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
	IL6011464	A. BUILDING: ________ B. WING ________	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER VILLAGE	1200 EAST PARTRIDGE METAMORA, IL 61548

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S 000	Initial Comments	S 000		

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Complaint #1724222/IL95423

Statement of Licensure Violations

S9999 Final Observations

300.610a)
300.1010h)
300.1210b)
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 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

Attachment A
Statement of Licensure Violations

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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. Restorative measures shall include, at a minimum, the following procedures.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

This failure resulted in 3 defiency Practice Statements:

1) Based on interview and record review the facility failed to assess for adequate hydration for one of five residents reviewed for hydration in a sample of nine. This failure resulted in R1 requiring hospitalization for intravenous fluid, medications to increase R1's blood pressure, and antibiotics for the treatment of Sepsis, Severe dehydration, Acute Kidney Injury, and Altered Mental Status.

2) Based on interview and record review the facility neglected to provide prompt medical care following a change in mental status and abnormal

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vital signs, neglected to assess once a change in condition was noted, and neglected to monitor for fluid intake for one of three residents (R1) reviewed for a change in condition in a sample of nine. This neglect resulted in R1 requiring hospitalization for intravenous fluids.

3)Based on interview and record review the facility failed to promptly notify a physician with a resident's change in level of consciousness for one of three residents (R1) reviewed for notification of changes in a sample of nine. This failure resulted in a delay in treatment for R1 and resulted in R1 requiring hospitalization for intravenous fluid, medications to increase R1's blood pressure, and severe dehydration

Findings include:

A Guidelines for Assessing and Documenting: Change in Resident Condition and Post-Occurrence Evaluation policy dated 10/03/13 states, "Signs/symptoms of potential change in resident condition will be assessed and documented in the nursing notes and shift communication report from the onset through resolution. Physician progress notes, new orders, and resident response to medical and nursing interventions will be documented in nursing progress notes and shift communication report as applicable. All resident occurrences will be assessed and resident condition monitored and documented in the nursing progress notes and shift communication report by each shift for a period of no less than 72 hours following the occurrence. Criteria for physician notification includes but is not necessarily limited to: Change and/or fluctuation in resident's vital signs from baseline. Change in level of consciousness, mental status and/ or behavior. Change in

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neurological sign such as speech."

A Resident Hydration and Prevention of Dehydration policy dated 8/1/16 states, "The facility will endeavor to provide adequate hydration and to prevent and treat dehydration. Minimum fluids needs will be calculated and documented on initial, annual, and significant change assessments, using current Standards of Practice. Nursing will assess for signs and symptoms of dehydration during daily care. Intake will be documented in the medical record. If potential inadequate intake and/or signs and symptoms of dehydration are observed, by nursing staff. Physician will be informed."

A Recommendations sheet (undated) documents that a Fever is a temperature over 100 degrees Fahrenheit (F) orally.

A Medication Administration policy dated 10/02/13 states, "The resident's physician must be notified of any withheld medication, and the Unit Nurse must document the notification and the physician's response."

A Psychotropic Medication Use policy dated 1/1/14 states, When a resident first exhibits behavior requiring intervention, the nursing staff will first attempt non-medical interventions. Document the behavior and include all interventions attempted and outcomes."

R1's physician's orders (POS) dated 2/20/17 to 2/24/17 documents R1 had a history of Urinary Tract Infection (UTI) and was treated with antibiotics for a UTI on five separate occasions from 9-8-16 to 1-3-17.

R1's Minimum Data Set assessment dated

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2/14/17 documents R1 is moderately cognitively impaired, and requires the assist of one person for walking and transfers, used a walker for ambulation, and requires set up with supervision for eating.

R1's Nutrition-Dietitian Nutrition Observation dated 8/17/16 and signed by E5 (Dietitian) documents that R1's estimated daily fluid recommendation as 1609cc (cubic centimeters/ about 6 1/2 cups).

R1's Medication administration record (MAR) dated 2/23/17 documents E6 (Licensed Practical Nurse) administered Tylenol 325mg (milligrams) two tablets to R1 on 2/23/17 at 5:58p.m., for a fever of 100.2 F. The MAR also documents that at 5:58p.m., R1's scheduled medications were not given to R1, "Due to condition." R1's nurse's notes for the same date do not document that Z2 (R1's physician) was notified that R1's medications were withheld as is stated in the Medication Administration policy.

R1's nurse's notes dated 2/23/17 at 12:01p.m., but recorded as a late entry on 3/1/17, document that R1 had a temperature of 100.2 and was administered Tylenol by E6. The nurse's note also documents, "Passed on to oncoming nurse to monitor and to obtain a urine dip for UTI." E6's nurse's notes do not explain what "condition" R1 had that prevented E6 from administering R1's scheduled medications. E6's nurse's notes do not include if R1 had any fluid intake during E6's shift. E6's nurse's notes also do not document that R1 was assessed for signs and symptoms of dehydration as instructed in the Hydration policy.

