STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	C 12/19/2016

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CITADEL CARE CENTER-KANKAKEE	**900 WEST RIVER PLACE KANKAKEE, IL 60901**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of Complaint Numbers: 1676921/IL90275 - F157, F309 cited and 1677031/IL90397 - F246 cited.	F 000		
F 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		1/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the physician of a resident's significant change of condition. This failure resulted in a delay in obtaining hospital treatment, a delay in stabilizing the resident's abnormally high blood pressure and resulted in seizures and admission to the intensive care unit. This applies to 1 of 3 residents (R1) reviewed for change of condition in the sample of 8. Findings include: On December 8, 2016, at 11:15 AM and 2:05 PM, E3 (RN) stated she was caring for R1 on November 26, 2016 on the day shift. E3 stated that she was new to the facility and not really familiar with R1's baseline. E3 stated that she learned in report that R1, who has some periods of confusion, had become more confused the	F 157		

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F 157	Continued From page 2	F 157		

night prior and had been up all night. R1's physician had been called the prior evening and labs were ordered which had been drawn, and results were pending. That morning, R1 was more difficult to arouse, but she took her morning medication. Her blood pressure was very high; E3 stated she thought it was around 191/76. E3 stated she documented this on R1's dialysis communication sheet but neglected to document it in R1's record in the computer. According to E3, R1 was groggy, but she put it down to R1 being up all night. E3 stated she did recognize that R1's blood pressure was high, and she went and looked at R1's blood pressure history and noted an occasional high reading at other times. When the transportation ambulance arrived somewhere around 10:30 AM or so, R1 was even less responsive; she would open her eyes to her name being called, but she was not speaking. E3 stated she did not call E2 (DON, Director of Nursing) (it was a Saturday and E2 was not in the building), nor did she call R1's physician; she stated she knew R1 was being transported by ambulance and if anything happened, could be taken to the hospital. E3 had the ambulance crew take her to dialysis.

Facility Weights and Vitals Summary Report for R1 from October 1, 2016 through November 8, 2016 reflects a range of blood pressure readings for R1. The lowest reading was 110/66. There were 3 abnormally high readings, one of 200/88 on October 20, 2016 and one of 198/84 and then 176/88, both on October 11, 2016. Most readings were in the normal range.

Nursing note dated November 26, 2016 authored by E3 timed at 1:15 PM as a late entry reads, "Resident confused with mild altered mental

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F 157	Continued From page 3	F 157		

status. Vitals WNL (within normal limits). Labs ordered, awaiting results. Upon dialysis transport arrival, resident appearing to have increased altered mental status." A note timed at 12:15 PM documents that R1 was sent out for dialysis and dialysis sent R1 to the hospital, where R1 was admitted.

At 1:30 PM on 12/8/16, Z3 (Patient Care Manager of Dialysis Unit) stated that when R1 arrived at their dialysis unit on November 26, 2016 she was unresponsive. Their dialysis staff did not feel that R1 was stable enough for her treatment and felt that she required evaluation in the hospital. Since the ambulance transport team was only a basic ambulance service, they put R1 in a dialysis chair and the dialysis staff called 911. According to Z3, R1's blood pressure on the transfer communication form from the facility was documented as 191/82. Z3 did not know what happened to the dialysis communication form, but thinks it went to the hospital with R1.

On December 8, 2016 at 2:55 PM, Z2 (Dispatch Manager for Ambulance Transport Company) stated she had spoken to her crew regarding the transfer of R1 to the dialysis center on November 26, 2016. The crew had concerns that the resident did not seem her usual self but the nurse had told them to take R1 to dialysis. Z2 stated that they provide basic transportation service, and the crew on November 26, 2016 consisted of an EMT (Emergency Medical Technician) and a medic.

Non-emergency Transport Form from transport company dated November 26, 2016 documents the following for R1: "crew dispatched for a 73 year-old female. Upon arrival patient not

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F 157	Continued From page 4	F 157		

responding to us. Nurse states she had an Ativan. We awoke her to have her fall back asleep. Told to bring her to dialysis anyway, so we monitored her en route. Turn care over to RNs." This form also shows R1's mental status to be "no verbal response"; R1 was noted to respond to pain.

