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	IL6012827	A. BUILDING: _____ B. WING _____	07/03/2018

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.1220b)3) 300.3240a) Licensure 1 of 2 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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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, 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.

These Reguations were not met as evidenced by:
Based on observation, record review and

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interview the facility failed to properly assess a resident with change in condition. This failure led to R1 receiving a delay in treatment and being sent to the emergency room with a diagnosis of GI (gastrointestinal) bleed.

This applies to 1 of 1 resident (R1) reviewed for change in condition in a sample of 13.

Findings include:

The Face Sheet shows R1 is 87 years old and was admitted on 6/7/18.

The MDS (Minimum Data Set) reads R1 is taking anti-coagulants.

The Physician's Order Sheet (POS) documents the following diagnoses: atypical chest pain, diabetes mellitus, coronary artery disease, atrial fibrillation, depression and chronic pain syndrome.

The POS and MAR (Medication Administration Record) documents the following medication: Heparin 5,000 units inject 1 ml SQ (subcutaneous) every 12 hours, ***NSAIDS increase GI (gastrointestinal) bleed risk; Aspirin EC 81mg tablet by mouth once daily; Ferrous Sulfate 325mg by mouth twice daily

On 06/26/18 at 10:55 AM, R1 was awake in bed with a wash basin lined with paper towels. R1 stated staff gave R1 the wash basin because R1 was nauseated. V11 (CNA/Certified Nursing Assistant) provided morning care for R1. R1 was pointing to R1's epigastric region stating "this is where it hurts. It hurts every time she turns me. "

On 6/27/18 at 9:00 AM, R1 was sitting in the chair

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in R1's room. R1 had 02 (oxygen) per nasal cannula. R1 stated I am very short of breath and therapy gave me oxygen. R1 stated R1 is not usually this short of breath. R1 stated "I can't breathe every time I turn." R1's skin was very pale. R1 stated R1 still feels nauseated. R1 stated "these dry heaves are awful." R1 stated R1's abdomen is still very uncomfortable and more painful than before. R1 stated the pain is worse and occurs every time R1 moves. R1 stated "its worse when I eat." At this time V3 (Registered Nurse/RN) was outside of R1's room. V3 was notified of R1's concerns but failed to go assess R1.

6/27/18, at 9:15 AM, R1 was stating R1 wants to go to the toilet. V3 placed R1 on the toilet and exited the room. R1 had a large dark BM (bowel movement) and was assisted off the toilet by V14 (RN).

On 6/27/18 as of 12:00 PM, R1's condition had not changed and R1's medical record reflected no documented assessment, VS (vital signs) or follow up on R1's condition. R1 was still complaining of abdominal pain and skin was pale. V2 (Director of Nursing) was notified.

On 6/27/18 at 2:00 PM, V2 came to the surveyor and stated "I just want to let you know V3 is updating the physician on R1's condition.

On 6/27/18 at 4:00 PM, V3 stated "I just got orders 10 minutes ago." The POS documented orders for lab work, gastroenterology (GI) appointment and chest x-ray. V3 stated "the orders had not been called in yet. I was being pulled in every direction." V2 was asked when R1's blood will be drawn. V2 stated the lab orders will not be carried out today because they

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were not ordered STAT. V2 stated the blood work will be drawn tomorrow.

On 6/28/18 at 9:00 am, R1 was sitting in the chair stating the nausea and abdominal pain is still there. R1 was still very pale. As of 9:52 AM, R1 had a large bowel movement with bleeding and had to be sent to the emergency room. V12 (RN) stated "it is dark with a large amount of blood." At 4:00 PM, V2 stated to the survey team "I forgot to tell you, R1 was admitted to the hospital with a GI bleed. R1 has a history of GI bleed."

Although R1 had been complaining of nausea on 6/27/18 - 6/28/18, the nursing notes documents: no nausea. The nursing notes on 6/27/18 documents that R1 has no pain, even though R1 complained of abdominal pain.

R1's Care Plan for Alteration in Comfort reads: Gastric distress. There were no interventions checked or documented on the care plan for the gastric distress. The section was not completed.

On 6/28/18 the facility was asked for the policy for Physician Notification which the facility did not present. On 6/29/18 at 7:40 AM, V2 presented the policy titled "Notifying Physician of Changes in Patient Condition." V2 stated "I just updated the policy last night." The policy read: The nurse will complete a thorough assessment of the patient condition. If the change in condition persists, the nurse will notify the physician using the SBAR format (situation, background, assessment, recommendation). The policy did not denote the timeframe in which the physician should be notified.

On 6/29/18 at 12:30 PM, V18 (Medical Doctor) stated on 6/27/18 he was not informed that R1

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had dark stools, was pale, or of any assessment. V18 stated R1 has a history of nausea and epigastric discomfort and he ordered the labs because the facility called him and stated "somebody suggests you orders labs for R1." V18 stated he then received a call on 6/28/18 when R1 had bloody stools and sent R1 to the emergency room. V18 stated if he was informed sooner of R1's additional symptoms he would've sent R1 out sooner. V18 added that R1's admitting diagnosis to the hospital was GI bleed.

