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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 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, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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

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

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to timely identify a significant change in condition and failed to assess/monitor for that significant change for 2 of 3 residents (R2, R4) reviewed for change in condition in a sample of 5. This failure resulted in R2's overall decline in functional ability due to an undiagnosed fractured femur for 4 days resulting in hospitalization and admission to Hospice.

Findings include:

1. R2's Admission Record documents R2 was admitted to the facility on 4/3/18 following hospitalization for Syncope with Collapse, urinary tract infection and history of fall.

R2's Electronic Health Record (EHR) Departmental Notes, dated 4/12/18, at 12:35 PM, written by V10, Licensed Practical Nurse (LPN), documents, "Therapy noted swelling to left knee area. Family here. Had FNP (facility Nurse Practitioner) look at it, denied pain or discomfort. NP ordered XRAY to area and relaying to therapy to not work with area til Xray results are received." An addendum entered by V10 at 2:26 PM documents, "Called (mobile xray) and

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scheduled XRAY to right knee." There was no documentation or assessment as to extent of R2's leg swelling, discoloration if any, any change or limitation in range of motion or ability to bear weight.

R2's EHR Departmental Notes, dated 4/13/18 at 12:24 AM, written by V12, LPN, did not address R2's swollen leg. The Note at 3:39 AM later that morning, documents she left a message with the general medicine with right knee x-ray results.

The Radiology Report of R2's Right Knee x-ray, dated 4/12/18 documents the conclusion as: "Modest arthritis of the right knee, old fracture deformity of the distal femur metaphysis, grossly intact hemiartroplasty along the medical aspect of the joint."

R2's EHR Departmental Notes, dated 4/13/18 at 11:33 AM, entered by V10 did not document anything regarding R2's right knee swelling. At 1:31 PM later that day, V10 documents "monitoring to right knee, continues to have swelling and noted discoloration to right side of knee. In bed resting. U/A (urinalysis) is still pending. Called for lab results." There is no documentation that V3, R2's Primary Care Physician, was notified of the continued swelling and the newly noted discoloration. The nurse notes did not document the extent of the swelling and discoloration.

R2's EHR Departmental Note dated 4/14/18 at 12:18 PM by V12 and documents edema and bruising to R2's right knee continues with no c/o pain voiced." Again, there is no description or status of R2's leg regarding the edema and bruising to determine if it was more extensive or not.

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R2's Departmental Notes, dated 4/14/18 at 1:44 PM, V4, Registered Nurse (RN) documents "Right upper leg from knee to upper thigh continues edematous, TED hose on. Stated right leg has pain if it is moved too fast. Pedal pulse present. Leg warm. Appetite poor, refused to eat meal offered, soup refused. Took fluids fair. Bruising to right leg outer thigh, under thigh and inner thigh area continues." There is no documentationV4 noted the change and notified R2's Physician, V3, or his nurse practitioner, V9.

R2's Departmental Note, at 10:08 PM on 4/14/18, written by, V13 (RN) documents "Resident remained in bed this shift" The Note continued to document "Assist required for dinner, resident consumed approximately 40% of meal and was fed by staff. Resident continues to have swelling of rt (right) leg from thigh to knee as reported by day shift, no redness or extreme warmth to Rt leg noted, TED hose in place, 2+ pitting edema present, able to flex and dorsal flex rt foot stated painful to touch rt thigh." Again, there is no documentation V13 notified V3 and V9 of R2's complaints of pain.

R2's Departmental Notes, dated 4/15/18 at 9:45 AM, written by V4 and documents "Right upper leg continues swollen, stated only hurts when weight applied to leg. Appetite poor, only ate few bites at breakfast, fluid intake fair this am, Bruising continues to right upper thigh area."

R2's Departmental Note, dated 4/15/18 at 3:05 PM, written by V4 documents "1pm resident noted to have change in condition. Hands and feet cold and pale in color. Pulse Ox (oximetry) 75% on room air applied O2 (oxygen) @ (at) 3L (Liter)/min (minute) bring up to 82%. Noted

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rubbing with expiration in bilateral upper lobes. Has not voided this shift Responds to verbal stimuli only." The Note documented R2 was transported to the emergency room via an ambulance.

