Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015523	A. BUILDING: _____ B. WING _____	12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF GLEN ELLYN	2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137

(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) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey.	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 330.720e)1)2)3) 330.1950c) 330.19501)A)B)C) 330.19502)A) 330.1950i) 330.1950g) 330.19501)A) 330.780a) 330.780b) 330.780c) 330.4240f) 330.70103)f) 330.1155b) 330.1155c) 330.1155e)1)2)3) 330.765a) 330.765b) 330.765c) 330.1710f)1) 330.911 330.1510a)4) 330.720 Admission and Discharge Policies e) No person shall be admitted to or kept in the facility: 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation;	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 2) Who is destructive of property and that destruction jeopardizes the safety of her/himself or others; 3) Who has serious mental or emotional problems based on medical diagnosis. This requirement is not met as evidenced by: Based on record review and interview, the facility admitted one resident (R6) who was at risk to inflict physical harm to self or others, had a history of destruction of property and had aggressive behavior problems. This applies to 1 of 1 resident (R6) evaluated for admitting residents to the facility with a history of physical aggression towards self and or others in the supplemental sample. The Findings include: R6 was admitted on 11/23/15 according to the move in record. On 12/3/15 at 10:00 AM E1 executive director said that R6's bed is being held while he is in the hospital. E1 said that R6 will be evaluated to determine if he will return to this facility or not. On 12/2/15 at 12:30 PM a family member of R9 expressed concern about a resident (R6) who became violent, broke a mirror and bit a staff member and may be readmitted. R6's medical record shows he was discharged from a hospital behavioral health unit on 11/23/15. R6's hospital discharge instructions dated 11/23/15 state R6 has a risk factor of violence that require ongoing treatment and evaluation. R6's primary diagnosis is frontotemporal dementia with disturbance of behavior.	S9999		

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A psychiatric examination report shows R6 was admitted to the hospital on 10/31/15. R6's 11/1/15 hospital psychiatric evaluation indicated R6's chief complaint was agitation. R6 was sent to the hospital emergency room for emergency psychiatric hospitalization from a skilled long term care facility due to behaviors. R6 was trying to hit and bite people at the nursing home. R6 was throwing things a the nurses and actually assaulted a paramedic staff enroute to the hospital. R6 had to be restrained in the emergency room. R6's mood is expansive and labile, behavior is unpredictable.

On 11/24/15 while there was no incident report made, E15 Licensed Practical Nurse (LPN) documented in service notes that R6 became agitated throwing objects at staff, pulled mirror from the wall, threw broken glass at caregivers. R6 picked glass up and began to cut his wrists. R6 bit care giver and attempted to cut staff with glass. The facility called 911 to transport R6 to hospital for emergency hospitalization.

On 12/3/15 per telephone interview E4 care giver recalled events of this incident. E4 was on duty on 11/24/15 when R6 became agitated close to 4:30 PM. A loud noise was heard from R7's room where R6 was seen on the floor with his wheel chair partially unassembled. R6 threw a piece of the wheel chair at staff while yelling verbally abusive comments. Another care giver, E18 came to help along with with E15. R6 was taken to the library where he was given a sedative. R6 was trying to grab at other residents while being wheeled down the hall enroute to the library. After dinner R6 wheeled himself into the tub room where he ripped the mirror from the wall, broke the mirror on the sink and threw broken pieces of

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S9999	Continued From page 3 glass at staff and cut his wrists with the broken glass. R6 bit E4 on the arm and broke the skin, and sprained her shoulder. R6 told E4 that "he was going for blood when he bit her, and this is suicide I need to be in the nut house." E4 said R6 should not be readmitted due to safety issues. On 12/3/15 at 3:00 PM E15 said that R6 was agitated, pulled E18 to the floor was yelling, cursing, trying to hit other residents as he was being transported down the hall. R6 took a butter knife and tried to poke E15 in the stomach saying " aren't you glad this is not a real one." R6 threatened to cut E18 with the glass. After 911 was called the police and paramedics came. R6 had a piece of glass in his hand. When the police told him to drop the glass or they would have to take it from him, R6 did put the glass down. On 12/3/15 at 3:20 PM E18 recalled the incident as documented above. E18 said that R6 grabbed him by his apron which was around his neck, E18 lost his balance, but was helped by E4. E18 said that family members were present and helped clean up broken glass and kept residents in the living room away from the broken glass. Facility policy revised 8/2014 Screening Guidelines for Move In states residents are not likely appropriate for admission if they have primary mood, anxiety, personality and psychotic disorders. (AW) Section 330.1950 Meal Planning	S9999		

