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S 000	Initial Comments Complaints 1840391/IL99648 No Deficiency 1840298/IL99541 F921 1840242/IL99477 F921 1840119/IL99343 No Deficiency 1747561/IL99127 F580 & F684	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	**Attachment A** **Statement of Licensure Violations**	

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but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

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S9999	Continued From page 2 neglect a resident These Regulations are not met as evidence by: Based on interview and record review, the facility failed to recognize, assess and treat a change of condition for 1 of 7 residents (R2) reviewed for a change of condition in the sample of 26. This failure resulted in R2 being found in bed unresponsive with a temperature of 104.1 degrees and being admitted to the hospital with diagnoses of Sepsis due to unspecified organism, coma. Finding includes: R2's current Electronic Medical Record (EMR) documented, R2 was admitted on 11/10/17 with diagnoses of unspecified psychosis, unspecified Dementia, Schizoaffective Disorder, Primary Hypertension, Heart Failure, Hypothyroidism, Type 2 Diabetes, Anxiety, Cardiac Pacemaker and Benign Prostate Hypotension. R2's Minimum Data Set (MDS) dated 11/17/17 documented R2 had a Brief Interview of Mental Status (BIMS) of 00 which indicated R2 was severely cognitively impaired. This same MDS documented R2 required extensive assistance of 2 staff members for bed mobility, limited assistance of 1 staff member for transfers, supervision of 1 staff member for locomotion on the unit in wheelchair, supervision with set up help only with dining and R2 was frequently incontinent of bowel and bladder. R2's Health Status Note, dated 11/22/17 at 9:43 PM, documented "Resident transfers around in wheelchair, but redirection is needed as resident displays much confusion. Resident becomes	S9999		

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irritable when redirected. Gait unsteady although he attempts to ambulate to the bathroom."

R2's Health Status Note, dated 11/24/17 at 10:29 AM, documented "Resident confused. Resident requires much attention and redirection. (Electronic monitoring bracelet) in place and functioning properly. Resident been sitting at nurses station."

R2's Nurse's Note written byV8, Licensed Practical Nurse (LPN), dated 12/24/17 at 12:00 PM, documented "Resident in room resting. Upon entering room Resident was easily aroused. Resident vital signs were taken blood pressure was 148/64 pulse 68 temperature was 98.9. Residents O2 (oxygen) sats (saturation) were fluctuating from 94% - 96%. Residents blood sugar was taken results were 108. O2 applied for comfort to resident at 2 Liters. CNA (Certified Nurse's Aide) noted to this nurse that resident was very sleepy so resident was assessed. This nurse completed an assessment residents pupils were Perrla (pupils equal, round, react to light, accommodation) Resident has good equal grips skin was warm pink and intact this nurse and 2 CNA's assisted resident out of bed with gait belt resident was offered water but drank very little. Resident was alert but sleepy this nurse and 2 CNA's assisted Resident with a gait belt back to bed family came to visit stated they would come back when resident was awake resident currently in bed resting w/ (with) HOB (head of bed) elevated w/ call light in place will cont (continue) to monitor."

R2's Health Status Note, dated 12/25/17 at 11:10 AM, written by, V6 (LPN), documented "Resident in lethargic state unable to administer medication resident spits it back out. VSS (vital signs stable)

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O2 on 2L (liters) per nasal cannula for comfort O2 sat 96%. "

R2's Health Status Note dated 12/25/17 at 12:55 PM written by, V5 LPN, documented "CNA reported that resident doesn't look right. Resident laying in bed resting with eyes closed. Skin hot and dry. Resident nonresponsive to verbal and physical stimulation. SPO2 (peripheral capillary oxygen saturation) at 82% on 2 liter of O2 via nasal cannula. Changed O2 to 3 litters via nasal cannula SPO2 99%. Call placed to (V4 Physician) with new orders to send resident to emergency department for evaluation and treatment."

R2's VS (vital signs) sheet, dated 12/19/17 shift 2-10, documented "Temp (temperature) 98.7, Resp (respiration) 18, Pulse 78, B/P 102/68."

