STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007181	A. BUILDING: _____ B. WING _____	C 07/12/2018

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S 000	Initial Comments Complaint # 1844398/IL103972	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210 b)d)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 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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,	S9999		

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S9999	Continued From page 2 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 neglect a resident These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to identify, assess, monitor and treat a significant decline in overall condition including mobility, continence and continuing bloody stools for 1 of 3 residents (R4) reviewed for significant change in a sample of 8. This failure resulted in delay in treatment and hospitalization for lower gastrointestinal bleeding requiring blood transfusions Findings include: The Electronic Health Record Profile section documented R4 as being a 77 year old male admitted to the facility following hospitalization on 4/23/18. Diagnoses include Parkinson's disease, Enterocolitis due to Clostridium difficile - not specified as recurrent, and muscle weakness in part.	S9999		

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The 30 day Minimum Data Set (MDS) dated 5/2/18 documents R4 to be cognitively intact with a Brief interview of Mental Status (BIMS) score of 13. The MDS documents R4 to require extensive assist of one person for bed mobility, extensive assist of 2 persons for transfers and ambulation in room/off unit. The MDS also documents R4 to be frequently incontinent of bowel and bladder.

The Electronic Health Record (EHR) Progress Notes dated 6/30/18 at 3:22 AM, entered by V11, Licensed Practical Nurse (LPN) documents "Upon preparation for bed this shift and performing resident ADL (activities of daily living) was noted that resident was very incontinent and had been this way for some period of time noting that his clothes were very well soiled as well as the pad in his chair. Resident was noted that upon him pulling down his pant that there was a very large amount of blood noted in his underwear with clots, resident inquired about the scheduling of his colonoscopy and writer noted to resident that she was unsure of place or time or if was in fact scheduled due to that last was aware that he had refused to have such treatment. Will continue to monitor and pass on to the next shift as to be sure that new facility is aware prior to move." There is no documentation V18, R4's Physician, or V14, R4's Power of Attorney (POA), was notified of R4's bloody stool.

The next entry into the progress note was dated 7/3/18 at 1:38 PM, written by V19 Social Service, and documents "Writer attempted to call POA of healthcare concerning how R4 was doing upon d/c (discontinue). Writer will attempt another call in a day or two." There record shows no discharge information.

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S9999	Continued From page 4 Discharge Logs dated 7/12/18 document R4 was discharged to an Assisted Living facility on 6/30/18. On 7/11/18 at 1:40 PM, V12 Certified Nurse Aide (CNA) stated he was very familiar with R4 and had taken care of him on his first admission. V12 stated R4 was alert and needed assistance with most of his ADL's adding that he was mostly continent during the day asking to go to the bathroom and/or use the urinal when he first arrived but that declined in the prior weeks before discharge. V12 stated R4 usually had his bowel movements on the toilet. V12 stated R4 would let staff know when he'd had an accident of bowel and/or bladder. V12 stated R4 was did not have any energy the last two weeks he was here and had a decline in his ability to ambulate. V12 stated R4 did not want to walk and/or go out of his room. V12 couldn't recall if R4 had any open areas on his coccyx or not but did know he had some redness they put barrier cream on. On 7/11/18 at 2:41 PM, V13 Director of Nurses at the Assisted Living where R4 was discharge to stated they received R4 on 6/30/18 at approximately10:30 AM. V13 stated R4 was "almost a different person that he was when they originally assessed him for admission around the first of June, 2018." V13 stated he was very pale/ashen and was much weaker than previously noted. V13 stated she received no information from the long term care facility (LTC) on R4 except that he'd been recently treated for chest congestion with a Z-pack which was finished before he came to them. V13 stated at 2:30 PM, staff reported that R4 had been incontinent of bowel and urine with a large soft stool with blood in it. V13 stated she had not been told he'd had one the early morning of 6/30/18	S9999		

