STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000723	A. BUILDING: _____ B. WING _____	C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

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S 000	Initial Comments Complaint Investigation #2145618/IL136776	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010h) 300.1210b)4) 300.1210d)3) 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 of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		
	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. 4) All nursing personnel shall assist and		Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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.	S9999		
	These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide interventions for poor fluid intake for 1 of 4 residents (R4) reviewed for hydration in the sample of 11. This failure resulted in R4 hospitalization with dehydration and acute renal failure. Findings include: R4's Admission Record, print date of 8/10/21, documents R4 was admitted on 3/13/21 with diagnoses of Hemiplegia and Hemiparesis following a stroke affecting the left non-dominant			

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S9999	Continued From page 2 side, Aphasia, Dyspaghia, personal history of COVID-19, Non - St Elevation Myocardial Infarction, Hypertensive Heart Disease, Chronic Kidney Disease Stage 3 and Type 2 Diabetes Mellitus. R4's Minimum Data Set (MDS), dated 6/16/21, documents R4 was severely cognitively impaired and required extensive assist of 1 staff member for eating. On 8/12/21 at 9:50 AM, V5, Licensed Practical Nurse (LPN), stated, "Upon admit, (R4) was a peg tube feeder. She was alert to self only and responded to tactile stimuli. Her left side was flaccid and required extensive assistance with all of her Activities of Daily Living (ADL's). She was getting Occupational Therapy, Speech Therapy and Physical Therapy. She improved. She started taking ice chips then pureed pudding thick liquids. She got to were she was able to feed herself with verbal cues and supervision. She became more alert to self and could hold down conversions with yes no answers. We were able to decrease her feeding tube and we were able to remove the tube. She was maintaining her weight. She took her medications crushed in applesauce. My observation is she started to decline after her first COVID shot. She started to need more verbal cues. She would eat 75% to 100% then 50% to 25%. then we had to start feeding her again. She was having less speech but remained responsive to tactile, verbal and painful stimuli. I was off the weekend, I came back Monday (6/28/21) and the bath aide said she noted a bruise on (R4's) left shoulder, axillary and breast. I did notify the Nurse Practitioner (V3) of the bruising and she said that she would see her on Tuesday (6/30/21). On that Tuesday she ordered X-RAYS, (laboratory test) and a CT (computed	S9999		

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S9999	Continued From page 3	S9999		

tomography) scan of the head. At this time, her vital signs were stable, we were feeding her and she was needing more assist with care. She was maintaining her weight and did not appear malnourished. I offer fluids every time I go into a room. It never appeared to me that she had a stroke just an over all decline. I had spoke with her daughter (V12) about her decline in appetite and that we were assisting with meals. I notify families of all changes that happen with the residents." On 8/12/21 at 2:25 PM, V5 stated, "I was unaware of (R4) having poor intakes. She was taking her pills fine and and swallowing fine for me. I was unaware of the aides having trouble feeding her." On 8/12/21 at 3:45 PM, V5 stated, "I did notice a decline in (R4's) intake and I did notify (V3 and V13 Physician). They said just to continue to monitor her. I can't believe I didn't chart that the doctor was notified. I was still getting her to drink fluids and take her medication pass without difficulty."

On 8/13/21 at 8:15 AM, V11, LPN, stated, "(R4) was declining. She could answer yes or no questions. She was being assisted with feeding. She really never had a good appetite for me. She would take her protein snack for me at bedtime without trouble. (V13 and V3) both knew of her poor intakes and they would say to just continue to monitor her and try. She was still able to eat, the only time she had trouble was when her blood sugar was low."

On 8/12/21 at 10:14 AM, V6, Certified Nurses Aide (CNA), stated, "When I first started, she (R4) would eat well. I was feeding her at the end. She wasn't eating or drinking by herself. The staff was telling the nurses and speech therapy about her decline in appetite. I offer fluids throughout the day. We will always help someone who needs

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S9999	Continued From page 4 assistance." On 8/12/21 at 11:30 AM, V7, CNA, stated, "I took care of her (R4) often. She did have a decline in her appetite and fluid intake. She wasn't swallowing and liquid would just run out of her mouth for about a week (before she went to hospital). We (the CNA's) had been telling the nurses about her decline. They said speech was working with her. I personally think that the nurses didn't act fast enough. I think she had another stroke, that's what it looked like to me." On 8/12/21 at 2:39 PM, V8, Speech Therapy, stated that he did work with R4 and that she was discharged from Speech Therapy. V8 stated he was not made aware of R4 having difficulty eating or drinking and if he would have been made aware V8 would have gotten an order to evaluate and treat her. On 8/12/21 at 3:00 PM, V9, CNA, stated, "(R4) was doing really well with her feedings then for about 2 weeks at the end she wasn't eating or drinking well. The nurses would say they know and we think something is going on with her but they didn't tell me what they were doing." On 8/12/21 at 3:10 PM, V10, CNA, stated, "A few weeks before her leaving she was having poor intakes. I was letting the nursing staff know. Some would say OK I will make a note about it." On 810/21 at 2:15 PM, V3, Nurse Practitioner, stated, "I was notified of (R4's) decline and bruising to the left axilla, breast area on 6/28/21. I sent her to the Emergency Room (ER). The ER basically sent her right back. The next day I assessed her and the bruising apparently had gotten worse according to (V14). During this	S9999		

