Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009237	A. BUILDING: _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

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S 000	Initial Comments Annual Licensure and Certification Survey An extended survey was conducted.	S 000		
S9999	Final Observations Annual Licensure and Certification Survey. STATEMENT OF LICENSURE VIOLATIONS 300.1010 h) 300.1630 d) 300.1630 e) 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. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be	S9999	Attachment A Statement of Licensure Violations	

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immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

These regulations were not met as evidenced by:

Based on interview and record review the facility failed to hold a medication used for behaviors when lethargy was present, failed to transcribe a physician's order related to medication administration for two months and failed to notify the physician of the resident's continued significant lethargy during this time. This failure affects one of one residents (R15) reviewed for death on the sample list of 27. This failure resulted in R15 having a significant weight loss and the development of three stage 3 facility acquired pressure ulcers due to continued untreated lethargy.

Finding include:

R15's Admission Assessment dated 1/12/21 at 8:50 AM written by V8 Registered Nurse documents R15 has an admitting diagnosis of Dementia with Behavioral Disturbances. This note documents R15 as weighing 184.2 pounds and documents skin as warm and dry with no excoriation, pressure areas of vascular ulcers.

R15's Nurse's Note dated 1/12/21 at 8:50 AM written by V8 documents R15 ambulates independently with verbal cues, wanders facility and needs redirection. This note documents R15

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S9999	Continued From page 2 appears well nourished. R15's 3 Day Weights sheet documents R15 weighed 195 pounds on 1/15/21. R15's Fall Risk Assessment dated 1/12/21 documents R15 does not have gait or balance problems and has not had a history of falls. R15's Pressure Ulcer Risk assessment dated 1/12/21 documents R15 is at moderate risk for the development of pressure ulcers. This assessment documents that R15 does not have pressure ulcers and has not had a history of pressure ulcers in the last 90 days. R15's Nursing Note dated 1/22/21 at 9:20 AM, documents R15 was sent to the hospital for a psychiatric evaluation due to physical aggression. R15's Social Service note dated 2/10/21 at 1:25 PM documents R15 was readmitted to the facility. This note documents, "(R15) arrived via stretcher. (R15) lethargic and responds to name by moving head towards speaker. Requiring (extensive) assist of 2 for all transfers. Totally dependent on staff for all ADLs (Activity of Daily Living) including meals." R15's Physician order sheet dated 2/10/21 documents orders for the following psychotropic medications Divalproex 125 milligrams (mg) 6 capsules by mouth twice a day, Divalproex 125 mg four capsules at noon, Gabapentin 100 mg at hours of sleep, Quetiapine 50 mg every morning, Quetiapine 100 mg every evening, Risperdal 1 mg twice at day, Risperdal 0.5 mg every day, Remeron 15 mg at hours of sleep, Trazodone 50 mg every evening, and Melatonin 10 mg at hour of sleep.	S9999		

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S9999	Continued From page 3 On 4/28/21 at 2:40 PM, V18 Licensed Practical Nurse stated when R15 was admitted(1/12/21), R15 was aggressive and would walk around. R15 was cognitively impaired. R15 could walk when R15 was first admitted but towards the end of R15's stay R15 could not walk at all. R15 was more lethargic towards the end of R15's stay and wouldn't eat much. After R15 was sent to the hospital and came back (2/10/21) R15 was more lethargic and couldn't do as much. R15's Physician Progress Notes dated 2/17/21 written by V24 Nurse Practitioner documents R15 is having, "(increased) lethargy, weak; (decreased) appetite, weight loss (10 pounds) just returned from geri-psych in Indiana." This note documents an order to check Valproic acid (Depakote) level, stop Melatonin and hold Depakote (Divalproex) if sleepy. R15's Physician Order sheet nor Medication Administration Record (MAR) for March and April of 2021 document the new order to hold Depakote if sleepy. R15's MAR does not document that R15's Divalproex was held after 2/22/21. R15's ADL flowsheet for March of 2021 documents R15 did not walk and required extensive assistance to total dependence of one to two staff for transfers, total dependence with bed mobility, dressing, eating, and toileting. R15's Physical Therapist Progress and Discharge Summary dated 3/17/21 documents under outcome that, "(R15) was unable to make progress in therapy due to multiple underlying conditions. (R15) presently requires total assist for all mobility tasks due to cognitive deficits."	S9999		

