

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6004089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/20/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HAVANA HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>609 NORTH HARPHAM STREET HAVANA, IL 62644</b>
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S 000	Initial Comments  Annual Health and Complaint# 1722139/IL93165  Statement of Licensure Violations	S 000		
S9999	Final Observations  300.610a) 300.1210a) 300.1210b) 300.1220b)3) 300.3240a) 300.3300d)1)  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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>05/15/17</b>
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S9999	<p>Continued From page 1</p> <p>resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>Section 300.3300 Transfer or Discharge</p> <p>d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances:</p> <p>1) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs; (Section 3-402(a) of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to do behavior tracking and care plan development, failed to anticipate potential behavioral changes after dosing changes in an anti-depressant and anti-psychotic and failed to educate staff on Dementia management for one of four residents (R1) reviewed with behaviors, in a sample of 15. This failure resulted in R1 being transferred to the emergency room on three different occasions when R1 exhibited behaviors towards staff, only to be sent back as "stable" thus causing overstimulation and excess stress on R1 and the facility attempting to Involuntarily Discharge R1.</p> <p>Findings include:</p> <p>The facility policy, titled "Behavior Tracking Sheets (no date)," documents "Each form has the resident's name and target behaviors. Some residents have more than 2 behaviors addressed, so there may be more than one form. Some</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>intervention are standard and resident specific interventions should be written on the form. The standardized interventions that may be appropriate for the resident should be highlighted. If you are aware of additional interventions that work, notify the Social Service/Psychosocial Director. Each shift should note the date and time of each targeted behavior. List the corresponding code/letter to the intervention you used. Code +, O, or - depending on the effectiveness of the intervention."</p> <p>The facility policy, titled "Comprehensive Care Planning (05/01/16)," documents "It is the policy (of the facility) to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining resident strengths, needs and preferences to develop a comprehensive plan of care for each resident with the goal of attaining or maintaining the resident's highest practicable physical, mental and psychosocial well-being." The "Comprehensive Care Planning" policy further documents, "The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the resident."</p> <p>The facility policy, titled "Abuse Prevention Program (11/28/16)," documents employees are to receive training on "Dementia management and resident abuse preventions; Including, how to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff" on a annual basis.</p> <p>A Physician's Order Sheet, dated 2/24/17, documents R1 was admitted 2/24/17 with the</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>diagnoses of Depression, Bipolar Disorder, Dementia and Pseudobulbar Affect. A Pre-Screening/Screening Assessment for Harmful Behaviors form scored R1 as a "Moderate Risk" for harmful behaviors, secondary to a history of "Talks about/threatens harm towards others and/or aggressive behaviors towards others," harboring "considerable fears" over "separation from support system," and "poor safety awareness and/or has poor judgement." A Minimum Data Set, dated 3/09/17, identifies R1 as having "severe cognitive impairment."</p> <p>A Physician's Order Sheet, dated 3/01/17, documents R1 was prescribed Zoloft 25 mg (milligrams) daily and Zyprexa 5 mg twice per day. A Telephone Order, dated 3/20/17, documents R1 was prescribed the anti-biotic Linezolid 600 mg twice per day for five days for a Urinary Tract Infection. The 3/20/17 Telephone Order advised staff to not give R1 her scheduled Zoloft 25 mg until the course of Linezolid was complete, due to a potential drug interaction. The 3/17 Medication Administration Record documents R1's Zoloft was not given 3/21/17 through 3/26/17, and restarted as ordered on 3/27/17.</p> <p>Nursing notes document R1 developed sudden onset of aggressive behavior towards staff on 3/28/17. Nursing notes document R1 displayed further aggressive behaviors directed towards staff, residents and visitors on 3/29/17, 3/31/17, 4/01/17, and 4/02/17. Nursing Notes, dated 4/02/17, document at 12:45 p.m. R1 "punched" a nurse in the left side of the chest as she was passing R1 in the hallway. Later on 4/02/17, at 5:00 p.m., Nursing Notes document R1 hit a resident in the back of the head with an open hand and the physician ordered R1 to be</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>evaluated by a Geriatric Psychiatric facility in a nearby town; however, that facility did not have an open bed for R1. Nursing Notes document at 8:00 p.m. that R1 was sent to the local hospital for evaluation and R1 was returned to the facility as R1 was determined "not a danger to herself."</p> <p>Nursing Notes, dated 4/03/17, document R1 was sent to the local hospital again for "medical clearance" to be admitted to a different Geriatric Psychiatric facility that did have an open bed. Documentation indicates R1 returned to the facility that evening at 5:25 p.m., with an increase in her anti-depressant and anti-psychotic medications.