R2's Vital Signs dated 12/25/17 at 12:53 PM documented "Blood Pressure 116/58 mmHg (millimeter of Mercury), Temperature 104.1 Fahrenheit Axilla, Pulse 68 bpm (beats per minute) Respiration 24 breaths/minute."

R2's local "FIRE DEPARTMENT INCIDENT REPORT" dated 12/25/17 at 12:55 PM documented, "Upon patient contact, found an 81 year old male supine in bed with his head elevated. PT (patient) is unresponsive with snoring respirations at 30/min (minute). Patient is hot to the touch, pale and dry, PERRLA with heavy discharge noted in and around both eyes. BP (blood pressure) 155/64, P (pulse) 93, R (respirations) 30, 89% O2 on 4 L by nasal cannula, blood sugar 242. Nurse (V5 LPN) arrived and stated that this was not her patient and she was not familiar with him. Chart reviewed, showing history of CHF (Congestive Heart Failure), behavioral disorder, diabetes and

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hypertension. The nurse then remarked that the patient has been in this condition 'Since Wednesday.' The nurse was asked to clarify and told that Wednesday would have been 5 days ago. She again stated that this was not her patient but that the aides on this hall all agreed no one has seen him awake since Wednesday of last week. She also advised that his normal mental status was alert and responsive but occasionally combative."

R2's local hospital Emergency Department Arrival Information dated 12/25/17 at 1:33 PM documented "Arrival Complaint unresponsive Diagnosis Sepsis, due to unspecified organism, Coma. Arrival vitals Temp (temperature) 101.8 Fahrenheit, Pulse 110, Resp (respirations) 23, BP 59/39, SpO2 85%. Assessment/Plan Septic Shock due to right lower lobe pneumonia."

R2's Medication Administration Record (MAR) documented R2 received Zyprexa 5 mg by mouth on 12/3/17, 12/13/17 and 12/14/17.

R2's MAR documented "12/19/17 all meds held 4p & 8p. lethargic."

R2's MAR documented "12/21/17 Resident lethargic 4p & 8p med pass."

R2's MAR documented "12/22/17 Resident refused medication at 4p MD notified."

R2's MAR documented "12/24/17 Resident lethargic refused 4p meds."

R2's telephone order dated 12/24/17 documented, "O2 2 liters for comfort."

R2's "SHIFT TO SHIFT 24 HOUR

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COMMUNICATION SHEET SOUTH / 200" dated 12/21/17 evening shift 2 pm - 10 pm written by, V6 (LPN), documented "Lethargic all shift. 4 p (pm) & 8 p (pm) meds held MD (Medical Doctor) aware."

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/22/17 night shift (this shift starts on 12/21/17 and ends on 12/22/17) 10 pm - 6 am documented "ok."

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/22/17 day shift 6 am - 2 pm documented "ok."

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/22/17 evening shift 2 pm - 10 pm has no documentation of R2's condition.

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/23/17 night shift (this shift starts on 12/22/17 and ends on 12/23/17) 10 pm - 6 am has no documentation of R2's condition.

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/23/17 day shift 6 am - 2 pm documented "ok."

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/23/17 evening shift 2 pm - 10 pm has no documentation of R2's condition.

R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/24/17 night shift (this shift starts on 12/23/17 and ends on 12/24/17) 10 pm - 6 am written by,

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S9999	Continued From page 7 V7 (LPN), documents, "Crush meds (medications), not swallowing." R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/24/17 day shift 6 am - 2 pm documents, has no documentation of R2's condition. R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/24/17 evening shift 2 pm - 10 pm has no documentation of R2's condition. R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/25/17 night shift (this shift starts on 12/24/17 and ends on 12/25/17) 10 pm - 6 am written by, V9 (Registered Nurse/RN), documented "O2 per Nasal cannula snoring wet respiration has never awaken this shift." R2's "SHIFT TO SHIFT 24 HOUR COMMUNICATION SHEET SOUTH / 200" dated 12/25/17 day shift 6 am - 2 pm written by, V6 (LPN), documented "Lethargic hard to arouse 0 (zero) meds given change in condition." On 1/29/18 at 11:28 AM, V2, Director of Nurse's confirmed there was no other documentation regarding R2 for the shifts of 12/22/18 evening shift, 12/23/17 nights shift, 12/23/17 evening shift or12/24/17 evening shift. On 1/3/18 at 3:10 PM, V17, Certified Nurse's Aide (CNA), stated, "On 12/20/17 (R2) was sleeping in the hall. He wasn't responding by waking up so we laid him back down. A week before Christmas he was very sleepy which was a change because he would propel himself in the wheelchair, be combative and try to get up."	S9999		

