08am V3 (Licensed Practical Nurse) stated that the consent is obtained immediately after the order is verbally given or written by the doctor or the nurse practitioner. If the patient is responsible the medication is explained to the resident and consent is obtained. If the resident had a Power of Attorney (POA) then the nurse calls the POA to request the consent. Medication is explained to the POA. (C)	S9999		