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S9999	Continued From page 5 assessment, she was showing pain. I ordered X-rays and labs. The X-ray showed a dislocated shoulder. I ordered her to be sent back to the local ER so that could be put back into place or they could get her to Springfield if need be for treatment. The ER called me and said the shoulder was not dislocated but they were going to admit her for dehydration and to have orthopedics look at her. In the hospital with some rehydration, she came around a little bit but, she has such a change/decline I ordered a scan of her brain. It showed a possible stroke. Now this scan was done 2 days after the admission so I really don't know when the stroke happened. The family did not want to get real aggressive at this point. During the hospital stay, she wasn't eating. She wasn't alert enough to eat. The family wanted a feeding tube placed. Unfortunately, there was no beds at the Regional Hospital. She was on the list for a bed. I last saw her on 7/2/21 at the local hospital then the hospitalist took over her care. When I came back to the local hospital on 7/5/21, she had been transferred to the Regional Hospital. She was admitted with dehydration. I would classify it as slight dehydration. It was not like she wasn't being taken care of or neglected. I think she had a slight stroke and that is why she was declining, but I can't tell you exactly when it happened. She was not a healthy woman and had a lot of comorbidities." On 8/16/21 at 11:25 AM, V3 stated, "When I saw her on 6/29/21, she did not appear as someone who had just had another stroke. I was not aware that (R4) had a decrease in fluid and food intake. Had I known this, I think the only thing different I would have done is be more aggressive about her decrease in insulin and encourage them to push fluids. I do expect to be notified of a decrease in food and fluid intake."	S9999		

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S9999	Continued From page 6 On 8/16/21 at 12:23 PM, V13, Physician, stated, "I was made aware of an overall general decline but not the specifics of her not having good intakes of fluid and food." On 8/10/21 at 4:05 PM, V2, Director of Nurses (DON), stated, "(R4) was having desired weightloss. We had taken out the peg tube because she was eating well. If someone does not eat well, the intake is put into the computer system and then the nurse will talk to to the resident and the staff to see what interventions have been tried." On 8/16/21 at 9:00 AM, V2 stated, "The computer system will flag poor intakes for the nurses to review. The aides are very good about bringing problems to me that they feel the nurses are not taking seriously. The aides never brought (R4's) intake concerns up to me." On 8/16/21 at 3:00 PM, V2 stated, "The nurses should have been notifying (V3 or V13) about (R4's) poor intakes."	S9999		
	R4's July Fluid and Meal Intake Report, print date of 8/10/21, documents, in part, that on 6/12/21 R4 intake was 240 milliliters (mls) and 1 meal of 0% to 25%, on 6/13/21 420 mls of fluid and 1 meal of 0% to 25%, on 6/18/21 280 mls of fluid and 1 meal of 75% to 100%, 1 meal of 26% to 50% and one meal of 0% to 25%, on 6/19/21 70 mls of fluid, 1 meal of 0% to 25% and 1 meal of 26% to 50%, on 6/20/21 360 mls of fluid, 1 meal of 0% to 25% and 1 meal of 51% to 75% and an hour of sleep snack, 6/23/21 180 mls of fluid, 2 meals of 0% to 25% and 1 meal of 26% to 50% and a pudding at hour of sleep, on 6/24/21 240 mls of fluid, 1 meal refused, 1 meal of 0% to 25% and 1 meal of 26% to 50%, on 6/25/21 60 mls of			

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S9999	Continued From page 7 fluid and 3 meals of 0% to 25%, 6/26/21 120 mls of fluid and 3 meals of 0% to 25%, 6/27/21 160 mls of fluid, 1 meal of 0% to 25%, 1 meal of 26% to 50 % and 1 meal refused, on 6/28/21 20 mls of fluid and 3 meals of 0% to 25% and on 6/29/21 0 fluid intake and 2 meals refused and 1 0% to 25%. R4's Speech Therapy Discharge Summary, dated 6/18/21, documents R4 was discharged from Speech Therapy on 6/18/21. This discharge summary also documents, "Short term goals: Pt (patient) will complete oral motor exercises with verbal and tactile stimulation. Baseline, 3/15/21, Pt demonstrates moderate to severe oral motor problems. Previous: Pt continues to demonstrate improvements in her oral motor processing skill. Pt was able to complete oral motor exercises with related, delayed, incomplete and complete responses. Pt continues to have some food and liquid loss from the left corner of her mouth, however, it has decreased considerably. Left side neglect remains an issue. Discharge, 6/18/21, Able to take 20 - 25 bites and 120 cc (cubic centimeters) of liquid. Diet texture analysis. Discharge, 6/18/21, pureed diet with honey thick liquids." R4's Nurses Note, dated 6/21/21, documents, "Notified provider of low blood sugar results over the last few weeks. NO (new order) received to decrease Lantus to 15 units at HS (hour of sleep) and update in one week per (V3)." R4's Nurses Note, dated 6/24/21, documents, "No s/x (signs and symptoms) of adverse reactions including hypo/hyperglycemia observed or reported related to decrease dosage of Lantus to 15 units @ hs (at night) however there is a decrease in appetite with self feeding and	S9999		