R1's Observation Report dated 2/23/17 at 1:05p.m., and documented by E14 (Certified

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Nurse Aide) states, "Resident was not responsive enough to give w/p (whirlpool) to, very tired, did not get weighed." R1's nurse's notes from 2/23/17 do not document that Z2 was notified of this change in condition as instructed in the Guidelines for Assessing and Documenting: Change in Resident Condition and Post-Occurrence Evaluation policy.

R1's nurse's notes dated 2/24/17 at 12:03a.m., documented by E8 (LPN) states, "Resident has been asleep all this shift. Staff will attempt to obtain a urine dip, when she awakens, d/t (due to) resident behaviors lately. T (temperature) 100.2 earlier and prn (as needed) Tylenol given. Resident T later was 98.6 axillary (under the arm). Fax placed in Z2's folder requesting an order for a urine dip for UTI." E8's nurse's notes do not include documentation that R1 was assessed for signs and symptoms of dehydration during care or if R1 had any fluid intake during E8's shift as instructed in the Hydration policy.

R1's MAR dated 2/24/17 documents E22 (LPN) administered Lorazepam 0.5mg at 2:41a.m. to R1 for the symptoms of, "Restless/anxious/crying." E22 did not document any nurse's notes, assessments, R1's fluid intake, non-pharmacological interventions tried prior to administering Lorazepam, or whether R1's temperature was monitored during E22's 11:00-7:30 a.m. shift.

R1's MAR dated 2/24/17 at 9:40a.m., documents R1 was administered Lorazepam 0.5mg for the symptoms of, "Behavior issue: agitation."

R1's nurse's note on 2/24/17 at 3:22p.m., documented by E10 (Registered Nurse) states, "R1 was somnolent this morning, not responding

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when being spoken to and would not follow commands. She would arouse, but would go back to unresponsive state right away. V/S (vitals) b/p (blood pressure) 78/50 mmhg (millimeters of mercury), pulse 94, Temp 99.6F, respirations 20, Spo2 (oxygen status) 94%. Nurse spoke to Z2 and received an order to send to (hospital)."

R1's Emergency Department (ED) note dated 2/24/17 at 4:06p.m., documented by Z4 (Emergency Room Physician's Assistant) states that R1 was admitted with the diagnoses of Acute Kidney Injury, Elevated Troponin, Severe Dehydration, Severe Sepsis." R1's ED note documents, Patient presents with Altered Mental Status. Family states that the pt (patient) has been altered since Wednesday (2/22/17). Pt has not been eating or drinking since Wednesday. The note documents, "Severe sepsis definition: sepsis-induced tissue hypo-perfusion or organ dysfunction (any of the following thought to be due to the infection), Sepsis-induced hypotension, Lactate level greater than or equal to 2, Creatinine greater than 2.0mg/dl (milligrams per deciliter), Platelet count less than 100,000ul. (micro liter). "

R1's laboratory (lab) results dated 2/24/17 document R1's Lactate level was 4.19mmol/l (millimoles per liter), Creatinine 3.66mg/dl, Platelet count 73,000. In addition R1's BUN (blood urea nitrogen) was 59mg/dl with the normal value stated as 5-20mg/dl; Troponin 0.247ng/ml (nanograms per milliliter) with the normal value stated as 0.000 to 0.040ng/ml.

Z4's progress note dated 2/24/17 at 7:10p.m., documents that Z4, "Spoke with (R1's) family at length about lab work and imaging. I explained

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that the patient's condition is not something that happens overnight. Son (Z12) explained that he was at the (facility) yesterday and that R1 was altered last night. The family said they were insisting to send R1 to the hospital but the (facility) stated that she did not need to go to the hospital. The next day (today) the family insisted again to send her to the hospital." I explained that she has a(n) elevated Troponin and is acute renal failure. I feel that both are related to her severe dehydration."

On 7/19/17 at 3:05p.m., and on 7/24/17 at 12:30p.m. E6 verified being R1's nurse on 2/23/17 from 6:30a.m. to 6:30p.m.. E6 stated that she had been told in report that R1 had been awake all night before her shift. E6 stated that R1, "ate a little of breakfast" then fell asleep in the recliner. E6 stated that she had the CNAs move R1 to the bed to make her more comfortable. E6 stated that R1 slept for the rest of her 12 hour shift. E6 stated she thought R1 was just sleepy from being up all night. E6 stated that around 5:00p.m. to 5:30p.m., Z12 (R1's son) came to the facility and was concerned that R1 was so sleepy. E6 stated that she took R1's temperature which was 100.2 F at that time. E6 stated she administered Tylenol crushed in apple sauce to R1. E6 stated that R1 normally takes her pills whole but because she was so sleepy E6 decided to crush the medication. E6 stated that Z12 wanted to send R1 to the hospital but that E6 told R1 that for just one symptom of a low grade fever; that was no reason to send R1 to the hospital. E6 stated that she told Z12 that a urine sample (Urine Dip) would be collected and checked at the facility to see if it indicated R1 had a UTI. E6 stated that since it was about 40 minutes before the end of her shift, she did not

