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
	IL6011803	A. BUILDING: _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS AT CRYSTAL LAKE, THE	1000 EAST BRIGHTON LANE CRYSTAL LAKE, IL 60012

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S 000	Initial Comments Complaint Investigation Survey # 1712978 / IL 94099	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3) 300.1220b)2) 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, but not limited to, the presence of incipient or manifest	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. c)Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of	S9999		

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the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect
a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility neglected to follow its "Resident Examination and Assessment" policy and "Change in a Resident's Condition or Status" policy when staff failed to comprehensively assess and immediately notify the physician when a diabetic resident's condition deteriorated on May 11, 2017. This failure contributed to R1's continued deterioration and delay in emergency treatment. R1 was noted to be confused at 5:00 PM, increasingly lethargic at 6:30 PM, and was unresponsive at 7:00 PM, 7:30 PM, and 8:00 PM. R1's condition continued to deteriorate for approximately 90 minutes before the facility sought Emergency Medical Services (EMS) at 8:23pm. R1 was found to be unresponsive, with cold and clammy skin. As a result, R1 was hospitalized in a diabetic coma, with hypothermia and acute respiratory failure.

This applies to 1 of 3 residents (R1) reviewed for change in condition in the sample of 3.

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The findings include:

R1's electronic medical record showed she has a diagnosis of diabetes. R1's May 6, 2017 admission progress note from 10:53 PM showed "patient is brittle diabetic ..." On May 19, 2017 at 2:25 PM, E8 (Dietician) stated "a brittle diabetic means if a resident doesn't eat right or misses a meal, they can get hypoglycemia where their blood sugar goes down."

On May 18, 2017 at 11:45 AM, E4 (LPN) stated if a resident had a blood glucose level of 70 mg/dl and was symptomatic, she would notify the MD. E4 stated she would give glucose gel if a resident was not coherent and then recheck the blood glucose in five minutes. E4 stated if she used up all the gel, she would give glucose as an injection but she would never not react.

On May 18, 2017 at 3:30 PM, E5 CNA (Certified Nursing Assistant) stated R1 was awake and responsive and talking before dinner on May 11, 2017.

On May 18, 2017 at 1:55 PM, E3 (RN) stated she went into R1's room around 4:30 PM to get her blood sugar and the reading was in the 80s. E3 stated she gave R1 a yogurt. E3 stated she went back into R1's room around 6:30 PM and R1's dinner meal was on the tray uneaten. E3 stated she tried to wake R1 up and R1 said "yeah, yeah I'll get up."

On May 18, 2017 at 1:55 PM, E3 stated when she went to tell the E2 RN the family wanted R1 sent to the hospital, it occurred to her R1 was diabetic. E3 stated R1's tongue was still sticking out when family came to the facility.

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E3 stated she went back into R1's room around 7:00 PM and R1 sounded like she was sleeping. E3 stated she reported to E2 (Director of Nursing) that "something wasn't right," and E2 told her to do a sternal rub (with her knuckles on R1's chest) and continue to monitor R1. E3 stated R1 did not move when she performed the sternal rub. E3 stated R1's tongue was sticking out.

On May 18, 2017 at 8:45 AM, Z1 (R1's family) stated he arrived at the facility on May 11, 2017, around 8:10 or 8:15 PM. Z1 stated R1 was "in her bed in her clothes and sprawled out in a weird position ... not in a way how she normally sleeps." Z1 stated "her tongue was out of her mouth." Z1 stated he "used his baseball stadium voice to scream in R1's ear and she did not respond." Z1 stated he asked E3 to take her blood sugar.

E3 stated Z1 came to her and told her they couldn't wake R1 up. E3 stated she told Z1 she had not been able to wake R1 up since around 6:30 PM. E3 stated R1's tongue was still sticking out when family came to the facility.

On May 18, 2017 at 11:45 AM, E4 (LPN) stated if a resident had a blood glucose level of 70 mg/dl and was symptomatic, she would notify the MD.

On May 18, 2017 at 1:55 PM, E3 stated when she went to tell E2 that Z1 wanted R1 sent to the hospital, it occurred to her R1 was diabetic. Blood glucose value entries for May 11, 2017 on R1's Vitals Report show 81 mg/dl at 5:05 PM, and 64 mg/dl at 8:38 PM. On May 19, 2017 at 3:10 PM, E3 stated "I think I should have sent [R1] out way before I did. I should have called [physician] when I sent her out- I should have called him before and let him know the symptoms I was

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seeing and how she was difficult to arouse." E3 added "I should have checked her blood sugar earlier- I should have done a lot of things differently."

On May 18, 2017 at 1:55 PM, E3 (RN) E3 stated she went into R1's room on May 11, 2017 around 6:30 PM, and R1's dinner meal was on the tray uneaten. E3 stated she tried to wake R1 up and R1 said "yeah, yeah I'll get up."

E3 stated she went back into R1's room around 7:00 PM and R1 sounded like she was sleeping. E3 stated R1's tongue was sticking out. E3 stated she had reported to E2 RN (Director of Nursing) because "something was not right." E3 stated she was instructed to do a sternal rub (with her knuckles on R1's chest) and continue to monitor R1. E3 stated R1 would not move when she did the sternal rub.

On May 18, 2017, E2 RN (Director of Nursing) stated she did not visualize R1 for herself, and R1's physician was not called about transport to the ER. E2 stated R1's family was present and wanted her sent so she called for transport. E2 stated 911 was not called for R1, and they should have been.