</p> <p>A SBAR (Situation Background Assessment Recommendation) Communication form, dated 4/04/17, documents E10 (Medical Director) instructed staff to send R1 to the Emergency Room after R1 "rammed her walker into a family member that was visiting another resident." The 4/04/17 Emergency Room Notes document R1 presented for evaluation of "agitated dementia" and after spending over three hours in the Emergency Room, "(R1) has NOT been agitated or aggressive while here." The 4/04/17 Emergency Room Notes further document "(R1) has chronic dementia and SHOULD remain at nursing home. (E10 - Medical Director) is aware of all, just spoke and also says (R1) belongs at nursing home and will not benefit from a 'psychiatric transfer.' (E10) even adjusted (R1's medication) yesterday (4/03/17). (E10) is upset that the nursing home is not being cooperative in this fashion and says that if (the nursing home) will not accept (R1) back, we should call the family to pick her up and find care elsewhere."</p> <p>On 4/17/17 at 11:56 a.m., E7 (Registered Nurse)</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>stated she had R1 sitting behind the Nurses Station with her on the evening of 4/05/17, in attempt to supervise R1 closely during dinner. E7 stated R1 just "out of the blue" hit her in the jaw. E7 stated R1 struck her once and expressed no further signs of aggression towards anyone. E7 stated E1 (Administrator) has advised staff to automatically send R1 out to the Emergency Room with any sign of aggression, even if the resident can be redirected.</p> <p>Hospital Emergency Room Records, dated 4/05/17, document "The patient presents to the emergency department with anxiety, chronic dementia with agitation. (R1) has been sent here multiple times due to the failure of nursing home staff to be able to manage and de-escalate a patient with dementia. Each admission here, the patient shows absolutely no aggression. POA (Power of Attorney) is trying to find an alternative living situation without success due to Medicaid. Nursing home has been told by Administrator to call 911 and send to ER (Emergency Room) each time. She has been evaluated by multiple physicians who do not believe there will be any benefit from (psychiatric) placement, as patient cannot participate due to level of dementia and need for assistance in most, if not all (activities of daily living). (Nursing Home) refuses to deal with the situation and I believe are actually getting into this patient's face to escalate her agitation." The Hospital Emergency Room Record further documents R1's aggressive symptoms a "non-existent" while in the Emergency Room, and R1 discharged back to the Nursing Home in "good" condition. The Hospital Crisis Report on 4/05/17, completed by Social Services, documents "(R1) is calm/resting. (R1) is not demonstrating any mental health symptoms that would require psychiatric hospitalization. (R1's)</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>mood is good. Affect congruent with mood. No delusions, illusions, or hallucinations reported. (R1) is not suicidal. (R1) does not appear to be a threat to herself or others."</p> <p>Nursing Notes, dated 4/06/17 at 5:40 p.m., document "(R1) in dining room, CNA (Certified Nursing Assistant) assisting with eating, slapped CNA (and) spit (at) her. 5:46 p.m. POA notified of incident. 5:50 p.m. 911 called for transport to ER." Nursing Notes at 6:30 p.m. document the ER physician evaluated R1 and "everything (alright and R1) to be discharged back to facility" with no new orders.</p> <p>Hospital Emergency Room Records, dated 4/06/17, document "(R1) presents to the ER with complaints of alleged aggressive behavior at nursing home - Chronic Dementia. (R1) has Chronic Dementia and lives at (nursing home) where every so often she will allegedly hit or try to hit a staff member. She does not have ongoing aggression, and this has been chronic for a long time. She has been repeatedly sent here for this many times, (six) times in the last (five) days. She has even had an evaluation by a mental health worker yesterday, and there are no new suggestions. Nursing home insists that 'due to policy', they will continue to send her here each time she does anything similar." The Hospital Emergency Room Record documents R1's Psychological Exam "as every other time, she is calm and not aggressive, but very demented with unintelligible speech. She carries a toy doll with her, whom she babbles to and seems very comfortable."</p> <p>On 4/17/17 at 2:19 p.m., E8 (Registered Nurse) stated, on 4/11/17, R1 took her walker and "rammed" a CNA up against the wall in the</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>hallway. E8 stated the CNA was not injured and R1 was able to be redirected immediately after the incident. E8 stated R1 had an appointment later in the afternoon with a Psychiatrist; however, she informed E1 of the incident. E8 stated E1 (Administrator) instructed her to get a order from E10 (Medical Director) to send R1 out to the Emergency Room for an evaluation. E8 stated E10 refused to give an order to send R1 to the Emergency Room for the behavior exhibited. E8 stated E1 instructed her to call 911 and have R1 transported to the Emergency Room anyway, which she did.</p> <p>On 4/11/17 at 9:30 a.m., E1 (Administrator) stated R1 was getting ready to leave the facility via ambulance for "ramming" a staff member with her wheeled walker. At that point, R1 was observed ambulating independently with her wheeled walker, accompanied by E11 (Activities Director). R1 was not displaying any aggression as she would sit down for 1-2 minutes and then get up and ambulate in the halls. R1 would occasionally cry for a short moment and hug her doll. R1 was observed continuously until the paramedics arrived at 9:55 a.m. R1 displayed no behaviors/aggression with the paramedics and complied with instructions to get on the stretcher.