Emergency Medical Services (EMS) Report dated 4/15/18 at 12:39 PM documents "pt (patient) was found alert in his bed not accompanied by with anyone. Pt was assessed and no palpable blood pressure was able to be obtained initially from EMS. Once staff arrived RN reported that he has been acting abnormal all today and is complaining of right leg pain. The area was visualized and bruising was noted from his calf to groin bruising was noted on his posterior only. He denied any other complaints. Pt was in a warm room but his extremities were cool to touch resulting in an accurate pulse ox reading. Pt was transferred to EMS cot and taken by ambulance" to the hospital.

The Hospital Physician Documentation dated 4/15/18 at 1:11 PM documents on admission, the "Patient's speech is incomprehensible, patient present to the ED (Emergency Department) by EMS (Emergency Medical Service)." The Exam completed by V14, ED Physician, documents "The patient does not display signs of respiratory distress," and under Appearance, he documents "normal except for affect area, significant amount of ecchymosis noted to posterior right leg from inguinal region down to mid calf" and "swelling of the hamstring, posterior aspect of right knee and right calf moderate amount of swelling with tenderness to palpation noted to left knee." R2 was diagnosed with "Acute Respiratory failure with hypoxia, hypotension - unspecified, acute kidney failure - unspecified, Displaced supracondylar fracture without intracondylar

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S9999	Continued From page 6 extension of lower end of left femur." The hospital History and Physical (H&P) dated 4/16/18 documents the same diagnoses and that a conversation was held with the family who determined to go with comfort measures. The H&P documented R2 was evaluated for Hospice, transitioned to Hospice and where he expired on 4/17/18. On 4/24/18 at 2:20 PM, V10 stated she had taken care of R2 since his admission and that he came into the facility for strengthening and therapy so he could return home. V10 stated on 4/12/18, R2 was in bed and the night nurse (V12 LPN) had told her R2 had a decline and also therapy had said he had declined from the day before. V10 stated therapy (V6 PTA, Physical Therapy Assistant) told her his knee was swollen with slight redness outer right side of knee. V10 stated she looked at R2 and noted the swelling/redness then asked the Nurse Practitioner (NP), V9, who was in the building to look at him. V10 stated V9 looked at him and ordered a urinalysis and a right knee x-ray. V10 identified V11 Certified Nurse's Aide (CNA) as not reporting anything unusual to her on 4/12/18. On 4/24/18 at 2:45 PM, V6, PTA, recalled noting R2's swelling on 4/12/18 and reporting it to V10. V6 stated she also reported it to V7, Physical Therapist, her supervisor. V6 stated R2 required two person assist to transfer from the wheelchair to the bed that afternoon and usually he was contact guard or supervision. V6 stated R2 was not guarding his leg that day but did state he was having some pain. V6 stated she saw R2 the next day on 4/13/18 and he was in bed "talking to people who weren't there" and was very different than he usually was. V6 stated she did leg	S9999		

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exercises on 4/13/18 since the x-ray was negative but R2 did not come to therapy after 4/12/18.

Physical Therapy (PT) Daily Treatment Notes dated 4/7/18 documents R2 ambulating with a front wheeled walker with contact guard for safety and he was instructed in proper hand placement when ascending/descending for sit to stand and w/x (wheelchair) to/from bed transfers. PT daily notes dated 4/10/18 entered by V7, PT, documents "no gait today secondary to B (bilateral) knee pain" and "pain 6/10 before tx (treatment)." On 4/12/18, the PT notes document "PT (patient) is very confused when attempting all bed mobility and transfers today. Assessed BLE (bilateral lower extremities) after transfer with Pt R (Right) knee swelling medially, instability with warmth (no redness). Notified nurse practitioner to who stated to hold rest of TX (treatment) and that she will order x-ray." Notes dated 4/13/18 document V6 continued to do exercise on R2 and "Pt exhibiting confusion with TX, notified RN. RN stated Rt knee x- ray was negative for FX (fracture) and only showing arthritis." A PT note documented at 9:23 AM on 4/13/18 documents "pt unable to verbalize pain rating."