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On 1/3/18 at 12:00 PM, V6, Licensed Practical Nurse (LPN), stated, "Usually (R2) is up all night and sleeps in the morning. On the 19th (R2) was lethargic. I held his medications on the evening shift.

On 1/4/18 at 11:20 AM, V11 (CNA) stated, "I worked the evening shift on 12/21/17. I came in at 6 pm. (R2) was up in bed. He slept through the shift after dinner. This was unusual because usually he is up roaming propelling himself in his wheelchair."

On 1/4/18 at 10:08 AM, V12 (CNA) stated, "On Thursday (12/21/17) day shift I worked another hall but I did see him in the dining room for lunch and he just finger painted in his food. Normally he would propel himself and feed himself but this day had to be pushed in his wheelchair and I assisted him with feeding. He didn't eat lunch. I came back and I worked with (R2) on 12/21/17 midnight shift and he slept all night. I changed him three times. He would tense up but never fully aroused or spoke to me. I did get report from evening shift that he was asleep all shift."

On 1/29/18 at 2:00 PM, V30, RN, stated, "(R2) was not responsive enough to give him his medications safely on 12/22/17 at 4:00 PM. (R2) was sleepy/lethargic. I left a voicemail on (V4's, R2's Physician) answering service that the medications were held. I never did hear back from (V4)."

On 1/4/18 at 10:08 AM, V12 (CNA) stated, "I worked with (R2) on 12/22/17 the midnight shift. He was incontinent 1 time throughout the night. He did not respond to me during incontinent care. I thought he was in a deep sleep. This sleeping at

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night was abnormal for him usually he would be up all night. I was not concerned because he did void."

On 1/3/18 at 2:00 PM, V10 (CNA/day shift) stated that on 12/23/17, R2 was asleep and snoring and he wasn't responding. V10 stated this was odd because he was usually up and dozing in his chair. V10 further stated, "On 12/22/17 and 12/23/17 (R2) slept on my shift and I told the nurse (V8/LPN). I don't know if she did anything. So for 3 days he was sleeping and not eating or drinking. (R2) would not respond during incontinent care. I didn't even try to get him up because it wouldn't have been safe."

On 12/28/17 at 2:20 PM, V8 (LPN), stated, "On 12/24/17 (R2) slept through breakfast. At approximately 11:00 AM/12:00 PM, (R2's) family came in we tried to get him up but he was sleeping. He would respond to me. The family requested I lay him back down. He has a history of staying up all night. I have worked the midnight shift and he is up. He will sleep through breakfast or get up and go back to sleep. Sometimes the same thing with lunch. If he gets his injection he is a heavy sleeper. I got vitals and O2 sats everything was normal. Nothing was out of the ordinary. Nothing was a red flag."

On 1/2/18 at 1:44 PM, V35, R2's daughter -in -law, stated, "My husband and I went down to see (R2) on Christmas Eve around lunch time. He was in bed asleep with the door shut. (R2) was in a gown and a diaper. There were half dissolved pills in his mouth. The nurse (V8) came in and said he was up earlier and took his pills. She tried to get him up or drink. She had to brush his teeth to try and get the pills out and to get his mouth cleaned out. She tried to get him to take some

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applesauce. Then she said "Lets get him dressed." While they were putting him in the wheelchair the applesauce came drooling out of his mouth and onto his shirt. She got his pulse ox and his numbers were low, she put oxygen on him, layed him back down and raised the head of his bed. I am unsure what the oxygen level was. When we went to the emergency room the next day he still had on the same shirt he had on Christmas Eve because it had the applesauce stain in the same place."