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S9999	Continued From page 4 Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the following Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. c) Vegetable and Fruit Group: Five or more servings of fruits or vegetables. 1) A serving consists of: A) ½ cup chopped, raw, cooked, canned or frozen fruit or vegetables; B) ¾ cup fruit or vegetable juice; or C) One cup raw leafy vegetable. 2) The five or more servings shall consist of: A) Sources of Vitamin C i) One serving of a good source of vitamin C (containing at least 60 mg of vitamin C); g) Meals for the day shall be planned to provide a variety of foods, variety in texture and good color balance. The following meal patterns shall be used. 1) Three meals a day plan: A) Breakfast: Fruit or juice, cereal, meat (optional, but three to four times per week preferable), bread, butter or margarine, milk and choice of additional beverage. These requirements are not met as evidenced by: Based on observation, review of menu plan and interview the facility failed to have 6 oz. of juice at the breakfast meal each day of the 4 week menu cycle. This applies all the residents in the facility. The findings include:	S9999		

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S9999	Continued From page 5 On 12/3/15 orange juice was served for the breakfast meal in 4 oz portions. Review of the four week menu cycle plan has the breakfast juice serving size as 4 ounces. On 12/3/15 at 4:00 PM E2 Director of Wellness Management said that the menus should have been planned to serve a 6 oz. portion of juice at the breakfast meal. E2 said they used the wrong glasses to serve the 4 oz. portions, and will have to get larger glasses to serve 6 oz. (AW) 330.780 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional	S9999		

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S9999	Continued From page 6 Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (Source: Amended at 37 Ill. Reg. 2315, effective February 4, 2013) These Requirements are not met: Based on observation, record review and interview the facility failed to notify the Department of any serious incident or accident within 24 hours after each reportable incident or accident. The facility also failed to send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This applies to 1 of 1 resident (R1) in the sample of 5 residents and one residents (R6) from the supplemental sample evaluated for serious accidents and incidents. The findings include: 1. On 12/2/15 at 10:30 AM R1 was seated in a chair and stationed in day area of the unit. R1's right hand was in full hard cast from wrist up to the upper arm. On 12/4/15 at 11:30 AM E8 (Care Giver) stated R1 wandered into another resident's room in the evening shift a couple weeks ago and the other resident pushed R1 out of the room. R1 fell to the ground injured R1's hand. E8 said that what she was told.	S9999		

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The facility documented an incident on 11/15/15 at 8:35 PM involving R1, which read "care giver found R1 lying on the hallway in the unit on his left side. Another resident verbalized he had pushed R1 out of his (another resident) room and R1 fell." R1 complained of right wrist pain.

On 11/16/15 X-Ray report of R1's right wrist showed "there is a transverse fracture of the distal radius with slight dorsal angulation and a nondisplaced fracture of the ulnar styloid tip, which may be acute to sub-acute in age."

The facility did not investigate the incident including the staff interviews to determine the cause of the incident. The facility also failed to report the incident to the Illinois Department of Public Health.

On 12/2/15 at 10:00 AM facility Executive Director stated the Nurse on duty was supposed to report the incident to the Department. On 12/2/15 at 11:40 AM the Nurse on duty stated the Nurse reports to the Executive Director and the Executive Director is supposed to report to the Department.

2. On 12/2/15 at 12:30 PM a family member of R9 expressed concern about a resident (R6) who on 11/24/15 during evening meal time became violent, broke a mirror and bit a staff member and may be R6 will be readmitted.