Occupational Therapy (OT) Daily Treatment notes dated 4/5/18 documents "resident completed bilateral resistance exercises with minimal resistance. Communicated with caregiver today regarding his treatment with OT and she was pleased and stated that he should be home shortly." On 4/6/18, an OT note documents "standing with walker support and SBA (stand by assist)." On 4/7/18, the OT documents R2 completely omnicycle for 15 minutes with resistance of 2 with activity output of 0%." On 4/10/18, the OT Note documents "Transferred

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from w/c to bed with Max A (assist) due to weakness and required constant verbal instruction for placement on body throughout transfer." On 4/11/18, the OT Note documents further decline "transfer from supine to sitting at edge of bed with mod (moderate) A (assist.) Required tactile and verbal instruction to complete transfer." On 4/13/18, the OT documents "Patient very confused on this date. Could not figure out how to utilize utensils. Spoke to CNA who concurred with confusion and weakness. R2 state that his knee was in a lot of pain, x-ray came back resulting in arthritis findings. Transferred back to bed with Max x (times) 2."

On 4/24/18 at 2:45 PM, V7, Physical Therapist (PT) stated he also saw R2's leg swelling on 4/12/18 and prior to the swelling in the earlier part of the week. V7 stated R2 was able to take a few steps with the walker. V7 stated after 4/12/18, R2 was maximum assist. V7 stated typically he would fill out a "stop and watch" for a condition change but did not on 4/12/18 as the NP saw R2. V7 stated he would expect the nurses to notify the physician of such a functional change as R2 had and to continue to monitor it.

On 4/24/18 at 2:55 PM, V3, Primary Physician, stated he understood that his Nurse Practitioner saw R2 the day the swelling was first identified and ordered an x-ray of the knee which was negative. V3 stated he typically likes to wait a week to re-x-ray unless the resident is exhibiting changes in condition such as R2 did with increased bruising, swelling and overall decline in functional ability. V3 stated the original x-ray may have been done when the fracture was non-displaced and with movement, the fracture may have become displaced causing the change.

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V3 agreed that continued monitoring would have been warranted. V3 also stated that mobile x-rays do not catch all the details that a hospital based one would and the fracture may have been there but undetected by the mobile x-ray when done on 4/12/18. V3 stated he was not aware of the increase/extent of the swelling or bruising nor was he aware of the overall functional decline R2 exhibited in the three days following the negative mobile x-ray. V3 stated he would have expected the nurses to monitor or any change and notify him or at least the NP of the changes as he would have sent him to be reevaluated at the hospital.

On 4/25/18 at 3:34 PM, V9 NP stated when she first saw R2 on 4/12/18, he had lateral right knee swelling with no bruising. V9 stated he was in his wheelchair in his room and she was told by the PTA, V6, that he was complaining of some pain in his knee as well. V9 stated R2 told her he was having pain when he stood but could flex/extend with no pain while in the wheelchair. V9 stated she ordered the x-ray and a urinalysis not knowing he was already on an antibiotic for a urinary tract infection at the time. V9 state mobile x-rays do not pick up everything and that she would have sent him out to the hospital or "at least ordered another x-ray" had she been informed of the increase in swelling/bruising and not being able to bear weight. V9 stated she would have expected the nurses to assess and monitor him to changes and to inform either her or V3 if they occurred.

On 4/25/18 at 11:15 AM, V16, Certified Nurse's Aide (CNA), stated he had taken care of R2 routinely since his admission to the facility and that at the beginning of the week, he was a stand by assist to supervision for transfer to a total lift by Friday 4/13/18. V16 stated R2's leg on 4/13/17

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was swollen from his knee to the mid thigh area with purple/brick red bruising to the outer knee and posterior aspect of his knee. V16 stated R2 had minimal confusion prior to this and that on Friday, he was more confused but denied pain saying he was "okay." V16 stated R2's eating/drinking declined also and on 4/13/18, he was still somewhat continent but not on Saturday. V16 stated the nurses were aware of R2's condition.

On 4/27/18 at 3:06 PM, V14, Emergency Room Physician, recalled R2 stating he came in with a severe femur fracture and the nursing home could not give him any information as to how long R2 had the bruising and extensive swelling on his right knee. V14 stated the swelling was so extensive he had to cut R2's pants off and the swelling went from his groin area to below his knee. V14 stated the bruising was also extensive. V14 stated the nurses should have noted it at the nursing home. V14 stated he talked with two nurses, one was the "head nurse" who also couldn't identify when the injury occurred and the other stating it occurred in the bathroom when staff was transferring him and he got his leg caught on the toilet seat/frame. V14 stated both of them said R2 was unable to ambulate and was a 2 person assist for transfers. V14 stated R2 was alert to self only and was unable to identify pain or the severity of it when he presented to the emergency room. V14 stated he had the conversation with the family when they chose Hospice.

