

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/21/2018
NAME OF PROVIDER OR SUPPLIER AVONDALE ESTATES OF ELGIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1754-1760 CAPITAL STREET ELGIN, IL 60124		
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000			
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b)4) 300.1210d)3) 300.1220b)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 plan	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/13/18

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other	S9999			

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S9999	Continued From page 2 functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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)	S9999			

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S9999	Continued From page 3 These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain food preferences for a resident who was identified as high risk for weight loss; failed to obtain weekly weights as ordered by the Physician and failed to provide nutritional assessment as per facility's policy and procedure in order to prevent a drastic weight loss. This failure resulted in R143 not eating his meals and having significant weight loss (16%) in two weeks. This applies to 1 of 1 resident (R143) reviewed for weight loss in the sample of 12. The Findings Include: Review of R143's electronic health record (EHR) showed R143 was admitted to the facility on 6/5/18 with diagnoses that included pancreatic cancer, status post exploratory laparotomy, with antecolic gastrojejunostomy, cholecystectomy, and antibiotic therapy. R143's 5 Day Minimum Data Set (MDS) dated 6/11/18 showed R143 with Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS also showed R143 requires minimum assistance of one staff member for bed mobility, transfer and hygiene. The MDS also showed R143 requires supervision with meals. The MDS swallowing/nutritional status section showed R143 with no swallowing problems. The nutrition section also showed R143 weighed 198 pounds on admission and his height was 70 inches. The section also showed R143 was on therapeutic diet. On 6/18/18 at 2:55pm, R143 was sitting in a chair	S9999			

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S9999	Continued From page 4 in his room with V13 (family member). R143 was noted to have bilateral lower extremity edema. R143 was alert and oriented times three. R143 stated he was admitted to the facility about two weeks ago after an abdominal surgery. R143 and family member complained about food choices since admission. R143 stated the menu given to him does not have varieties of food items he could eat. Family member also stated as a result of this R143 has not been eating his meals. R143 stated gravy is added to most facility's meals and he does not like gravy. On R143's bedside table, there was a cup of cold water and a cup of coffee for the family member. There were no snacks or any food items observed in R143's room. On 6/19/18 at 10:35am, V4 (Dietitian) stated she comes to the facility once a month for 8 hours. V4 stated she only sees residents that are high risk. When asked to define high risk. V4 stated she sees residents with pressure sores and weight loss. V4 stated her last visit to the facility was on 6/11/18 and she did not see R143 because he was not on her list of residents she had to see. V4 further stated she believed someone in the facility met with R143. On 6/19/18 at 12:01pm, V2 (Director of Nursing) DON stated normally dietitian or someone from the dietary meets with new residents. V2 stated the facility did not have a dietary manager for some time but someone started yesterday (6/18/18). V2 further stated someone should have done the dietary assessment for R143. On 6/19/18 at 12:31pm, V1 (Administrator) stated menus are given to new admits within 24 hours to fill out. V1 stated the facility has been out of a dietary manager for about six weeks. V1 stated V12 (Assistant Dietary Manager) was supposed	S9999			

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S9999	Continued From page 5 to fill in the gap but because of the workload the facility acquired outside company to monitor new residents, fill out nutritional assessment. V1 stated the expectation is for the dietary technician or Food service manager to see newly admitted residents within 24 to 48 hours for their food preferences. On 6/19/18 at 2:44pm, V1 stated the facility hired a dietary technician about a month ago. V1 stated "apparently the process is broken because the old Food service manager was no longer around and the newly hired dietary technician has not been coming to the facility as scheduled. R143 should have been seen for his food preferences. On 6/19/18 at 2:44pm, V4 also stated R143's record showed R143 eats about 75-100% of his meals. On 6/20/18 at 2:23pm V1 stated, "the process fell off with the absence of dietary technician." On 6/20/18 at 2:27pm, V5 (Dietary Technician) stated she was hired by the facility about a month ago. V5 stated she visits once a week but did not on the week of June 3 to June 8 because of family commitment. V5 stated the dietitian was supposed to visit when she was absent. V5 stated she tried to visit R143 on 6/15/18 but R143 was not in his room. V5 stated she did not see R143 on 6/15/18 but wrote the nutritional assessment notes. V5 stated she wrote the 6/15/18 assessment note based on the information she obtained from Matrixcare. The information included height, weight, gender, appetite, diet, and consumption. When her note was shown to her, V5 stated "I wrote the notes but did not see this particular resident. V5 understood her role as "to visit new admissions and perform a dietary assessment." On 6/20/18 at 8:40am, V13 (Family Member) stated she stays with R143 most of the day	S9999			