On 1/2/18 at 2:25 PM, V36, R2's son, stated, "My wife and I went to see my dad on Christmas Eve around lunch. (V8/LPN) told me (R2) probably wouldn't get up. He was up this morning and he must have chewed up his pills he must have been "pocketing" them. I helped raise him up, she tried to brush his teeth and give him something to drink. She took his oxygen level which she said was 82 to 84% and she put oxygen on him. They layed him back down and raised the head of his bed. Once he had the oxygen on his color did come back. She told me his days and nights are messed up. My dad only said a few things nothing that was coherent. He never did really wake up. I believed her and that he was ok. She is the medical professional."

On 1/3/18 at 3:10 PM, V17 (CNA) stated, "On 12/24/17 he was asleep for the shift me and (V18/CNA) tried to get him up for dinner but he just layed there asleep. We brought his tray (to his room) he took a couple sips. After dinner he slept through all his care. This was the evening shift. This was unusual for him. I did not tell the nurse. I assumed the nurse saw what I saw so they would know, I did not get vital signs I don't know if someone else did. I did not get report from the CNA or the nurse. All of this behavior

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was unusual for him."

On 1/3/18 at 1:25 PM, V13, CNA, stated, "The week before he went out, on Monday or Tuesday he was asleep. I cleaned him up and he didn't wake up. I did tell the nurse about it."

On 1/3/18 at 1:20 PM, V14 (CNA) stated, "I don't honestly remember when but he wouldn't wake up in the dining room, he wasn't eating. Usually he would feed himself. The nurses or anyone that was in the dining room would try and feed him and he wouldn't eat."

On 1/4/18 at 3:30 PM, V9, RN, stated, "Usually (R2) is up all night. When I came in on Sunday night (12/24/17), I was surprised because he had O2 and he was sleeping when I came on. I asked the CNA's why he was sleeping, why O2. They said he was sleeping and they said he had been sleeping all day. I related his sleeping to maybe he got his Zyprexa. I meant to look into why he was on O2 but I didn't. I was concerned about him. I was waiting for him to 'get busy' because he is up at night with me at the nurse station. His vital signs were normal. I don't think I charted them. He had no food or drink this shift and I started around 8:00 PM. In the morning (12/25/17) he would arouse to touch and repositioning. I told (V6/LPN) on 12/25/17 day shift to watch him because I was concerned about him."

On 1/3/18 at 12:00 PM, V6 (LPN) stated, "On Christmas day I couldn't get him to take his medications. He wouldn't open his eyes. He would open his mouth but would not swallow. Those were his 8:00 AM medications. I took his vital signs and they were stable. I think I charted them in the 24 hour chart. O2 was on. When I

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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
S9999	Continued From page 12	S9999		

went to his room nothing was alarming that something was wrong. (R2's) skin was not hot not shivering. (R2) stayed in bed all morning. He did not get up. The CNA's didn't report that he didn't eat. The protocol is if a resident doesn't eat to let the nurses know. I gave report to (V23/RN) before I left around 12:00 PM. I thought maybe he had gotten his prn (as needed) Zyprexa injection or by mouth because when he gets that he goes into a deeper slumber. I did check his MAR and he had not been given a prn."

On 1/29/18 at 11:25 AM, V6 (LPN) stated that she left a message with the doctors answering service on 12/25/17 in regards to R2 not taking his medication.

On 1/3/18 at 2:00 PM, V10, CNA, stated "On 12/25/17 my shift started at 6 AM. (R2) was still asleep and unresponsive. I told (V6/LPN) to go look at him around 9:00 AM - 9:30 AM. I didn't receive any feedback from her. Right after (V6/LPN) left I went in and (R2) was shaking and trembling. I touched his hand and he was hot. I went and got (V5/LPN)."

On 1/3/18 at 10:35 AM, V15, CNA, stated, "On 12/25/17 day shift he was asleep. We went to change him and he was running a fever. He was warm to touch. Another CNA got vital signs and got the nurse. The dayshift starts a 6 AM. I only saw him right before he went to the hospital. On 12/25/17 no one told me anything was wrong with (R2). I was working with (V16/CNA)."