On 11/24/15 E15 Licensed Practical Nurse (LPN) documented in service notes that R6 became agitated throwing objects at staff, pulled mirror from the wall, threw broken glass at caregivers. R6 picked glass up and began to cut his wrists. R6 bit care giver and attempted to cut staff with glass. The facility called 911 to transport R6 to

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S9999	Continued From page 8 hospital for emergency hospitalization. R6's medical record shows he was discharged from a hospital behavioral health unit on 11/23/15. R6's hospital discharge instructions dated 11/23/15 state R6 has a risk factor of violence that require ongoing treatment and evaluation. R6's primary diagnosis is frontotemporal dementia with disturbance of behavior. A hospital psychiatric examination report showed R6 was admitted to the hospital on 10/31/15. R6's 11/1/15 hospital psychiatric evaluation indicated R6's chief complaint was agitation. R6 was sent to the hospital emergency room for emergency psychiatric hospitalization from a skilled long term care facility due to behaviors. R6 was trying to hit and bite people at the nursing home. R6 was throwing things a the nurses and actually assaulted a paramedic staff enroute to the hospital. R6 had to be restrained in the emergency room. R6's mood is expansive and labile, behavior is unpredictable. The facility not only did not document R6 on 11/24/15 physically attacking staff and other residents, breaking glass and cutting his wrist as an incidents, but also also did not investigate R6's self destructive behavior and his physical aggressive towards staff and other residents. The facility also failed to report the incident to the Department of Public Health. (B) 330.4240 f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility	S9999		

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S9999	Continued From page 9 is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) (Source: Amended at 15 Ill. Reg. 516, effective January 1, 1991) This requirement is not met: Based on observation, record review and interview the facility failed to immediately evaluate a resident (R8) to determine if R8 was at continued risk for the safety of self and other residents. This applies to one of two two residents (R3) evaluated from the sample of five residents and one resident (R8) from the supplemental sample evaluated for undesirable behaviors. The findings include: On 12/3/15 at 8:45 PM the facility documented an incident involving R8 being physically attacked a fellow resident (R3). R3 hit and slammed R8 onto the floor causing redness and swelling to R8's head. On 12/4/15 at 11:15 AM R8 was seated in a chair in dining area. R8 was restlessly swinging legs, biting his teeth with a grimace on his face and he could not be engaged to talk. R8's admission record indicated R8 is 71 years old and was admitted to the facility on 1/3/14 with multiple diagnoses including Dementia, Alzheimer's with Amnesia.	S9999		

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R3's 12/3/15 service notes indicated at 10:45 PM the facility sent R3 to the hospital for evaluation and treatment of a head injury.

On 12/4/15 at 10:30 AM R3 was in the facility. E20 (Care Giver) stated R3 returned to the facility early morning. E20 stated R3 has behaviors including wandering into other residents' rooms, taking off dirty diapers and leaving in garbage cans. R3 also grabs things including clothes from other residents' drawers and wears them. E20 also stated R8 is possessive of his belongings. These behaviors may be the reason for R8 attacking R3, but R3's behaviors can't be changed except monitoring.

The facility had no service plan for R3 or R8's behaviors.

On 12/4/15 at 11:30 AM E19, (Care Giver) said "R8 has been agitated, anxious, and R8 put his hand on E19's face and it could happen to anyone.

There is no documentation to show if the facility contacted R8's physician to evaluate if R8 is safe to be in the facility. On 12/4/15 at 12:05 PM Z1 Home Health Psychiatric Nurse for R8's physician stated R8's behavior is not the same since she saw R8 last time. Z1 said R8 is anxious and angry and she could not evaluate R8 and the doctor has to evaluate R8. The facility did not remove R8 from the facility until the surveyor expressed the concern for the safety of R8 and other residents.

