STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S 000	Initial Comments Complaint Investigations 2262709/IL145487 2262522/IL145267	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 300.3240 a) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.1210 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. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to operationalize their policy regarding physician notification of changes in resident's	S9999		

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condition and recognizing when a resident needs emergent medical intervention. This failure resulted in R1 not receiving needed emergency medical treatment in a timely manner, despite, over the course of five and a half hours, R1 exhibiting a significant decline in physical status including frank red blood clots, coffee ground emesis, decrease in level of consciousness, increased assistance for transfer, and new onset inability to chew or swallow his food. R1 died of Hemorrhagic Shock secondary to a Mallory Weiss Tear(tear of the tissue of the lower esophagus). R1 is one of three residents (R1) reviewed for timely treatment in the sample list of seven.

Findings include:

R1's Physician Order Sheet (POS), dated February 2022, documents R1 was diagnosed with Atrial Fibrillation, Chronic Kidney Disease, Congestive Heart Failure, and Dementia. The same POS documents R1 was prescribed Eliquis (Anticoagulant) five milligram tablet two times per day for Atrial Fibrillation.

R1's Minimum Data Set (MDS), dated 2/17/22, documents R1 is cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13. The same MDS documents R1 requires supervision only for transfers, mobility in his room, and eating. The same MDS documents R1 requires partial assistance (less than half of the effort) from staff for toileting. The same MDS documents R1 has no impairment in range of motion for either upper or lower extremities and can stabilize himself during transitions and walking without staff assistance. The same MDS documents R1 does not require any mobility

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devices. The same MDS documents R1 is independent for self-care, indoor mobility, and functional cognition.

On 3/31/22 at 12:50 PM, V6, Certified Nurses Assistant (CNA), stated V6 was the CNA assigned to R1 on the morning of 2/17/22. On the morning of 2/17/22 at approximately 6:15 AM, V7, Housekeeper, notified V6 that V7 was walking by R1's room, and noticed R1 was lying on the floor by the bathroom door. V6, CNA, stated V6 went to get R1's nurse (V8, Registered Nurse/RN), and both V6 and V8 went into R1's room to assess R1, and help R1 off the floor. V6, CNA, stated when asked what R1 was trying to do, R1 replied R1 was trying to go to the bathroom and fell. V6 stated V6 and V8, RN, helped R1 into a wheelchair. V6 noticed R1 was swaying back and forth as R1 stood, and even while sitting in the chair. Vital signs were taken, and R1's blood pressure was low and R1's pulse was high (V6 could not remember what the actual values were). V6, CNA, stated R1 had a small skin tear on R1's left elbow. V6 stated V6 and V8, RN, helped R1 transfer to the toilet, and V6 noticed R1 required a lot more assistance than normal, and looked as though R1 was dizzy and weak, swaying back and forth, and R1 kind of slumped on the toilet and couldn't keep himself up right. R1 had a bowel movement, which V6 described as "all blood, bright red, with a lot of clots. The entire toilet was red." V6 stated R1 then began to throw up coffee ground emesis, and was not responding or talking like R1 normally did. V6 stated V8, RN, saw the bloody bowel movement and the emesis, and told V6 to continue to monitor R1. V6 stated both V6 and V8, RN, then transferred R1 into R1's bed. V8 dressed R1's skin tear, and both staff left the room. V6, CNA, stated V6 continued to check on V8 every once in

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awhile, and V6 noted R1 was becoming more and more lethargic, not talking, and overall did not look like R1 was feeling good. V6, CNA, stated V8, RN, instructed V6 to try to feed R1 breakfast. R1 could normally feed R1, however, when V6, CNA, tried to feed R1, R1 would not even chew or swallow R1's food, and would just hold it in R1's mouth. V6, CNA, stated V6 swept the food out of R1's mouth, and notified V8, RN, concerning this change of condition. V6, CNA, stated again V8, RN, told V6 to just keep monitoring R1. V6, CNA, stated R1 continued to decline after breakfast, and V6 was scared for R1's life, and stated V6 felt V8, RN, was not addressing R1's changes in condition, and R1 might become critical. V6, CNA, stated when V8, RN, went to lunch around 11:30 AM, V6, CNA, went to alert V3, Director of Nursing (DON), about R1's declining physical/mental condition. V3, DON, went to assess R1. V6, CNA stated R1 had vomited again, and it was red emesis. R1 was not very responsive. V3, DON, called 911 emergency medical services.

R1's Progress Note, dated 2/17/22 at 11:50 AM and written by V3, DON, documents the CNA (V6) notified V3 R1 was not acting per R1's regular self and was throwing up dark red emesis. R1 was not very responsive, blood pressure was 87/63 and emergency medical services were called. R1 was sent to the emergency room. V14, Nurse Practitioner, and V18, (R1's) Power of Attorney, were notified.

