STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003289	A. BUILDING: _____ B. WING _____	C 01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKFORT HEALTHCARE & REHAB CENTEI	2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896

(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 Complaint Investigation 1750500/IL91319	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)3) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on record review and interview, the facility failed to adequately address the potential underlying environmental cause of a confused resident's (R2) catastrophic reaction to a room change, by failing to identify and implement alternative non-pharmacological interventions, prior to administering an injection of anxiolytic medication. These failures affected 1 (R2) of 3 residents reviewed for psychotropic medication use in relation to falls. These failures resulted in R2 falling upon standing, sustaining a brain injury, hospitalization, and being placed on hospice care with a poor prognosis.

The facility's January 2017 Fall Log showed that R2 fell on 1/19/17. An Accident/Incident Report from that same date showed that at 6pm, R2 was sitting at the dining room table after supper, stood up, and fell, falling on his right side, which caused a large contusion to the right side of his head. This document further stated R2's physician was called and R2 was sent to the emergency room for evaluation. A January 2017 Physicians Order Sheet showed an order dated 01/19/17 for Ativan 1mg (milligram) IM (intramuscular) x (times) one dose. A Nurses Note dated 01/19/17 at 1pm stated, "Resident had been verbally aggressive with staff and peers for a few hours. Attempted to redirect multiple times without success. Resident went down hallway staff attempted to redirect related to going in the wrong room. (Resident) then became physical with staff member. He was very agitated when speaking with him. I called the doctor related to the matter. He requested to give IM Ativan and increase Risperdal from 0.25mg

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S9999	Continued From page 2	S9999		

twice daily to 0.5mg twice daily." A Medication Administration Record showed that R2 received Ativan 1mg IM on 01/19/17 at 1:30pm. A Nurses Note dated 01/19/17 at 3pm stated, "Daughter came in...asked (R2) if he would like to go to his room and he refused." A Nurses Note dated 01/19/17 at 6pm stated, "Resident was sitting at the dining room table and got up to go to his room and fell in the floor. Resident fell on his right side, causing a large contusion to the side of his head. Called ambulance and sent to emergency room, doctor notified, Director of Nurses notified, family notified." A Hospital History of Present Illness note dated 01/19/17 showed that R2, "Had a fall today after receiving Ativan for agitation...Impression: Intraventricular hemorrhage...extensive discussion with the family of poor prognosis, no planned surgical intervention at this point given age and advanced Dementia, they understand and reiterated DNR (do not resuscitate) status." A Diagnostic Imaging Report dated 01/19/17 stated, "Impression: 1.7x1.4cm(centimeter) right frontal convexity area of Parenchymal Hemorrhage. Likely Punctate Contusions in the left Parietal region. Intraventricular Hemorrhage is seen within the right Occipital Horn and Temporal Horn. Large right front scalp Hematoma." A Minimum Data Set dated 10/19/16 showed R2 had a Brief Interview for Mental Status Score of 6, indicating R2 is severely cognitively impaired. A Face Sheet listed Alzheimers Disease and Unspecified Psychosis among R2's diagnoses. Behavior Tracking for January 2017 showed R2 was being monitored for the behavior of displaying physical and verbal aggression to others (staff and peers).

On 01/25/17 at 8:20am, Z1, R2's family member, stated that the facility called her on 01/18/17 or 01/19/17 and informed her they were going to

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have to move R2 into a different room because they needed R2's room for another resident. Z1 stated R2 had been in a room by himself up until that time. Z1 stated she begged the facility not to move R2 because of his confusion and problems with agitation and she did not feel R2 would respond well to having a roommate and being in a different room. Z1 stated she was told the move was going to happen in spite of her concerns. Z1 stated she was notified on 01/19/17 in the early afternoon that R2 was very agitated after his room had been changed and that they had gotten an order from his doctor for an injection of Ativan to calm him down. Z1 stated about 6pm on 01/19/17 the facility called and notified her R2 had fallen and was being sent to the emergency room. Z1 stated R2 sustained bleeding in the brain from the fall, is now on hospice, and is not expected to survive. Z1 stated R2 has a history of falling when he lived in assisted living and has fallen two other times while at the facility. On 01/26/17 at 1:30pm, E1, Administrator, stated R2 had to be moved to make room for a new resident. E1 stated Z1 expressed concern about the room change because of R2's confusion and periods of agitation. E1 stated R2 seemed okay with the room change until he saw his roommate and then he became very agitated. E1 stated staff were going to give the situation a couple of days to see if R2 calmed down, and that if he didn't, then "They would look into alternatives." On 01/26/17 at 9:30am, E2, Director of Nurses, stated that after the room change, R2 kept trying to go back into his old room, was getting loud, and shoved a staff member who attempted to redirect him back to the new room.

(A)