Emergency Room (ER) Physician Documentation for R1 dated November 26, 2016 documents that R1's Blood Pressure upon arrival was 182/104. ER record notes that R1 was sent for normal dialysis treatment and found to be unresponsive. Ambulance personnel advised ER staff that upon their arrival at the facility, R1 was unresponsive. R1 was not able to answer questions. She was also noted to be "twitching". Upon re-evaluation, R1 was having jerking of her body intermittently and was not verbally responsive. Clinical Impression was Hypertensive encephalopathy with seizures, end-stage renal disease on hemodialysis, hyperkalemia and Leukocytosis. R1 received intravenous (IV) Keppra to control seizures as well as medication to lower her blood pressure. She was admitted to the intensive care unit. Consultation note of November 27, 2016 documents that R1's highest blood pressure reading thus far had been 242/121. On November 27, 2016, R1 was awake but not making eye contact nor speaking. The jerking movements were lessened, having responded to medication. The facility's Progress note of December 1, 2016 timed at 8:05 PM reflects R1 was re-admitted to the facility.

R1's Admission face sheet provides numerous diagnoses for R1 including end-stage renal disease, diabetes, hypertensive kidney disease, atrial fibrillation, chronic obstructive pulmonary disease; there is no diagnosis indicating a past

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F 157	Continued From page 5 history of seizures. On December 8, 2016 at 3:20 PM, Z1 (MD for R1) stated he was not contacted on November 26, 2016 regarding R1's elevated blood pressure. Z1 stated that he should have been contacted. Had he been contacted and told that R1 had such a high blood pressure and decreased responsiveness, he would not have sent her to dialysis. According to Z1, in that situation, he would err on the side of caution and have her evaluated in the hospital first. If the ER felt she was stable enough, she could go to dialysis later. Z1 stated that if she was alert enough to take oral medication, he may have ordered medication be given at the facility. On December 14, 2016 at 10:40 AM, E2 stated that when R1's blood pressure was very high on November 26, 2016 and she had decreased responsiveness, E3 should have contacted someone; she could have called me (E2), I am always available by phone, or she could have spoken to other staff more familiar with R1. E2 further stated E3 should have contacted R1's physician. Facility policy entitled "Functional Impairment-Clinical Protocol" was provided by E1 (Administrator) when asked for the facility policy on Change of Condition. This policy states that staff will monitor and discuss the resident's functional progress during therapy and in general; it does not address an acute change in a resident's condition, nor does it instruct nursing staff to notify the physician for a change in medical condition. It does not indicate what constitutes a change in condition. On December 15, 2016 at 12:05 PM, E1 stated that this was	F 157		

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F 157	Continued From page 6 their only policy on change of condition and agreed that it did not direct staff to call the physician for a change in medical condition. R1's current MAR (Medication Administration Record) reflects that R1 is now on Keppra 500 mg daily for seizures. Prior to this, R1's MAR did not reflect any medications for seizures. On December 15, 2016 at 12:00 Noon, E2 confirmed that R1 had not had seizures previously, and had returned from the hospital on Keppra.	F 157		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that call lights were answered in a timely manner. This applies to 3 of 4 residents (R4, R5, and R7) reviewed for call light response in the sample of 8. The findings include: On December 14, 2016 at 12:51PM call lights from two rooms on the west side of the building were ringing and the lights over the door were	F 246		1/6/17

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F 246	Continued From page 7	F 246		

flashing. The call light panel at the nurses station lit up to show which rooms initiated the call light. No staff were seen in corridor. Two nurses, E6 and E7, were seated at the nurses station in view of the call light panel and within the sound of the audible call lights ringing.

On December 14, 2016 at 12:57PM E7 walked through the corridor past the rooms with call lights sounding without stopping into the rooms or answering the call lights. A staff member went into one room at 12:58PM and the call light went off. The second call light was still ringing at 1:02PM when E7 returned walking down the corridor, and walked past the call light without stopping in the resident's room.