On May 18, 2017 at 3:30 PM, E5 (CNA) stated he cared for R1 the night she was sent to the hospital. E5 stated before dinner on May 11, 2017, R1 was awake and responsive and talking. E5 stated he saw R1's full dinner tray in her room "around 7:00 PM" and he tried to wake her up, and added he was not sure of the time. E5 stated R1 continued to snore and he tried to shake her right arm. E5 stated R1 moved her arm at him a little bit but her eyes were closed, she kept snoring and said no words. E5 stated he told the

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S9999	Continued From page 6 nurse he could not wake her up. E5 stated he went into R1's room a second time and he shook her left arm and poked at her left arm for one or two minutes and R1 kept on sleeping. E5 stated the second time he was in to try to wake R1 she did not resist at all and kept snoring. E5 stated he could not remember the time he was in the room. On May 19, 2017 at 12:35 PM, Z2 (Nurse Practitioner) stated she would expect a phone call when a change in a resident's condition is initially discovered. Z2 stated she would like to be notified so she could instruct staff what needed to be done for the resident, such as administer glucagon, or oxygen, or run the ABCs (airway, breathing and circulation assessments) with staff. On May 19, 2017 at 3:10 PM, E3 stated "I think I should have sent [R1] out way before I did. I should have called [physician] when I sent her out- I should have called him before and let him know symptoms I was seeing and how she was difficult to arouse." E3 added "I should have checked her blood sugar earlier- I should have done a lot of things differently." R1's May 11, 2017 nursing progress note from 9:17 PM showed at 7:00 PM, "writer went into the room again, not response from the patient. Writer went into the room again at [7:30 PM] resident was still not responding ..." The facility's undated "Diabetes Mellitus: Prevention and Emergency Treatment of Hypoglycemia" policy showed "2. Assess for symptoms of hypoglycemia." The policy described "Severe Hypoglycemia as disoriented behavior, loss of consciousness, inability to arouse from sleep, seizures."	S9999		

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The policy showed "Procedure: 1. Observe daily for conditions which may predispose the resident to hypoglycemia on a daily basis: a. Too little food; 2. Skipping or delaying a meal or snack."

Blood glucose value entries for May 11, 2017 on R1's Vitals Report show 81 mg/dl at 5:05 PM, and 64 mg/dl at 8:38 PM.

Nursing interventions outlined in the policy for "low blood glucose (70 mg/dl or below) and symptoms of severe hypoglycemia," showed "elevate the head of the bed ... administer the physician orders for emergency treatment of severe hypoglycemia. If orders are not present then implement the procedure below and instruct another nurse to notify the physician of blood glucose values ..."

R1's May 11, 2017 progress note from 9:17 PM showed "Fax sent out to MD about transfer" after Emergency Medical Services (EMS) transported R1 to the hospital.

R1's Emergency Medical Services (EMS) Run form for May 11, 2017 showed an ambulance was dispatched for transport at 8:23 PM and arrived at R1 at 8:44 PM. R1 was unresponsive and her skin was cool, pale, and clammy. R1 had no verbal or motor response, and did not open her eyes. R1 had shallow labored breathing an oral airway was placed at 8:46 PM. On May 18, 2017 at 8:45 AM, Z1 (R1's family) stated another EMS crew that was in the building for another resident assisted R1's EMS responders.

A bear hugger was applied for a rectal temperature of 94 degrees Fahrenheit.

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S9999	Continued From page 8 R1's September 14, 2016 diabetes care plan (from previous admission) showed an intervention to "Monitor for signs of hypoglycemia (blood glucose <60 mg/dl, sweating, cold, clammy skin, numbness of fingers, toes, mouth, rapid heartbeat, nervousness, tremors, faintness, dizziness). The purpose of the facility's Resident Examination and Assessment policy (revised April 2007) showed "to examine and assess the resident for any abnormalities in health status ..." Steps in the procedure showed to "examine and note ... Neurological: alertness and orientation ... strength and equality of hand grasps ..." and to document the date and time the procedure was performed." The "Reporting" section showed to "notify the physician of any abnormalities, such as but not limited to .... Change in cognitive, behavioral or neurological status from baseline ..." The facility's Change in a Resident's Condition or Status policy (revised April 2007) showed "Our facility shall promptly notify [a resident's] attending physician ... of changes in the resident's medical/mental condition and/or status ..." Nursing interventions outlined in the policy for "low blood glucose (70 mg/dl or below) and symptoms of severe hypoglycemia" showed for licensed staff to notify the physician of blood glucose values. Under "Neglect" in the facility's February 2014 "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property" policy showed " ...2. a. Types of neglect may include: d. Employees did not provide medical help promptly ..."	S9999		

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The facility's undated Diabetes Mellitus: Prevention and Emergency Treatment of Hypoglycemia policy showed "Procedure: 1. Observe daily for conditions which may predispose the resident to hypoglycemia on a daily basis: a. Too little food; 2. Skipping or delaying a meal or snack." The policy showed "2. Assess for symptoms of hypoglycemia." The policy described "Severe Hypoglycemia" as "disoriented behavior, loss of consciousness, inability to arouse from sleep, seizures."

Nursing interventions outlined in the policy for "low blood glucose (70 mg/dl or below) and symptoms of severe hypoglycemia" showed "elevate the head of the bed ... ADMINISTER THE PHYSICIAN'S ORDERS FOR EMERGENCY TREATMENT OF SEVERE HYPOGLYCEMIA. IF ORDERS ARE NOT PRESENT THEN IMPLEMENT THE PROCEDURE BELOW AND INSTRUCT ANOTHER NURSE TO NOTIFY THE PYSICIAN OF BLOOD GLUCOSE VALUES."

The "Reporting" section in the facility's "Resident Examination and Assessment policy (revised April 2007) showed " ...2. Notify the physician of any abnormalities, such as, but not limited to ... 2.c. change in cognitive, behavioral, or neurological status from baseline..."

(A)