(B)

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S9999	Continued From page 11 Section 330.710 Resident Care Policies 3) F) 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. These requirements are not met: Based on record reviews and interviews, the facility failed to update/review care plans for resident who is identified as high risk for falling and has multiple fall incidents. This applies to two of three residents (R5 and R3) reviewed for fall incidents and behaviors in the sample of five residents and one resident (R8) from the supplemental sample evaluated for behaviors . The Findings include: R5 is an 85 year old resident who requires assistance with activities of daily living and has multiple fall incidents. From 9/2/15 through 10/29/15, R5 had 13 fall incidents in the facility and per R5 ' s individual service notes, R5 has 3 other fall incidents that were not documented. There was no updated care plan / service plan for R5 ' s fall incidents. No assessments or investigations made for the causes of R5 ' s fall incidents. On 12/3/15 at 1:30 PM E2 (Director of Wellness Management) stated, if a resident is identified as high risk for fall or has repeated fall incidents a service plan should be developed and/or if there is service plan it should be reviewed for efficacy of goals and interventions.	S9999		

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S9999	Continued From page 12 On 12/3/15 at 8:45 PM the facility documented an incident of R8 physically attacking R3 by hitting and slamming her to the floor causing head injury including redness and swelling. On 12/4/15 11:00 AM stated E20 (Care Giver) R3 has behaviors including wandering into other residents' rooms, leaving dirty diaper in their garbage can, rummaging through other residents' clothes and wearing them. E20 said R8 is possessive of his belongings and this might be the reason for R8 attacking R3. The facility has no specific policy to identify, assess, and develop strategies to control risk of injury to residents who are identified as high risk for fall and having undesirable behaviors.. (B) Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs b) c) e) 1) 2) 3) 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) 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	S9999		

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S9999	Continued From page 13 accordance with Section 330.Appendix E. e) For the purposes of this Section: 1) "Duplicative drug therapy" means any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. For example, any two or more drugs, whether from the same drug category or not, that have a sedative effect. 2) "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic or antianxiety behavior modification or behavior management purposes in the latest editions of the AMA Drug Evaluations (Drug Evaluation Subscription, American Medical Association, Vols. I-III, Summer 1993), United States Pharmacopoeia Dispensing Information Volume I (USP DI) (United States Pharmacopoeia Convention, Inc., 15th Edition, 1995), American Society of Health Systems Pharmacists, 1995), or the Physicians Desk Reference (Medical Economics Data Production Company, 49th Edition, 1995) or the United States Food and Drug Administration approved package insert for the psychotropic medication. (Section 2-106.1(b) of the Act) 3) "Antipsychotic drug" means a neuroleptic drug that is helpful in the treatment of psychosis and has a capacity to ameliorate thought disorders. The finding include Based on record reviews and interviews the facility failed to obtain consent for psychotropic medications prior to administration and failed to identify specific behaviors which warrants the use	S9999		

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of multiple psychotropic medications.
This applies to one of four residents (R5) reviewed for psychotropic medications in the sample of five residents.
The Findings include:
Per demographic information sheet, R5 is an 85 year old who has multiple medical diagnoses including dementia and mood disorder. R5 was admitted to the facility on 9/2/15.
The Physician's Order Sheet (POS) dated 9/2/15 indicates; Haldol 1 mg tablet every day at bed time and Haldol 1 mg three times daily as needed (prn), Depakote 250 mg tablet everyday at bedtime, Clonazepam 1 mg at bedtime, Lexapro 5 mg everyday at bedtime, and Olanzapine 5 mg everyday at bedtime.
Haldol 1 mg daily at bedtime was given until 9/20/15, however, the Haldol 1 mg prn still continued as a standing order. Clonazepam 1 mg was given daily at bedtime until 11/10/15.
Olanzapine was increased to 2.5 mg at 12 pm and 5 mg at bedtime.
There were no consents obtained from R5's power of attorney for the used of Haldol, Depakote, Clonazepam, and Lexapro.
R5's service notes / progress notes from September 2015 through present do not have documentation or evaluation / assessment made by staff that describes specific behaviors which indicates needs for use of psychotropic medications, or had no behavioral re-assessments. R5 had 13 fall incidents documented. The facility also documented 3 other fall incidents that were not documented as an incident report.
Physician's visit notes dated 9/9/15 and 11/18/15 showed R5 indicates agitation, behavioral changes, confusion, gait disturbance, depression and hallucination related to Dementia, . However, there was no specific description of what type of

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agitation or behavioral changes or specific description of what hallucination R5 was displaying that contributed for the use of multiple psychotropic medications including antipsychotic medications.
On 12/3/15 at 1:30 PM E2 (Director of Wellness Management) stated, consents are obtained for psychotropic medications prior to administration based on state regulations.