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S9999	Continued From page 6 because she currently resides in the hotel across the street from the facility since she and R143 are primarily from out of state. V13 stated she consumes most of R143's meals because he would not eat it and that the "girls" know about it. V13 stated "what is the point wasting the food when (R143) would not eat." V13 did not want the food to be wasted. When asked about obtaining a guest tray, V13 stated she cannot afford to purchase \$10 guest tray on a daily basis because she is also paying for her hotel stay. V13 stated the "girls" would sometime give her a tray when there is an extra one, but "they have not done that lately." V13 further stated R143 was served sausage links for breakfast on 6/19/18 which he was not able to eat. On 6/20/18 12:40pm, V11 (Nursing staffing coordinator/reception) stated guest trays are usually \$5 and the kitchen needs to be notified two hours prior to lunch. V11 stated "there was no guest tray order for (V13) today." Review of R143's Physician order sheet (POS) dated 6/5/18 showed an order for weekly weights x 4 after admission, (Special instruction: weigh weekly for 4 weeks after admission once a day on Tuesdays). The POS also showed a diet order for "Soft diet, low fiber diet." On 6/20/18 at 11:30am, V7 (Physician) stated R143's weight loss issues has not been brought to his attention. V7 stated he can only address issues that were brought to his attention. When briefed regarding R143's drastic weight loss, V7 stated R143 should have been seen by a dietitian for his food preferences and the doctor's order for weekly weights should have been followed. On 6/20/18 at 11:45am, V8 (Nurse) stated she is	S9999			

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S9999	Continued From page 7 a regular nurse on the second floor and she has cared for R143 many times. V8 stated R143 eats fair amount and not too much. V8 stated R143's wife shares his food with him. V8 further stated Certified Nursing Assistants (CNAs) obtain resident's weights as it appears on their to do list. V8 just realized weight was not done weekly as ordered. On 6/20/18 at 11:55am, V9 (CNA) stated she had served R143 his meal trays many times. V9 stated she thinks R143 eats even though she did not physically see him eat but she collects his trays. V9 stated V13 is always in the room with R143. On 6/20/18 at 12:05pm, V10 (CNA) stated she served R143 a late lunch on 6/19/18 because R143 was down in the therapy room. V10 stated R143 ate about 50% of his lunch meal at that time. V10 stated V13 did not ask for extra lunch tray yesterday when she served R143 but she sometimes gives V13 a tray when there is an extra tray available. Review of R143's weight history showed R143 with an admission (6/5/18) weight of 197.8 pounds. The history also showed no recorded weekly weight as ordered by Physician. The next weight record was obtained on 6/19/18 after being prompted by the surveyor and it was 165.6 pounds. This showed R143 with a 16% significant weight loss. Review of R143's care plan initiated on 6/6/18 showed: R143 "has/at a risk for weight gain/loss related to recent abdominal surgery, infection, pancreatic cancer with a goal of maintaining adequate nutritional intake to keep body weight +/-5pounds on normal body weight." One of the approaches on the care plan showed, "Record weights as ordered and report weight	S9999			

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S9999	Continued From page 8 loss or gain of 5pounds or more to the Primary Care Physician (PCP)." The facility failed to follow this approach. Review of facility's policy and procedure titled, "Dietary Department-Organization and Staffing" dated 2010 showed, "Dietary Manager or designated person will visit newly admitted residents to obtain food preferences, complete a nutrition assessment and participate in care plan conferences." Review of facility's policy and procedure titled, 'Dietary Department-Nutrition Therapy' dated 2016, showed, "New admissions may be weighed weekly for the first four (4) weeks". (C)	S9999			