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S9999	Continued From page 8 assistance abdomen non-tender or distended bowel sounds present x 4 normal no s/x of GI (gastrointestinal) distress no c/o (complaint of) or non-verbal s/x of pain no acute distress v/s (vital signs) 118/67, 50, 22, 97.4 spo2 (oxygen saturation) 93% RA (room air)." R4's Nurses Note, dated 6/25/21 at 4:50 AM, documents, "Resident observed to have BGL (blood glucose level) of 46 at this time; cool, no sweats, responded appropriately, A&O (alert and orientated) to self. Order for GlucaGen per MD (medical doctor) standing order. MD made aware of use of standing order." R4's Nurses Note, dated 6/25/21 at 3:46 PM, documents, "Seen by (V13, Physician) in facility with new order to hold Lantus for 3 days and notify of blood sugar results." R4's Nurses Note, dated 6/28/21 at 9:56 AM, documents, "Lantus insulin remain on hold with no s/x (signs and symptoms) of hypo/hyperglycemia decrease in appetite and fluid intake <25% with or without assistance alert non-drowsy skin warm and dry abdomen non-tender or distended bowel sounds present normal no s/s of GI distress v/s 108/58, 96.9, 72, 18 spo2 96% RA." R4's Nurses Note, dated 6/29/21 at 1:19 PM, documents, "(V3) here in facility to see orders received for x-ray of L (left) shoulder and chest, CT scan of head without contrast dx (diagnosis); CVA (cardiovascular accident), (labs) in am." R4's Nurses Note, dated 6/29/21 at 9:50 PM, documents, "Chest x-ray results and Left shoulder x-ray results called to (V3) New orders received to send to ER for left head humerus to	S9999		

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S9999	Continued From page 9 be put back in place." R4's Hospital Record, dated 6/29/21 at 11:21 PM, documents, "Impression: Dehydration and Acute Renal Failure. Admit: This patient is admitted to the services of (V3). The patient is an inpatient admission and admitted to Medical/Surgical Services. The patient condition upon disposition was poor." R4's Hospital Registered Nurse (RN) Chart, dated 6/29/21, documents, "Skin: The skin is warm. Skin color is pale. Skin tugor is decreased." R4's Laboratory Values, dated 6/29/21 documents, BUN (blood urea nitrogen) (mg/dl) (milligrams per deciliter) 62 (High) Normal values (7 - 20). R4's Laboratory Values, dated 6/29/21 documents, Creatinine (mg/dl) 3.10 (High) Normal values (0.52 - 1.04). R4's Hospital History and Physical, date of service 6/30/21, documents, "Patients labs revealed that she was in acute renal failure and dehydration. Today patient will only respond to tactile stimuli. CT(Cat Scan) of the head done last evening was inconclusive for stroke and MRI (magnetic resonance imaging) was recommended so that was ordered to be done today. The results of this show that there is a subacute infarct superimposed along the margins of the more extensive chronic right cerebral infarct without edema or mass effect. Plan Dehydration: continue the Intravenous Fluids of normal saline at 125 ml/hr and recheck labs in the am. Date of Service 7/2/21 Plan: Dehydration change her fluids to .45% Normal Saline due to	S9999		

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S9999	Continued From page 10 increase in sodium. Due to family wanting a to have (feeding) tube placed, we will need to transfer to a different hospital." R4's Discharge Summary, dated 7/6/21, documents, "Patient discharged for higher level of care per ambulance on 7/2/21. Case closed." R4's State of Illinois Death Worksheet, documents, date of death 7/10/21. Cause of Death. a. Cardiopulmonary Arrest (pt on hospice) approximate interval between onset and death 7 days. b. acute encephalopathy. c. severe dehydration hypernatremia." The Hydration Policy, dated 1/2016, documents, 1. Dietary will provide a minimum of 1440's cc's of fluids with meals for each resident unless contra-indicated by a fluid restriction. Additional fluid will be provided from bedside water pitchers, medication pass, activities and snacks.2. All residents will be assessed by the Dietician for individual fluid needs in "Dietician Assessment" in (computer). The standard of 25 -30 cc's of fluid per kg of body weight will be used unless contra-indicated by the resident's medical condition and or per professional opinion of the Dietician. (25 cc's will be used with a diagnosis of Congestive Heart Failure)." R4 does not have a current Dietician Assessment available for review. (R4 is 74 kilograms. 74 kilograms x 25 equals 1850. R4 required 1850 cc of fluid for hydration.) (B)	S9999		