On 1/3/18 at 9:45 AM, V5 (LPN) stated, "I normally don't have him. That day on 12/25/17 the aides just came and got me. (V6/LPN) gave report (V23/RN) not to me. (R2's) O2 was down to lower 80% on 2L/NC (nasal cannula). I

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	IL6009534	A. BUILDING: _____ B. WING _____	C 01/30/2018

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bumped up his oxygen to 3L/NC and that increase to 99%. (R2's) temperature was 104.1. I called (V4/Physician) and received an order to send him to the emergency room. I called 911 and called his daughter. When I found him he was totally unresponsive. I had no prior knowledge that he had had a change of condition."

On 1/3/18 at 10:45 AM, V23, RN, stated, "On 12/25/17 (V6) gave the medications then left. I did not get report on him (R2). Usually at shift change we will do a report. To my knowledge I was not in charge of (R2). If the CNA's needed us they could come to us. I did not lay eyes on (R2) before (V5) came and got me to come and assess (R2) with her because (V5) and I were just covering for a short time. I agreed with (V5) that (R2) needed to be sent out to the hospital."

On 1/3/18 at 3:40 PM, V2, Director of Nurses (DON), stated, "On 12/25/17 (V5/LPN) called me and told me about (R2's) temperature and that he did not want to get up. I told her to send him out which is what she wanted to do. I was not aware that he had been lethargic prior to this. Every time I send someone out I do an investigation. I looked at his MAR. I talked to staff. I and (V1/Administrator) determined that he was up all night. I was told he wasn't drinking or eating well because he was up all night. None of the night staff told me he was sleeping a few days before Christmas on nights. The day staff stated that he was up at night. I do expect staff to notify me if a resident has a change of condition. I do agree that the 24 hour reports and MAR documents that (R2) was lethargic. (R2) was private pay he is charted on for the first 72 hours after that only with behaviors or a change of condition."

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On 1/4/18 at 1:00 PM, V2, stated, "I expect that (V9/RN) should have notified the doctor and myself regarding (R2's) wet respirations and that he had never awakened that shift (12/24/17 into 12/25/17). On 12/24/17, I was in building and on the phone with (V8/LPN) and she never mentioned a change of condition for (R2) the need for oxygen. I expect staff to notify me of a need for oxygen. (V8) should have notified me and the doctor of his change of condition on 12/25/17. I would expect an aide to notify me if a nurse is not addressing a situation."

On 1/11/18 at 2:40 PM, V1, Administrator, stated, "The nurse on duty on 12/25/17 that the fire department mentioned was (V5). (V10) was the CNA. In my investigation, I questioned (V10) and she stated that is not what she said she said that he had been sleeping more the last 5 days. My investigation concluded that his appetite was poor." V1 further stated, "(V8) told me she did not feel he was sleeping more. My investigation is "kinda" incomplete because (V8) is no longer employed here, she left voluntarily and I need to talk to her more."

On 1/17/18 at 10:20 AM, V4, Physician, stated, "I do know that he (R2) does refuse medications at times. From a respiratory stand point with wet respirations the man sounded like a very sick man. He at least deserved a phone call to notify me of change of condition. A change in sleeping patterns is also is a change of condition that I should have been notified of. A delay to notify me of his change of condition contributed to his death because it delayed his treatment."
On 1/18/18 at 8:51 AM, V4, Physician, stated, "I believe I was notified of the use of the oxygen. It is common practice that the nurses will apply oxygen and then notify me. I expect them to

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S9999	Continued From page 15 monitor O2 saturations and the resident while a resident is on oxygen. When his respirations became wet I should have been notified. I would have sent him out." The facility policy and procedure "Change in a Resident's Condition or Status" dated December 2016 documented "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status." The Policy documented "1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): d: significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center. 2. A "significant change" of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standards disease related clinical interventions. b. Impacts more than one area of the resident's health status." (A)	S9999		