On 3/31/22 at 1:47 PM, V3, Director of Nursing, confirmed V3 was alerted around 11:30 AM on 2/17/22 by V6, CNA, that R1 had been physically/mentally declining, vomited red emesis, and V6 was concerned for R1's life. V3, DON, stated V3 went to assess R1 immediately, and

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found R1 with red emesis, very lethargic, and not responding verbally. R1's vital signs were taken, and R1's blood pressure was low (87/63). V3, DON, stated V3 felt R1 was critical, and called 911 right away. V3, DON, stated V3 then notified V14, Nurse Practitioner, about R1's status, and impending transfer to the hospital. V3, DON, confirmed if R1 had been showing signs of physical decline throughout the morning, his nurse (V8, RN) should have notified the physician, and provided R1 medical intervention, and/or transferred R1 to the emergency room much earlier. V3, DON, confirmed prior to 2/17/22, R1 was alert and oriented, could make R1's needs known, was continent of bowel and bladder, would take R1 to the bathroom, would feed R1, and was pretty independent with R1's personal care. V3 confirmed when V3 observed R1 at 11:30 AM on 2/17/22, R1 had a significant change of condition, and had declined to the point of it being an emergency.

On 3/31/22 at 4:00 PM, V8, Registered Nurse, confirmed V8 was R1's nurse on 2/17/22, and R1 did have a fall that occurred at the start of V8's shift around 6:15 AM. V8, RN, stated V8 assessed R1 at around 6:30 AM, and found the only injury R1 had from the fall was a skin tear to R1's left elbow. V8 confirmed V8 knew about R1's bloody stool and bloody emesis, and did not notify a medical provider concerning this abnormal finding. V8, RN, also stated V8 was aware R1 was requiring more assistance than normal, and V8 did not think too much of it because R1 had just fallen. V8, RN, stated R1 was not as alert as usual, and was declining throughout the morning, however, V8 did not notify R1's physician. V8, RN stated V8 was aware R1 normally fed R1, however, when V6, CNA, attempted to feed R1 breakfast on 2/17/22, R1 would not chew or

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swallow R1's food. V8 confirmed V8 told V6, CNA, to keep an eye on R1, and did not notify a medical provider of R1's new onset inability to chew or swallow. V8, RN, stated now V8 realizes V8 should have notified R1's medical provider of the changes of condition, and R1 should have been sent to the emergency room sooner than what R1 was.

On 4/4/22 at 10:50 AM, V14, Nurse Practitioner (NP), stated V14 was notified of R1's fall on 2/17/22, but not until around the same time (11:50 AM) she was notified of R1's transfer to the emergency room due to a significant change in condition. V14, NP, stated V14 expects to be notified of falls when they occur, and also expects to be notified of any resident's change in condition. V14, NP, confirmed prior to 2/17/22, R1 was alert and oriented, and could make R1's needs known. V14 confirmed V14 was never notified by V8, RN, about any of R1's changes in condition on the morning of 2/17/22. V14 stated V14 would have expected V8, RN, to notify V14 immediately if R1 was no longer able to stand or walk safely on R1's own, or if R1 could no longer eat on R1's own or wasn't able to chew or swallow R1's food. V14, NP, stated V14 should have been alerted when R1 had blood in R1's stool, or was vomiting bloody emesis, or when R1's blood pressure was low post fall. V14 confirmed R1 was on a anticoagulant medication, which increased his risk of bleeding complications.

R1's Hospital Provider's Note, dated 2/17/22, documents R1 arrived to the emergency department with hypotension, new onset seizure, stridor, a Hemoglobin of 3.9, large amount of bright red blood per rectum, and decreased level of consciousness. R1 was noted to be on Eliquis

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S9999	Continued From page 7 anticoagulant medication and reversal agents for blood thinners were started, and the massive transfusion protocol was started. R1 was intubated. R1 was admitted for Hypovolemic Shock, Gastrointestinal Bleed, and Seizures and transferred to the Intensive Care Unit. On 4/5/22 at 1:30 PM, V16, Hospitalist, stated R1 was received to the Emergency Department on 2/17/22 in critical condition. R1 was treated for a massive gastrointestinal (GI) bleed. V16 stated, "With any massive GI bleed, the sooner the patient is treated the better. If (R1) would have been treated sooner, it could have changed the outcome of his situation for the better. (R1) was on blood thinners, showed evidence of a GI bleed, had hypotension, and decreased level of consciousness. The sooner you get blood and fluids replaced for these patients the better chance you have of a positive outcome." V16 confirmed R1 died from Hemorrhagic Shock complications. On 4/5/22 at 1:40 PM, V17, Hospitalist, stated V17 completed the Death Certificate for R1. V17 confirmed R1's cause of death was Hemorrhagic Shock secondary to Mallory Weiss Tear (tear in esophagus that caused GI bleed). The facility Change of Condition Policy, dated 1/28/22, documents the nurse on duty will promptly notify the physician or physician representative upon changes in the resident's medical/mental condition. This would include an accident or incident involving the resident, changes in the resident's physical/emotional/mental condition, or a need to transfer the resident to a hospital/treatment center.	S9999		

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S9999	Continued From page 8 The facility Abuse Prevention Policy (August 2011) documents: "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion." The same policy states: "Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual." (A)	S9999		