STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016752	A. BUILDING: _____ B. WING _____	C 07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN VILLAGE HLTH & WELL	12525 W RENAISSANCE CIRCLE HOMER GLEN, IL 60491

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S 000	Initial Comments Complaint Investigation 1874285/IL103844	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c)1)3) 300.3240a) 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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	S9999	Attachment A Statement of Licensure V	

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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. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to provide immediate treatment and services regarding R1's diarrhea and vomiting. Failed to administer medication as ordered and to provide interventions to minimize discomfort and possible complications.

These failures resulted in R1's admission at the hospital (on June 23, 2018) with diagnosis of coffee-ground vomiting, secondary to gastrointestinal bleeding. R1 expired in the hospital on June 24, 2018.

This applies to 1 (R1) resident reviewed for care and services.

The findings include:

R1 was admitted at the facility on June 7, 2018 with diagnoses to include spinal stenosis (lumbo sacral region), anemia, and acute pain due to trauma, constipation and muscle weakness. R1's ADL medical record report (Care Partner's/Certified Nursing Assistant documentations) dated June 23, 2018 showed the following:
3:42:36 AM, R1 has 3 extra-large, brown loose

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stool.
2:30:34 PM, R1 has 2 extra-large, brown loose stool.
4:17:56 PM, R1 has 2 extra-large, brown loose stool.

On July 5, 2018 at 12:30 PM, V5 (Care Partner/Certified Nursing Assistant) explained, "R1 was perky and very pleasant lady. She was a total care, able to feed self and can stand with one assist. When I saw her on June 23, 2018 (Saturday), she looked totally different. She looked very weak, pale and sleepy. She refused to eat, she said she does not have a appetite. V6 (3rd shift [10:30 PM to 6:00 AM] CP/CNA) stated to me (V5) that R1 had a rough night (on June 22 to June 23 from 10:30 PM to 6:00 AM). She had diarrhea all night long. She soiled herself, the bed and the floor because her diarrhea stools were pure liquid. Yes, she was wearing a diaper (adult disposable incontinence disposable brief). I (V5) worked a double that day. On my shift (1st shift, 6:00 AM to 2:30 PM) she had 2 diarrhea stools, extra-large amount and very loose and she was also throwing up that looked like BM (bowel movement) brownish color. Same thing on my 2nd shift (2:30 PM to 10:00 PM), she was still throwing up and having diarrhea."

On July 6, 2018 at 11:10 AM, via telephone interview, V6 (3rd shift Care Partner/Certified Nursing Assistant) described, "I was passing by her room at around 10:30 PM and I smelled a strong diarrhea odor. I went to her, she looked so pale and weak. She had multiple diarrhea stools on my shift. It was very watery, no consistency and extra-large amount. Her bed and the disposable brief she was wearing was soiled with liquid stool. When I took her to the bathroom, she was not able to hold it and was incontinent of

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watery stool all over the floor. Yes, I told the nurse each time I finished cleaning her up."

R1's nurse's notes dated June 23, 2018 at 7:52 AM, V2 (3rd shift Agency nurse) documented, "Resident having multiple diarrhea throughout the night. New order for Imodium (anti-diarrheal medication) every 4 hours as needed was obtained..."
R1's medication administration record showed this medication was not administered. This finding was confirmed by V1(Nurse Supervisor) on July 5, 2018 at 2:50 PM. On July 6, 2018 at 9:40 AM, V8 (Pharmacy Technician) via phone explained that this medication was called (e-system) at 8:31 AM (June 23) and was delivered at 4:40 PM on June 23, 2018." On July 6, 2018 at 2:40 PM, V7 (1st shift/ Agency Nurse) via phone said "The night shift nurse did not give her nothing for it." V7 also described, "When I went to see R1 she told me she does not feel good. The Certified Nursing Assistant (V5) was cleaning her up. She had a low grade fever. She was having diarrhea, nausea and vomiting. (There was no documentation found in R1 record for this shift). When I called the doctor, I told him about the urinalysis report obtained from few days ago, I was not able to tell him about the diarrhea and vomiting. The doctor was short and said text me the result and hung up on me or maybe he got disconnected. No, I did not give her any medication for the diarrhea or vomiting, I was not able to tell the doctor. When the next shift came (2nd shift) I told the Nurse (V3), do what's best because R1 does not look good."

On July 5, 2018 at 2:40 PM, V3 (2nd shift [2:30 PM to 10:00PM] RN) said, "I was worried, R1 was not eating and she even refused her pain medication which she always asked for. She said

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she's afraid she going to vomit more. She also was having diarrhea during my shift. I saw her vomit. I never seen vomitus like that! It was weird looking! It was a weird shade of brown, maybe darker color and oatmeal consistency. She was vomiting but not a lot. Her eye balls are sunken, very pale, she looked very different. No, there was no medication or intra-venous infusion that was given. The family wanted to call 911, I told them I can call for them and gave them an option between 911 and an ambulance. I called the ambulance because we have a note at the nursing station to utilize the ambulance. I called the ambulance (regular transport ambulance) they arrived after 30 minutes. R1 was discharged around 5:00 PM. No, I did not consider this as emergency!" There was no documentation in R1's EHR (Electronic Health Record) regarding the time R1 was transfered to the emergency room.

The emergency room history and physical/discharge summary showed R1 was admitted at the emergency room on June 23, 2018 at 8:05 PM, the report reads: The patient (R1) was brought from a skilled facility because the patient had been having coffee ground emesis and hypotension. On June 24, 2018 at 5:00 AM, R1 was pronounced dead. The cause of death: acute cardiopulmonary failure and coffee ground vomiting, likely secondary to gastrointestinal bleed.

(B)