On 4/27/18 at 2:23 PM, V17 Director of Emergency Services at the hospital stated R2's "admitting diagnosis to Hospice was Fractured Femur."

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On 4/27/18 at 3:00 PM, V2, Director of Nurses stated she observed R2 on 4/12/18 and noted the swelling but not any bruising. V2 stated she did not see him after 4/12/18.

The facility's policy/procedure entitled "Notification of a change in a resident's status" dated 11/17 documents the policy as: "the attending physician/physician extender (Nurse Practitioner, physician assistant, or Clinical Nurse Specialist) and the resident representative will be notified of a change in resident's condition, per standards of practice and Federal and/or State regulations." Under Procedure, it documents the guideline for notification includes, in part, change in level of consciousness, abnormal complaints, and unusual behavior.

2. R4's Admission Record documents R4 was admitted to the facility on 3/23/18.

R4's Minimum Data Set (MDS) dated 4/5/18 documented R4's Brief Interview of Mental Status (BIMS) score to be 11, or moderately cognitively impaired. The MDS also documents R4 to be continent of bowel and bladder.

R4's EHR Nurse's Notes documented R4 to be "usually incontinent" on 3/25/18 at 12:30 AM. On 3/28/18 at 3:57 AM, the nurse notes document R4 to be "incontinent bowel" but did not document any other information regarding this. On 4/3/18 at 1:04 PM, 4/4/18 at 2:00 AM, 4/5/18 at 12:23 AM and on 4/8/18 at 12:47 AM to be "usually continent of b&b (bowel and bladder)."

On 4/8/18 at 12:00 PM, the EHR Nurses Note documents R4 "remained in her room thought out the day. Complain of diarrhea. PRN given." There was no further documentation regarding

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R4's diarrhea.

On 4/9/18 at 12:21 AM, EHR Nurse note document again, R4 was "usually continent of B&B."

On 4/10/18 at 12:45 PM, the EHR Nurse's Note documents "Resident had1 small loose stool this am, received Imodium as ordered with no further stools."

R4's EHR Nurse's Note, dated 4/12/18, documents she was discharged to home with her son.

R4's History and Physical records dated 4/14/18, documents R4 was presented to the hospital with diarrhea, cough, congestion, and feeling unwell. The note continues to document "upon arrival to ER (emergency room) was diagnosed with possible pneumonia - treated with abx (antibiotic) and diagnosed with C-diff (Clostridium difficile) with severely elevated WBC (white blood count) and started on oral vancomycin."

On 4/24/18 at 9:45 AM, V18, R4's family representative/son, stated R4 had diarrhea most of the time she was at the facility and the facility did not take measures to identify and/or treat the C-diff. V18 stated she ended up in the hospital two days after discharge.

R4's Elimination Reports document R4 to have "loose stools" the following dates and times: 4/4/18 at 1:27 PM, 4/5/18 at 5:51 AM, 4/6/18 at 1:13 PM, 4/7/18 at 10:15 PM, 4/8/18 at 1:21 PM which was large, 4/8/18 at 7:49 PM and 4/9/18 at 4:12 AM.

The Medication Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

(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 13 documents only one dose of Imodium given on 4/10/18 at 12:45 PM even though the nurse documents a "PRN" was given on 4/8/18 at 12:00 PM for complaints of diarrhea. There was no documentation of notification to V3, R4's Physician, of the continued diarrhea from 4/4/18 to discharge on 4/12/18. On 4/25/18 at 11:15 AM, V16, Certified Nurse's Aide (CNA), stated he works full time on R4's hallway. V16 stated R4 had "diarrhea most of the time she was" at the facility which was watery, foaming at times. V16 stated he did not recall if it had any odor to it as she was usually continent and had the bowel movements in the toilet. V16 stated he had reported the diarrhea to the nurses on several occasions. (B)	S9999		