

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000293	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2020
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NAME OF PROVIDER OR SUPPLIER GENERATIONS AT PEORIA	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 GLEN ELM DRIVE PEORIA, IL 61614
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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
S 000	Initial Comments	S 000		
	Complaint Investigation #2027910/IL127484			
S9999	Final Observations	S9999		
	<p>Statement of Licensure Violations:</p> <p>300.1010 h) 300.1210 b) 300.1210 d)2) 300.3240 a)</p> <p>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, 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.</p> <p>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.</p> <p style="text-align: center;">Attachment A Statement of Licensure Violations</p>			

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/27/20

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to notify the Physician in a timely manner when they were unable to initiate intravenous (IV) fluids, and failed to ensure intravenous fluids were received as ordered for one of three residents (R2) reviewed for dehydration in the sample of 10. This failure resulted in a delay of treatment, and R2 was admitted to the hospital intensive care unit with diagnoses including Altered Mental Status, Sepsis, Acute Kidney Injury (AKI), and elevated serum sodium, blood urea nitrogen (BUN), and creatinine measurements.</p> <p>Findings include:</p> <p>The facility's Change in a Resident's Condition or Status (revised 5/17) documents, "The nurse will notify the resident's attending physician when: c. There is a need to alter the resident's treatment significantly," and "f. Deems necessary or appropriate in the best interest of the resident."</p> <p>V3's Skilled Progress Note regarding R2, dated 9/28/20, documents R2's oral mucosa is dry, and "Opens her eyes to verbal and physical stimuli.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Does not answer questions. Appears restless and drowsy." V3's Plan documents, "Due to patient's lethargy, poor appetite and chronic medical conditions with recent acute illness, order for stat labs, 1 (one) L (liter) IV fluid, 150ml per hour, CXR (chest x-ray) and UA. Recommend close monitoring by nursing staff."</p> <p>R2's Physician Orders, dated 9/28/20 at 2:45 PM, documents the following order: Normal Saline 0.9% (percent), 1 (one) liter to run at 100ml per hour for a total of one liter, signed by V3.</p> <p>R2's Progress Notes, dated 9/28/20 at 3:06 PM, document R2 was "seen by ((V3, Physician's Assistant (PA)), during rounds new orders received for 1 (one) liter IVF (intravenous fluids) at 100 ml (milliliters) per hour due to dehydration, UAC&S (urinalysis/ culture and sensitivity) and chest x-ray."</p> <p>R2's Medication Administration Record (MAR), dated 9/29/20 at 12:25 AM documents Normal Saline solution 0.9%, one liter, IV, "Not administered, busy with patient cares, unable to get stick," and at 2:28 AM, "Not administered, unable to get IV started." R2's Progress Notes, Medicare Charting Notes, and MAR, dated 9/27/20 and 9/28/20, do not document any other attempts to initiate the IV fluids.</p> <p>R2's Progress Notes, dated 9/29/20 at 7:53 AM document R1 was "sent to ER (Emergency Room) for evaluation r/t (related to) change in LOC (loss of consciousness)/ mentation."</p> <p>R2's ER Provider Notes, dated 9/29/20 at 8:40 AM, document diagnoses of Sepsis, Altered Mental Status, COVID-19. R1's Comprehensive metabolic panel, dated 9/29/20 and obtained in</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>the ER, document the following lab values: Sodium 149 millimoles/liter (mmol/L), BUN 32 milligrams/deciliter (mg/dL), creatinine 1.60 mg/dL</p> <p>R2's Hospitalist History and Physical, dated 9/29/20, documents, "The nursing home attempted to get IV access but was unable to," and the following active hospital problems: Pneumonia due to COVID-19 virus, Altered Mental Status, Sepsis, Acute Kidney Injury, Hyponatremia likely due to hypovolemia, given IVF.</p> <p>On 10/7/20 at 12:51 PM and 1:50 PM respectively, V6, Registered Nurse (RN) /second shift nurse working 9/28/20, and V7, Licensed Practical Nurse (LPN) /third shift nurse working 9/28/20-9/29/20, stated they were unable to initiate R2's IV fluids, and they did not notify R2's physician.</p> <p>On 10/7/20 at 9:10 AM, V4, RN, and first shift nurse coming on duty 9/29/20, stated she immediately notified the on-call physician of R2's condition and that the IV fluids had not been initiated, and the on-call physician ordered R2 transported to the ER immediately.</p> <p>On 10/7/20 at 9:50 AM, V3, PA, stated she examined R2 on 9/28/20, and R2 was very dehydrated. V3 stated due to R2's condition, she expected staff to notify the physician right away if they could not get the IV fluids initiated. V3 stated she was not surprised that it was difficult to start R2's IV because she (R2) was "very dry (dehydrated)."</p> <p>On 10/7/20 at 11:41 AM, V5, LPN (Licensed Practical Nurse) and Ward Clerk, stated she</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>received the order from V3 to administer the IV fluids for R2 on 9/28/20 and entered the order into the computer about 2:45 PM. V5 stated she then interrupted report between V4, RN (Registered Nurse) (the nurse going off duty), and V6, RN (the nurse coming on duty), and told them R2 was to have IV fluids initiated. V5 stated the order for the IV fluids was not stat, but it was meant to be initiated "as soon as possible." V5 stated she thought the nurses would implement the order, and she could not start the IV because she was an LPN.</p> <p>On 10/7/20 at 12:51 PM, V6, RN (second shift nurse), stated he does not remember being told about R2's order for the IV fluids during report. V6 stated he was very busy during his shift with several new admissions, and he didn't have time to try to start the IV for R2. V6 stated he stayed after his shift and tried twice to start R2's IV after 2:00 AM.</p> <p>On 10/7/20 at 1:50 PM, V7, LPN (third shift nurse), stated when V6 reported off to her, he told her she needed to start an IV on R2. V7 stated she told him she was an LPN and could not start an IV. V7 stated V6 stayed late and tried twice unsuccessfully to start R2's IV, and then went home.</p> <p>On 10/7/20 at 3:00 PM, V2, Director of Nursing, could provide no other information or documentation regarding notification of the physician regarding the inability to administer the IV fluids for R2.</p> <p>(A)</p>	S9999		