

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002711</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY NSG &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1095 UNIVERSITY DRIVE EDWARDSVILLE, IL 62025</b>
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S 000	Initial Comments  Annual Licensure and Certification Survey F 692 G cited	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b)4) 300.1210c)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	<b>Attachment A Statement of Licensure Violations</b>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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 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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Based on observation, interview and record review, the facility failed to provide feeding assistance to prevent weight loss in 2 residents (R42 and R51) reviewed for nutrition. This failure resulted in R51's severe weight loss of 10.12% in 6 months and R42's severe weight loss of 5.63% in 90 days.</p> <p>Findings include:</p> <p>1. R42's Face Sheet documents a diagnosis of Alzheimer's Disease, Dementia and Diabetes.</p> <p>R42's Minimum Data Set (MDS), dated 01/01/21, documents R42 requires supervision with staff assistance for eating.</p> <p>R42's MDS, dated 12/04/20, documents R42 has had a weight loss and is not on a physician prescribed weight loss regimen.</p> <p>R42's Care Plan, dated 05/14/20, documents R42 is at risk for alteration in nutrition related to cognitive impairment with an intervention to assist as needed with meals.</p> <p>R42's Physician Order Sheet documents orders for a mechanical soft diet and ensure 8 ounces twice daily.</p> <p>R42's weights are as follows: 11/03/20 - 132 lbs; 11/24/20 - 123 lbs; 12/14/20 - 130 lbs; 12/15/20 - 127 lbs; 12/23/20 - 123 lbs; 12/28/20 - 125 lbs.</p> <p>R42's Interdisciplinary Note, dated 11/24/20 at 11:11am, documents R42's weight is 123 lbs. Resident has been eating fair but, has had weight loss.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R42's Dietician Note, dated 12/03/20 at 1:33pm, documents the following: Current weight of 124 - shows a 6% loss for 1 month. Diet is regular, 60 milliliters of med pass daily just added as an intervention for weight loss. Encourage intake of meals and supplement.</p> <p>R42's Occupational Therapy note, dated 12/14/20, documents R42 requires supervision or touching assistance with a helper to provide verbal cues.</p> <p>R42's Speech Therapy Note, dated 12/15/20, documents R42 is at risk for weight loss due to a history of difficulty swallowing, resident is responsive to cues and staff should be available for assistance with cueing to maximize safe intake.</p> <p>On 01/20/21 at 8:31am, R42 was observed in the hallway, stating she is hungry.</p> <p>On 01/20/21 at 8:55am, R42 was observed in her room, feeding herself breakfast. R42 propelled herself away from the food several times during the observation and stated, she was hungry. No staff supervision or cueing was provided during observation. R42 consumed 25% of the sausage and 50% of the pancakes.</p> <p>On 01/20/21 at 9:37am, staff laid R42 down in bed and then took her breakfast tray without providing assistance with the meal.</p> <p>On 01/21/21 at 9:06am, R42 was in the hallway and stated, she was hungry and hasn't had breakfast. R42's breakfast tray was observed in her room on the bedside table. R42 consumed only a few bites. Staff did not provide supervision or cueing and took the tray without providing</p>	S9999		

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S9999	<p>Continued From page 4 assistance.</p> <p>On 01/26/21 at 11:50am, V2, Director of Nurses (DON), states R42 requires constant cueing with meals due to her Dementia.</p> <p>2. 01/19/21 12:45 PM, R51 was sitting in his wheelchair in his room with a plate containing a grilled cheese sandwich on the table in front of him. The sandwich had a few small bites taken out to the crust, but no full bites taken out of the sandwich. V8, Certified Nursing Assistant (CNA), was in R51's room sitting with his roommate who was done with his lunch as evidenced by paper napkin and utensils stacked on his plate. V8 stated R51 just needs verbal cues from staff and then he can feed himself. She stated to R51, "Pick up your sandwich and take a bite." R51 did not respond and did not pick up his sandwich off his plate. V8 stated R51 has good and bad days with eating. She did not offer hands on assist to help R51 eat, instead, she left the room.