On December 14, 2016 at 1:07 PM E6 (Registered Nurse) explained the call light panel at the nurses station and noted the lights were lit denoting residents' call lights were active. E6 stated, "Everyone is to answer call lights. No one is to walk past a call light."
At 1:15PM, E7 stated, "anyone can answer a call light."

On December 14, 2016 at 1:25PM E1 (Administrator) stated, "Everyone, all staff, should be answering call lights, nurses too."

The facility presented the policy, "Answering the Call Light" dated December 2015.

R4, R5, and R7 were also reviewed for call light response time. They each verbalized concerns that the call lights are not answered promptly.

On December 19, 2016 at 3:00PM, R4 stated she knows staff have other residents to take care of,

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F 246	Continued From page 8 and stated she considers an appropriate time for response is ten minutes. R4 stated it can take 30 minutes or more for staff to respond to the call light. R4 stated that sometimes the staff answers the light quickly and says they will be back, "but you don't see them again." Review of the facility's call light log showed that on December 13, 2016 call lights on the day shift were answered at 17, 25, 36 and 54 minutes, and on the afternoon shift at 14 and 28 minutes. The call light log showed on December 18, 2016 night shift call lights were answered at 17 and 23 minutes.	F 246		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		1/6/17

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F 309	Continued From page 9 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to properly assess and seek immediate emergent care for a resident (R1) experiencing a significant change of condition. This failure resulted in a delay in obtaining hospital treatment, a delay in stabilizing the resident's abnormally high blood pressure and resulted in seizures and admission to the intensive care unit. This applies to 1 of 3 residents (R1) reviewed for change of condition in the sample of 8. Findings include: On December 8, 2016, at 11:15 AM and 2:05 PM, E3 (RN) stated she was caring for R1 on November 26, 2016 on the day shift. E3 stated that she was new to the facility and not really familiar with R1's baseline. E3 stated that she learned in report that R1, who has some periods of confusion, had become more confused the night prior and had been up all night. R1's	F 309		

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F 309	Continued From page 10	F 309		

physician had been called the prior evening and labs were ordered which had been drawn, and results were pending. That morning, R1 was more difficult to arouse, but she took her morning medication. Her blood pressure was very high; E3 stated she thought it was around 191/76. E3 stated she documented this on R1's dialysis communication sheet but neglected to document it in R1's record in the computer. According to E3, R1 was groggy, but she put it down to R1 being up all night. E3 stated she did recognize that R1's blood pressure was high, and she went and looked at R1's blood pressure history and noted an occasional high reading at other times. When the transportation ambulance arrived somewhere around 10:30 AM or so, R1 was even less responsive; she would open her eyes to her name being called, but she was not speaking. E3 stated she did not call E2 (DON, Director of Nursing) (it was a Saturday and E2 was not in the building), nor did she call R1's physician; she stated she knew R1 was being transported by ambulance and if anything happened, could be taken to the hospital. E3 had the ambulance crew take her to dialysis.

Facility Weights and Vitals Summary Report for R1 from October 1, 2016 through November 8, 2016 reflects a range of blood pressure readings for R1. The lowest reading was 110/66. There were 3 abnormally high readings, one of 200/88 on October 20, 2016 and one of 198/84 and then 176/88, both on October 11, 2016. Most readings were in the normal range.

Nursing note dated November 26, 2016 authored by E3 timed at 1:15 PM as a late entry reads, "Resident confused with mild altered mental status. Vitals WNL (within normal limits). Labs

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F 309	Continued From page 11	F 309		

ordered, awaiting results. Upon dialysis transport arrival, resident appearing to have increased altered mental status." A note timed at 12:15 PM documents that R1 was sent out for dialysis and dialysis sent R1 to the hospital, where R1 was admitted.

At 1:30 PM on 12/8/16, Z3 (Patient Care Manager of Dialysis Unit) stated that when R1 arrived at their dialysis unit on November 26, 2016 she was unresponsive. Their dialysis staff did not feel that R1 was stable enough for her treatment and felt that she required evaluation in the hospital. Since the ambulance transport team was only a basic ambulance service, they put R1 in a dialysis chair and the dialysis staff called 911. According to Z3, R1's blood pressure on the transfer communication form from the facility was documented as 191/82. Z3 did not know what happened to the dialysis communication form, but thinks it went to the hospital with R1.