</p> <p>R1's current Plan of Care (no date), documents "My behavior is sporadic. I have no cognitive ability to understand or be educated. I have a (diagnosis) of Dementia, Depression, Bipolar Disorder and Pseudobulbar Affect. My behaviors include approaching peers with my walker and ambulating too close at times, bumping into them. I lack safety awareness. I will attempt to sit on my peers laps and I will hit my peers with my baby doll. I have limited verbal interactions and I cry often." The interventions identified on the</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>Plan of Care to manage R1's behaviors are: increasing visual checks on 3/22/17, implementing activities of interest and relaxation for redirection on 3/27/17 and sending R1 to the hospital with each aggressive episode on 4/03/17. The current Plan of Care fails to identify specific interventions for staff to de-escalate/manage R1's aggressive behavior and failed to anticipate potential behavioral changes that could have been contributed to the discontinuation of R1's Zolofit for five days.</p> <p>On 4/11/17 at 12:27 p.m., E6 (Care Plan Coordinator) stated she "tries to change the (resident's) care plan immediately, if a resident has a new behavior/change in behavior" and then develop a intervention to correspond with the behavior. E6 stated behavior monitoring includes Behavior Tracking, which allows the facility to analyze and identify triggers/trends to a resident's behavior. E6 stated R1's Plan of Care was not updated after she developed aggressive behaviors (on 3/29/17), until 4/03/17. E6 stated E1 (Administrator) advised her on 4/03/17 to include the the intervention of sending R1 out of the facility for a psychiatric evaluation with each episode of aggression, and no specific interventions to de-escalate R1's aggression towards staff were developed.</p> <p>Behavior Tracking for the months of March and April 2017 document the facility was monitoring R1 for a "sad expression; tearful, crying" and "exit seeking." There is no documented evidence R1 was being monitored for aggressive behaviors or what interventions staff implemented after episodes of aggression.</p> <p>On 4/11/17 at 10:41 a.m., E5 (Social Service Director) stated the facility does not currently</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>have behavior tracking, as outlined in the "Behavior Tracking Sheets" policy, for R1's aggression. E5 stated "if they monitor and document (R1's) aggression, it looks like they are allowing (R1) to ram people with her walker and strike out." E5 stated R1 does respond well to her baby doll and staff need to approach R1 in a calm manner. E5 stated, "unless staff are with (R1) 1:1, you couldn't anticipate R1's behaviors" because there is no pattern. E5 also stated that the facility doesn't "send residents out to the (emergency room) if they are aggressive with staff, typically. They try to manage those behaviors."</p> <p>On 4/18/17 at 10:25 a.m., Z2 (Emergency Room Supervisor) stated each time R1 has been transferred to the Emergency Room, she has never displayed signs of aggression. Z2 stated R1 might resist when assessing vital signs, but R1 is easily redirected with the correct approach. Z2 stated E10 (Medical Director) and the Emergency Room Physicians have all agreed that R1 would not benefit from inpatient psychiatric care, but needs behavior management and medication.</p> <p>On 4/17/17 at 2:19 p.m., E8 (Registered Nurse) stated staff need to visualize R1 at all times and would benefit from someone to do constant activities with her. E8 stated R1 cries frequently and likes someone to be with her all the time to comfort her. E8 stated R1 needs someone with her 1:1, but the facility doesn't have the staff to do so.</p> <p>On 4/13/17 at 2:10 p.m. Z3 (Psychiatrist) stated he felt R1's increased behaviors could have been triggered by a recent urinary tract infection and the need to hold R1's anti-depressant for 5 days</p>	S9999		

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(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
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S9999	<p>Continued From page 11</p> <p>due to a potential drug interaction. Z3 stated the facility sending R1 to the Emergency Room for agitation/aggression towards staff on 4/5/17, 4/6/17 and 4/11/17 was unwarranted, because the staff should be able to manage those types of behaviors in a resident with Dementia. Z3 stated, if a resident has aggression towards staff that can easily be redirected or is not ongoing, the resident would benefit from staying in their current environment rather than the excess stimulation that occurs when being transferred out of the facility. Z3 stated a facility that admits a resident with a history of known behaviors/aggression, should be able to manage that resident when aggressive with staff. Additionally, Z3 stated the increase made to the dosage of R1's anti-depressant and anti-psychotic on 4/3/17, could take two to four weeks to see a therapeutic effect and could potentially help decrease her behaviors.</p> <p>A Notice of Involuntary Transfer or Discharge and Opportunity for Hearing, dated 4/05/17, was mailed to Z4 (Power of Attorney for R1), citing the facility was seeking to Emergency Transfer R1 out of the facility, due to R1's "welfare and needs cannot be met in this facility, as documented in your clinical record by your physician" and "the safety of individuals in this facility is endangered." The Notice of Involuntary Transfer cites R1's proposed transfer/discharge date as 5/05/17.</p> <p>On 4/11/17 at 11:17 a.m., E1 (Administrator) stated the facility did not have a written statement from E10 (Medical Director) stating why the facility is unable to meet the needs of R1, but was awaiting one. E1 stated she has tried to convince R1's family to transfer R1 to a facility that has a secured unit, but they have no interest. E1 confirmed that the facility staff had not had the</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6004089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/20/2017</b>
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S9999	Continued From page 12  Dementia Management training, as outlined in the 11/28/16 Abuse Prevention Program, and that effective 4/10/17 that training had been initiated.  (B)	S9999		
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