</p> <p>On 1/20/21 at 9:02 AM V7, CNA, was feeding R51 his breakfast. She stated R51 can do a little on his own when eating, but staff end up feeding him to ensure he finishes his meal.</p> <p>R51's weights for the past six months as documented in his Electronic Medical Record, (EMR), are as follows: July 18/2020 (168#); August 13/2020 (168#); no September weight was recorded; October 05/2020 ((160#); November 24/2020 (155#); December 23/2020 (153#); and January 04/2021 (151#) which indicated R51 had a 10.12% weight loss in 6 months and a 5.63% weight loss in 90 days.</p> <p>R51's Dietician Progress Note, dated 01/14/2021</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>at 10:56 AM documents, " Nutrition follow up regarding weight, (wt): January wt: 155# - stable x1 month readmit, noted a -13% loss x 3 months. Diet continues as No Added Salt, (NAS), Low Concentrated Sweets, (LCS), mechanical soft. Supplemented with 30ml prostat TID (45g PRO, 200kcal) for wound healing along with Vit c, and 60ml SF, (sugar free) med pass BID (240kcal). Resident continues with a pressure to coccyx: 2.6x0.5cm and a stage III to coccyx: 3.0x0.8cm. Continue with current plan of care. Will continue to monitor and follow up as needed.</p> <p>R51's Dietician Progress Note dated 12/07/2020 at 9:45 AM documents, "Nutrition assessment for readmission. Recent hospital stay for septic shock. Last wt: 155# - shows a -10% loss x 1 month, -8% loss x3 months. Diet restarted as LCS NAS, glucose well controlled. Diet is supplemented with 30ml prostat BID for wound healing, 60ml med pass daily now d/t recent wt loss. Resident continues with a stage III wound to coccyx. Recommend increasing med pass to BID. Please obtain a readmit wt. will monitor and follow up as needed.</p> <p>R51's Dietician Progress Note dated 11/19/2020 at 11:01 AM documents, "Nutrition follow up regarding skin. Resident has a new stage III to coccyx: 2.0x0.4cm. On Vit C, Zn. Diet is LCS NAS. Recommend to start 30ml prosource BID x 30days. RD (Registered Dietician) to monitor."</p> <p>Nursing Progress Notes: 12/23/2020 04:03 PM IDT: NAR Resident had a positive weight gain this week. Working with speech therapy. Feed assists by staff. Resident recently returned from hospital stay. Dietician to monitor for interventions.</p> <p>MDS dated 12/23/20 documents he is severely</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>cognitively impaired, requires extensive assist with bed mobility, transfers, personal hygiene and is dependent for dressing, toileting, and bathing, and supervision for eating. His pressure wounds to coccyx, and significant weight loss was not assessed on his MDS.</p> <p>R51's Care Plan documents: "PROBLEM: I am at risk for alteration in nutrition r/t wearing dentures, prefers not to eat breakfast. Dx: diabetes, GERD, Gastroparesis, Erosive Esophagitis, Hx: GI bleed and small bowel obstruction." There was no intervention to assist R51 to eat.</p> <p>01/26/21 at 9:10 AM V25, Speech Therapist, stated R51 had a bad UTI, (Urinary Tract Infection), a couple weeks ago and had a decline. She stated he refuses to wear his dentures but, tolerates a mechanical soft diet, but staff should sit with him during meals and give him constant cues to eat and help as needed.</p> <p>On 01/26/21 at 11:53 AM V2, Director of Nursing, stated she has been helping out on the floor, including feeding R51, and he requires physical assist to eat his meals. She stated the CNA should have sat down to help him eat his grilled cheese sandwich, not just given him verbal cues. She stated since he had COVID he has gone downhill physically and requires more help. She stated his care plan should be updated with his current status, including his need for assist with feeding and his indwelling urinary catheter should be care planned.</p> <p>The facility policy and procedure titled "Weight Assessment and Intervention", dated 09/2008, documents "The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month - 5%</p>	S9999		
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S9999	Continued From page 7  weight loss is significant; greater than 5% is severe. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: Cognitive or functional decline. Interventions for undesirable weight loss shall be based on careful consideration of the following: Functional factors that may inhibit independent eating".  (B)	S9999		