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and would not have admitted him if she had. V13 stated "The stool had a large clot, almost the size of my fist in it along with other large clots and mucus." V13 stated the DON, V2, at the facility told her he had been having bloody stools throughout his stay but nothing that was consistent when she called to inquire about R4's condition upon discharge. V13 stated R4 was much lower functioning on admission than what he had been when they initially assessed him. V13 stated home health care was in the building at the time R4 had the bowel movement and they assessed him as well. V13 stated R4 had an area measuring approximately 7cm (centimeters) x (by) 7cm on his coccyx/buttocks that was excoriated with diffuse small open areas present that she was also unaware of. V13 stated they notified R4's physician and sent him to the emergency room for evaluation. V13 stated R4 had since been released to another long term care facility for rehabilitation services.

On 7/11/18 at 4:00 PM, R4 stated he had bloody stools throughout his stay at the facility and the nurses were aware. R4 stated he had been told in the past that it was the result of a polyp removal which continued to bleed. R4 stated he told both the nurses and the CNA's when he had bloody stools but nobody seemed to care. R4 stated the last couple of weeks at the facility he "could hardly move" and he felt weaker the prior two weeks doing nothing but sitting in his chair in his room. V4 stated he did have sores on his "bottom" which were very sore which the nurses were also aware of but did not treat.

On 7/12/18 at 10:00 AM, V11 LPN stated she knew R4 had bloody stools sporadically since the first time he was there and that she had monitored it but determined it was not a

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consistent thing so she didn't notify the physician. V11 stated R4 had a large decline in the weeks prior to his discharge and was almost totally incontinent and went from stand by assist to transfer to almost needing a partial mechanical lift adding that he required maximum assist of two to move. V11 stated R4 used to be able to get out of bed on his own but no longer could in the couple weeks before his transfer. V11 stated R4 had developed sores which were not opened on his coccyx with excoriation before he left. V11 stated she did pass on the bloody stool information to V6 LPN so she could let the Assisted Living facility know upon transfer.

On 7/12/18 at 10:15 AM, V6 LPN stated V11 informed her of the bloody stools describing it as large with clots but that R4 had it before with the physician ordering a colonoscopy only to have R4 refuse to have it done. V6 stated she did not notify R4's physician and/or POA about the bloody stool. V6 stated they thought it could be bleeding from hemorrhoids too. V6 stated she did not inform the Assisted Living of the bloody stools nor was the information included in any discharge papers she sent. V6 stated R4 had a definite overall decline in mobility the few weeks prior to discharge but added that he had also been treated with antibiotics on 6/25/18 for a cough/chest congestion. V6 also confirmed that she failed to document his discharge. V6 stated she could not recall documenting any information on bloody stools.

On 7/12/18 at 2:05 PM, V20 Physical Therapist stated she recalled assisting R4 to the bathroom and seeing a very large bloody stool in the toilet with bright red blood noted when she wiped him. V20 stated R4 told her he had hemorrhoids when she asked him about it. V20 stated R4 had

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declined and required much more care the last few weeks than what assisted living was able to provide wondering why he would be going there since he was "bleeding profusely from his bottom." V20 stated she called the day shift nurse into the bathroom and showed her the stool but couldn't remember exactly which day shift nurse it was. V20 did recall having conversations with V6 about R4's rectal bleeding and also stated she discussed it with R4's POA.

Progress Notes from admission on 4/23/18 through R4's discharge were reviewed and found to have only one reference to bloody stools and rectal bleeding which was on 6/30/18 at 3:34 AM.

Hospital Records dated 6/30/18 document R4 was admitted to the hospital with acute lower GI (gastrointestinal) bleeding requiring blood transfusions.

The facility's Significant Condition Change & Notification Policy and Procedure, undated, documents its purpose as "To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: 'bleeding' and 'mobility changes' in part. The policy continues to document "When any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. Prior to calling the medical practitioner the nurse will complete the SBAR (Situation, background, assessment, recommendation) assessment." The policy continues to document that all significant changes will be recorded on the Communication board and in the resident record with charting including an assessment of the resident's current status as it relates to the change in condition.

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