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get the urine sample. E6 stated that she passed on to the next nurse (E8) that R1 had been very sleepy and needed a urine dip to see if R1 had a UTI. E6 stated that R1 did not eat any lunch. E6 also stated that she did not know whether or not R1 drank any fluids. E6 stated, "I told the CNA's to offer drinks."

On 7/19/17 at 3:50p.m., E9 (CNA) stated that E9 was R1's CNA on 2/23/17 between 2:30p.m. and 11:00p.m.. E9 stated that sometime during the shift E9 noted that R1 was "moaning a little bit." E9 stated that R1 was unable to get up to go into the bathroom because she was "so tired." I didn't know how R1 normally behaved. I didn't know if that was her normal. I told the nurse."

On 7/20/17 at 2:54p.m., E8 verified E8 was R1's nurse on 2/23/17 from 6:30p.m. to 11:30p.m.. E6 stated, "R1 had symptoms in the previous days. I'm not sure what the symptoms were." E8 stated that R1 was very hard to arouse, "We couldn't get R1 to take any fluids. I couldn't get R1 to take any medications or fluids. I didn't take her blood pressure. R1 didn't get up all evening and we weren't able to get it (urine dip)." E8 stated that she did not notify Z2 about R1's condition because, "It didn't seem urgent, that's why I put a fax sheet in Z2's file which is sent, usually, the next day by day shift." E8 stated that she normally works the first shift, during the day, and was not sure if the difficulty waking R1 up to take drinks and medications was normal for R1.

On 7/19/17 at 11:10a.m. E10 (RN) stated that E10 was R1's nurse from 6:30a.m. until R1 was sent to the hospital at approximately 2:40p.m.. E10 stated that E10 was an agency nurse and did

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not know R1 very well. E10 stated, "My CNAs told me R1 is not acting like R1 this morning. She was not very responsive, somnolent. She was kind of drooling. Drooling a little bit and the CNAs said that was not R1's usual. It made me think we needed to call the doctor. R1 could still rouse but she would go right back to sleep. I didn't send her out (to the emergency room) right away because of the process of getting permission from the physician."

On 7/18/17 at 9:20a.m. Z12(R1's son) verified asking E6 (LPN) on 2/23/17 at around 5:00p.m., to send R1 to the hospital because R1 was "unresponsive." Z12 stated that E6 told him it was probably a UTI and that they should wait until the facility could check a urine sample. Z12 stated that the next day on 2/24/17 in the early afternoon, Z12 went to the facility to check on R1. Z12 stated that R1 was still unresponsive and he told E10 (RN) that he was concerned about R1 because she was still unresponsive. Z12 stated that E10 took R1's blood pressure and when E10 saw that it was really low, she contacted Z2 to have R1 sent to the emergency room. Z12 stated R1's lips were dry and blistered. Z12 stated that the emergency room physician told Z12 that R1 was severely dehydrated, septic, and her kidneys were failing. Z12 stated that R1 never regained consciousness while she was in the hospital.

On 7/20/17 at 11:35a.m., Z4 verified treating R1 when R1 arrived in the emergency room on 2/24/17. Z4 stated that R1 was so severely dehydrated that her lips were cracked and dry, and her mucous membranes were extremely dry. Z4 stated that R1's dehydration was so severe that R1 was hypotensive (low blood pressure) and required intravenous fluids and a drug called levophed to help increase R1's blood pressure.

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S9999	Continued From page 10 Z4 stated that R1's low fluid volume resulted in kidney damage which was why R1's Troponin level was so elevated. Z4 stated that R1 did not become so dehydrated in just one or two days. Z4 stated that R1 needed fluids indicating that her dehydration did not occur in just one or two days. Z4 stated that R1 had a decreased level of consciousness and was unable to answer questions the whole time R1 was in the emergency room. On 7/20/17 at 12:50p.m. and on 7/24/17 at 4:40p.m., Z2 (R1's physician) stated that he had not been notified that R1 had a temperature and was not able to be aroused to take medications or drink fluids until the afternoon of 2/24/17. Z2 stated that the first time he was notified was when E10 stopped him in the hall on the afternoon of 2/24/17 at which time he ordered for R1 to go to the hospital. Z2 stated that if R1 had been prescribed an antibiotic sooner it may have made a difference. (A)	S9999		