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S9999	Continued From page 4 This Summary also documents, "(R15) requires total assist and wheelchair for mobility." This note documents start of therapy as 2/17/21 and end of therapy as 3/17/21. R15's Occupational Therapy (OT) Plan of Care dated 2/22/21 documents, (R15) was referred to skilled OT after recent psych (psychiatric) hospitalization stay after choking a CNA (Certified Nursing Assistant) and resulting in sacral wound, weakness, balance, and endurance deficits, and three recent falls out of bed. R15's Occupational Therapist Progress and Discharge Summary dated 3/22/21 documents under outcome that, "(R15) discharging due to max potential achieved and plateau in progress due to various fatigue levels, alertness, command following, and aggression. (R15) will remain at this SNF (skilled nursing facility) with assist in all aspects of self care, transfers, positioning and use of high back reclining wheelchair for positioning." This note documents start of therapy as 2/22/21 and end of therapy as 3/22/21. R15's Monthly weight and vital sheets documents R15 weighed 188 pounds in January 2021, 172.8 pounds in February of 2021, and 159.2 pounds in March of 2021. R15's Dietary notes dated 4/14/21 documents R15's weight as 159.2 pounds and documents R15 is underweight and has had a significant weight loss of 8.4 % in thirty days. R15's wound evaluation and management summary written by V22 wound physician dated 2/18/21 documents an unstageable deep tissue injury of the coccyx caused from pressure measuring 3 centimeters by 4 centimeters and a stage two pressure wound of the right buttock caused from pressure measuring 1.2 centimeters by 1 centimeter. R15's wound evaluation and	S9999		

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management summary dated 3/4/21 documents R15 as having a stage 3 pressure ulcers to the sacrum measuring 2 by 1.5 centimeters by not measurable, stage 3 pressure ulcer to the right buttock measuring 2 by 1.5 by 0.1 centimeters and stage 3 pressure wound of the left buttock measuring 1 by 0.8 by not measurable. This summary documents a recommendation for a gel cushion to the chair.

On 4/29/21 at 2:00 PM, V26 Certified Nursing Assistant stated R15 could walk unassisted, feed self, and turn self in bed. V26 stated when R15 returned from the hospital (2/10/21) R15 was chair and bed bound. V26 stated R15 could no longer turn self in the bed. V26 stated when R15 would try to feed self R15 would miss R15's mouth. V26 stated R15 had to be fed but wouldn't eat much because R15 was too sleepy. V26 stated R15 slept a lot.

On 4/28/21 at 3:00 PM, V6 Care Plan Coordinator stated R15 was admitted to the facility on 1/12/21. R15 was ambulatory and had behaviors. R15 was not easily redirected. R15 began to be physically abusive to the staff so R15 was sent to a geriatric psychiatric facility for an evaluation. R15 returned to the facility on 2/10/21. R15 was more lethargic when R15 returned. R15 stated a couple days later they had a psychotropic meeting due to R15 being so lethargic from R15's medication. After that the physician was called and the nurse practitioner (V24) came in to see R15 on 2/17/21. V24 gave orders for labs and an order to hold the Divalproex if lethargic. V6 stated R15 remained lethargic. V6 stated R15 could not feed self and would not eat. V6 stated R15 wouldn't stay awake to eat. V6 stated R15 had a significant weight loss. V6 stated could not ambulate. V6 stated R15 ended up getting

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pressure ulcers due to R15's not getting up out of the chair and not eating. V6 stated the facility did not call to report that R15 continued to remain lethargic after R15 was initially seen on 2/17/21. V6 stated the order to hold the Divalproex if sleepy wasn't carried over onto the March and April 2021 physician orders or medication administration records.

On 4/29/21 at 9:20 AM, V24 Nurse Practitioner stated R15 was prescribed Divalproex for behaviors. V24 stated V24 gave the order to hold the Divalproex when R15 was sleepy/lethargic. V24 stated when V24 reviewed the medication list that V24 gave the order to hold the Divalproex because it is known to cause sleepiness. V24 stated R15 was seen by telehealth on 3/3/21 and was seen on 4/7/21 but the staff reported no concerns. V24 stated V24 would have expected the facility to hold the Divalproex when R15 was lethargic and would have expected them to call and report that R15 continued to be lethargic.

R15's psychotropic medication care plan dated 2/19/21 documents, "Observe for antipsychotic side effects: somnolence...Notify (physician) of noted side effects to determine if benefit of therapy outweigh the side effects."

The facility's Medication Administration Policy with a revision date of 11/18/17 documents, "18. Omit giving a medication if the resident has symptoms suggestive of an undesirable reaction to the drug and report your observations to the physician as soon as practicable."

(B)