(B)

Licensure 2 of 2

300.610a)
300.1210b)5)
300.1210 c)
3001210d)6)
300.3240a)
300.3240d)2)

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 300.1210 General Requirements for

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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:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the

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Department. (Section 3-610 of the Act)
2) All treatments and procedures shall be administered as ordered by the physician.

These Regulations were not met as evidenced by:

Based on observation, record review, and interview the facility failed to provide supervision and implement appropriate fall prevention measures. The facility also failed to develop a policy for supervision. This failure led to R274 sustaining a laceration to the scalp, being sent to the emergency room and receiving staples to the scalp.

This applies to 2 of 3 residents (R274, R325) reviewed for falls in a sample of 13.

Findings include:

The Face Sheet documents R274 is 87 years old and was admitted to the facility on 5/30/18.

The POS/MAR (Physician's Order Sheet) documents the following orders:
5/30/18 Coumadin (with dose adjustments)
5/30/18 Metoprolol 50mg ER oral 2 X day (anti-hypertensive)
6/6/18 Triamterene/HCTZ 37.5/25mg oral daily (Thiazide diuretic combo);
5/30/18 Digoxin 0.125 by mouth daily (Inotropic Agent/Antidysrhythmic)

The fall risk assessment 5/30/18 documents score of 13, indicating fall risk.

The medical diagnoses section on both the Face Sheet and POS were left blank.

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The care plan dated 5/30/18 documents chair pad alarm at all times.

The facility incident reports read R274 fell the following dates in the facility:
5/31/18 in R274's room at 5:15 PM;
6/15/18 in R274's room at 12:20 PM; sent to emergency room and received staples
6/21/18 in R274's room at 3:15 PM;
6/25/18 in R274's room at 6:20 AM

On 6/28/18 at 1:36 PM, V15 (Registered Nurse/RN) stated on 6/15/18 staff was passing lunch trays when V16 (Certified Nursing Assistant/CNA) notified her that R274 was lying on the floor. V15 stated "It was lunch time. R274 will get up from the chair. I think R274 wanted to go to the bathroom. R274 was lying on the ground next to the bed." V15 stated that R274 stated that R274 had tripped. "It could've been the bed side table, it was near. R274 was on Coumadin. R274 had a history of stroke and leans when R274 stands. R274 does not stand up straight. R274 is confused and requires assistance with everything.

On 6/28/18 at 2:10 PM, V16 stated she was the caregiver for R274. V16 stated R274 is confused at times and bends down while in the chair. V16 stated "Someone has to be with R274. R274 keeps falling down. R274 thinks R274 can do everything R274's self." V16 stated on 6/15/18 when R274 fell the alarm was not sounding. V16 stated "I heard a hitting something. I was passing food trays on the hall. When I got there, R274 was on the floor beneath the bed. R274 was bleeding from the back of the head. The nurse was saying the bleed was from a bump R274 had with a previous fall." V16 stated "there was an alarm but it wasn't on." V16

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stated that R274 can turn the alarm off, but if R274 comes off the attached pad, the alarm will sound. V16 stated the alarm can be placed out of reach where R274 cannot reach it. V16 stated "sometimes we hide it in the pocket on back of the chair and R274 can't find it." V16 stated when R274 fell, the alarm was attached at the top of the chair and not in the pocket. V16 stated R274 was in the room without staff supervision.

On 6/28/18 at 2:21 PM V2 (Director of Nursing) stated she and V13 (Nursing Supervisor) are the fall coordinators. V2 stated R274 is high risk for falls and has history of falls at home. V2 also stated R274 was a previous resident of the facility in March/2018 where R274 also sustained a fall in the facility. V2 stated "R274 requires supervision when out of bed, staff supervision." V2 stated "the nurses' stations aren't centered where the nurses can see into R274's room. Ideally they would be centered to monitor rooms. R274 is forgetful." When asked about medical diagnoses that may put R274 at risk for falls, V2 did not know. Located in R274's medical record was a physician's progress note which documented diagnoses including multiple falls, history of pelvic fracture, stroke, spinal stenosis, degenerative joint disease and Coumadin therapy. V2 stated when R274 fell on 5/31/18 the interventions added were to instruct R274 to call for assistance. V2 stated however, R274 is non-compliant with this intervention. V2 added "R274 believes R274 is independent but is not. R274 needs supervision." V2 also stated R274 has an unsteady gait. V2 stated the intervention after the fall on 5/31/18 was staff educated on regular rounding to check alarms. V2 stated R274 again fell on 6/15/18 and hit the back of R274's head and went to the emergency room and received staples. V2 stated R274 was in the

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room without staff supervision. Review of the care plan reads that when R274 fell and sustained a laceration to the head on 6/15/18, R274 stated "I removed the pad because it will beep when I stand up." V2 stated "V13 wrote this on the care plan." V2 stated V13 was not working on 6/15/18. V2 stated if R274 removed the pad, it would beep. "If pressure is off the pad, it beeps."