(B)
Section 330.1710 Resident Record Requirements
f) 1)

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.

1)The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

The finding include

Based on record reviews and interviews, the facility failed to re-assess and update plan of care for resident who is identified as high risk for fall and has multiple fall incidents and failed to report other fall incidents.
This applies to two of three residents (R5 and R3) reviewed for fall incidents in the sample of five residents and one resident (R8) from the supplemental sample. .
The Findings include:
R5 is an 85 year old resident who requires assistance with activities of daily living and has multiple fall incidents. R5 has history of craniotomy due to subdural hematoma related to

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S9999	Continued From page 16 a fall incident at home. From 9/2/15 through 10/29/15, R5 had 13 fall incidents in the facility and per R5 ' s individual service notes, R5 has 3 other fall incidents that were not recorded as incidents. There was no evidence assessments or investigations were made for R5's frequent falls. There was no update on R5's plan of care or interventions and goals for preventions of falls. On 12/3/15 at 1:30 PM E2 (Director of Wellness Management) stated, if a resident is identified as high risk for fall or has repeated fall incidents a service plan should be developed and/or if there is service plan it should be reviewed for efficacy of goals and interventions. On 12/4/15 at 9:50 AM E1 (Facility Director) stated, for every fall incident. staff must write an incident report and follow fall incident protocol. Care plans should also be updated especially for a resident who has multiple fall incidents. On 12/3/15 at 8:45 AM the facility documented an incident indicating R8 physically attacked a fellow resident (R3) by hitting and slamming her onto the floor causing head injury to R3. The circumstances surrounding this incident is not documented in R8's progress notes. There is no documentation to show if the facility notified R8's physician of the incident. The facility sent R3 to the hospital for evaluation and treatment on 12/3/15 at 10:45 PM. There is no documentation to show when R3 returned to the facility or what is the service plan for the head injury. (B) Section 330.765 Initial Health Evaluation for Employees a) b) c) a) Each employee shall have an initial health	S9999		

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S9999	Continued From page 17 evaluation which shall be used to insure that employees are not placed in positions which would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to the employee beginning employment in the facility. The evaluation shall be completed not more than 30 days after the employee begins employment in the facility. c) The initial health evaluation shall include a health inventory. This inventory shall be obtained from the employee and shall include the employee's immunization status and any available history of conditions which would predispose the employee to acquiring or transmitting infectious diseases. This inventory shall include any history of exposure to, or treatment for, tuberculosis. The inventory shall also include any history of hepatitis, dermatologic conditions, or chronic draining infections or open wounds. Based on record reviews and interviews, the facility failed to ensure newly hired employees have completed health screening or clearance prior to starting employment or within 30 days after being hired. This applies to six of the ten newly hired staff (E9 to E14) who were reviewed for background reference check and health screening. This failure could potentially affect all residents in the facility. The findings include:	S9999		

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On 12/3/15 at around 2:30 PM E1 (Facility Executive Director) and E2 (Director of Wellness Management stated completion of employees medical clearance or health care status and required vaccinations should be completed within 30 days of hiring.

E9 (Caregiver) was hired on 9/15/15 and E10 (Nurse) was hired on 10/28/15. Both E9 and E10 has no employee medical history form check list.

E11 (Caregiver) hired 9/15/15, E12 (Caregiver) hired 10/28/15, E13 (Nurse) hired 10/28/15, E14 (Caregiver) hired 8/25/15.

E9 to E14 all signed for consents to obtain Hepatitis B vaccine from the facility, there was no hepatitis B vaccine given to all 6 employees up to this date which is more than 30 days after they were hired.

This facility's policy and procedure for employment (Employee Health) indicates:

Policy: It is the facility's policy to comply with the state and federal regulations regarding the health of employees and to ensure that employees are free of communicable diseases. The company may also require physical examinations to determine whether the applicant who has received a conditional offer of employment is physically capable of performing the essential functions of the position, with or without accommodations.