On 6/28/18 at 2:50 PM, V13 stated sometimes R274 can removed the alarm pad. V13 stated she did not interview R274 and R274 did not state to her that R274 removed the alarm on 6/15/18. V13 stated "R274 requires supervision and is occasionally confused. R274 has multiple falls." When asked if the alarm can be placed out of R274's sight, V13 stated "I don't think so. It always has to be on the chair. We normally don't place it in the pocket, it will fall." V13 stated the conclusion was that on 6/15/18 "R274 was attempting to walk to the bathroom per self. R274 fell and hit R274's head." V13 stated on 6/21/18, R274 fell again in R274's room without supervision. V13 stated "R274 was trying to pull the privacy curtains when R274 fell.

The care plan did not list alternate interventions for when R274 turns off the alarm or does not call for assistance.

On 6/28/18 at 3:10 PM, along with V13, R274 was in R274's room. The alarm was on the chair handle just above R274's left shoulder. R274 was able to remove the alarm when asked, but not able to place it back on the chair. The alarm was then placed in the pocket of the attachment to the back of the chair. As V16 had stated, R274 was unable to visualize the alarm. The alarm was out of R274's reach. The cords and alarm remained in place and the alarm was functioning.

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V13 then stated "Well R274 can't reach that unless R274 stands up."

6/29/18 10:07 AM, V17 (Nurse Practitioner/Primary Care Provider) stated R274 is a unique case. R274 is in a room with R274's spouse. V17 stated the spouse is the one watching R274 and telling R274 to sit down while in the facility. V17 stated R274's spouse is here for rehab and acknowledged the spouse is unable to take care of R274 at this time. V17 stated on 6/15/18, R274 fell and required staples to the back of the head. V17 added "I can't speak to terms of the facility. I can speak to the fact of R274 being high fall risk. I believe they are responsible for providing supervision. R274 has poor safety awareness."

The Minimum Data Set documents that R274 is not steady, and only able to stabilize with staff assistance when moving from seated to standing position; when moving on and off toilet; and when transferring from surface to surface.

On 6/29/18 at 7:30 AM, V2 stated the facility does not have a policy for supervision.

The Patient Summary from the local hospital dated 6/15/18 reads: Chief Complaint TRAUMA LEVEL 3 FALL. Remove staples in 5-7 days.

2.) On June 26, 2018 at 12:00 PM, R324 was sitting up in bed eating mechanical soft lunch in R324's room without supervision and his anti-slip mat was laying sideways up against the wall and not at the side of bed.

On June 27, 2018 at 11:50 AM, V9 RN (Wound Care Registered Nurse) stated to V10 RN to bring

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R324 a lunch tray to his room in case R324 wants lunch. V9 provided R324's wound care treatment and exited the room while leaving R324'santi-slip mat sideways against the wall and not at the side of bed.

On June 28, 2018 at 8:20 AM, R324 was sitting up in bed eating breakfast with no staff supervision and anti-slip mat was laying up against the wall by door.

On June 28, 2018, at 3:16PM, V2 (Director of Nursing) stated R324 is a fall risk and should have anti-slip mat next to bed when R324 is bed and next to R324 when up in wheelchair in his room. V2 stated R324 should be supervised when eating and if R324 does not want to eat in room staff should be assisting/supervising meal intake.

R324's Baseline Care Plan and Fall Risk Assessment dated June 13, 2018, shows R324 as at a risk for falls. R324's fall intervention is an anti-slip mat.

R324's POS (Physician Orders) dated June 15, 2018, shows mechanical soft- chopped diet and to eat in dining room supervised.

R324's Speech Therapy Care Plan dated June 15, 2018 shows problem as Aspiration with Swallowing/Aspiration Precautions.

R324's Care Conference Patient Summary dated June 21, 2018, shows current diet as Mechanical soft with thin liquids.

On June 29, 2018 at 8:30 AM, V2 (Director of Nursing) stated the facility does not have a resident Supervision Policy. V2 stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERMAN WEST COURT	1950 LARKIN AVENUE ELGIN, IL 60123

(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 should know better and not leave R324 in room unsupervised when eating. The Facility's Fall Risk Policy revised August 2017 shows Facility will identify residents/patients at high risk for falling, upon admission and quarterly, when there is a significant change in condition, using developed criteria so special precautions can be instituted to prevent potential falls ....reassess each resident every ninety (90) days or when a significant change in condition occurs, and post fall ...update resident/patient individualized care plan, documenting the fall, date and alternative interventions/approaches implemented. (C)	S9999		