Procedures:

Pre-placement physicals will be designed to

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S9999	Continued From page 19 indicate the following: a) That the applicant is free of communicable diseases (such as tuberculosis or hepatitis B). (B) Section 330.911 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). (Source: Amended at 29 Ill. Reg. 12891, effective August 2, 2005) Based on record reviews and interviews the facility failed to follow their policy and procedure with regards to pre-employment reference check for newly hired employees. This applies to six of the ten newly hired employees (E9, E10, E12, E13, E15, E16). This failure can potentially affect all the residents in the facility. The Findings include: On 12/3/15 at around 10:00 AM a healthcare background check was conducted for most recent 10 newly hired staff. Seven of the ten new staff (E9, E10, E12, E13, E15, E16) have no evidence of background reference check. On 12/3/15 at around 10:15 AM, E17 stated a reference check is part of the employee	S9999		

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S9999	Continued From page 20 background check. E17 also stated she checked some of them but forgot to fill out the forms. E17 was unable to tell who she contacted and when was the reference check done. The facility's policy and procedure for employment (Reference Request for Prospective Employees) indicates: Once the applicant's signature is obtained, conduct an oral reference check using the Telephone Reference Check form. Contact , at a minimum, the two most recent places of employment (contact present employer only if applicant has consented) and any other employers in at least the past 2 years of employment. A reasonable effort should be made to contact the employee ' s previous or current supervisor to obtain the required information. If the supervisor is unavailable or unwilling to provide a reference, all reasonable efforts should be made to obtain the information from the former company via the human resources/personnel department or member of management. If a former employer refuses to provide a telephone reference, complete and mail / fax Verification of Employment History forms that has been signed by the applicant. Keep a copy of all sent forms with the application, including notes when originals were sent and to whom. Copies can be destroyed once originals are returned. (B) Section 330.1510 Medication Policies a) 4)	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.

4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident.

These requirements are not met:

Based on observations, interviews and record reviews, the facility failed to follow their policy and procedure for medication administration and failed to follow physician instruction.

This applies to three of nine residents (R10, R11, R12) observed for medication administration.

The Findings include:

On 12/2/15 at 12:30 PM, E6 (Nurse) attempted to administer medications Seroquel 50 mg tablet orally (PO) and Depakote 250 mg tablet PO to R10 which E6 crushed. R10 initially refused medications. E6 signed it off as given when R10 did not take the medications.

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On 12/2/15 at 12:46 PM, E6 attempted to administer medication Carbidopa-Levodopa 25-100 mg 3 tablets to R11. E6 crushed the medication and mixed it with a pudding. R11 only took part of the medication, the rest was stuck to the side of the cup walls. E6 did not give the full dose and threw the remaining part of it in the garbage.
On 12/3/15 at 9:20 AM, E6 administered medications Memantine HCl 10 mg tablet PO and Pradaxa 150 mg tablet PO to R12.

Physician Order Sheet dated 11/2015 indicates that R12 is also supposed to received Doxycycline Hyclate 20 mg tablet twice daily.

On 12/3/15 at around 1:30 PM, E6 stated they (staff) couldn't find R12's Doxycycline Hyclate medication.

12/4/15 at around 12:00 PM E2 stated that staff finally found the missing Doxycycline Hyclate in the medication cart.

Medication Administration Record (MAR) dated 11/2015 indicates that Doxycycline Hyclate was not given from 12/1/15 at 9:00 AM to 12/3/15 at 9:00 AM. A total of 5 doses missed.

On 12/4/15 at around 12:30 PM, E2 stated (Director of Wellness Management) when a medications dose is missed physician should be notified. Staff must only sign in the medication administration record after medication is given to resident.

There was no evidence that physician was notified for the missing dose of medication.

Facility's Policy/Procedure for Medication

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S9999	Continued From page 23 Administration indicates: Policy: Medications are administered in accordance with a physician's order. Medications shall be prepared, administered and charted by the same person. (AW)	S9999		