On December 8, 2016 at 2:55 PM, Z2 (Dispatch Manager for Ambulance Transport Company) stated she had spoken to her crew regarding the transfer of R1 to the dialysis center on November 26, 2016. The crew had concerns that the resident did not seem her usual self but the nurse had told them to take R1 to dialysis. Z2 stated that they provide basic transportation service, and the crew on November 26, 2016 consisted of an EMT (Emergency Medical Technician) and a medic.

Non-emergency Transport Form from transport company dated November 26, 2016 documents the following for R1: "crew dispatched for a 73 year-old female. Upon arrival patient not responding to us. Nurse states she had an Ativan.

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F 309	Continued From page 12	F 309		

We awoke her to have her fall back asleep. Told to bring her to dialysis anyway, so we monitored her en route. Turn care over to RNs." This form also shows R1's mental status to be "no verbal response"; R1 was noted to respond to pain.

Emergency Room (ER) Physician Documentation for R1 dated November 26, 2016 documents that R1's Blood Pressure upon arrival was 182/104. ER record notes that R1 was sent for normal dialysis treatment and found to be unresponsive. Ambulance personnel advised ER staff that upon their arrival at the facility, R1 was unresponsive. R1 was not able to answer questions. She was also noted to be "twitching". Upon re-evaluation, R1 was having jerking of her body intermittently and was not verbally responsive. Clinical Impression was Hypertensive encephalopathy with seizures, end-stage renal disease on hemodialysis, hyperkalemia and Leukocytosis. R1 received intravenous (IV) Keppra to control seizures as well as medication to lower her blood pressure. She was admitted to the intensive care unit. Consultation note of November 27, 2016 documents that R1's highest blood pressure reading thus far had been 242/121. On November 27, 2016, R1 was awake but not making eye contact nor speaking. The jerking movements were lessened, having responded to medication. The facility's Progress note of December 1, 2016 timed at 8:05 PM reflects R1 was re-admitted to the facility.

R1's Admission face sheet provides numerous diagnoses for R1 including end-stage renal disease, diabetes, hypertensive kidney disease, atrial fibrillation, chronic obstructive pulmonary disease; there is no diagnosis indicating a past history of seizures.

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	145043	A. BUILDING _____ B. WING _____	C 12/19/2016

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(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) COMPLETION DATE
F 309	Continued From page 13 On December 8, 2016 at 3:20 PM, Z1 (MD for R1) stated he was not contacted on November 26, 2016 regarding R1's elevated blood pressure. Z1 stated that he should have been contacted. Had he been contacted and told that R1 had such a high blood pressure and decreased responsiveness, he would not have sent her to dialysis. According to Z1, in that situation, he would err on the side of caution and have her evaluated in the hospital first. If the ER felt she was stable enough, she could go to dialysis later. Z1 stated that if she was alert enough to take oral medication, he may have ordered medication be given at the facility. On December 14, 2016 at 10:40 AM, E2 stated that when R1's blood pressure was very high on November 26, 2016 and she had decreased responsiveness, E3 should have contacted someone; she could have called me (E2), I am always available by phone, or she could have spoken to other staff more familiar with R1. E2 further stated E3 should have contacted R1's physician. Facility policy entitled "Functional Impairment-Clinical Protocol" was provided by E1 (Administrator) when asked for the facility policy on Change of Condition. This policy states that staff will monitor and discuss the resident's functional progress during therapy and in general; it does not address an acute change in a resident's condition, nor does it instruct nursing staff to notify the physician for a change in medical condition. It does not indicate what constitutes a change in condition. On December 15, 2016 at 12:05 PM, E1 stated that this was their only policy on change of condition and	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	C 12/19/2016

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F 309	Continued From page 14 agreed that it did not direct staff to call the physician for a change in medical condition. R1's current MAR (Medication Administration Record) reflects that R1 is now on Keppra 500 mg daily for seizures. Prior to this, R1's MAR did not reflect any medications for seizures. On December 15, 2016 at 12:00 Noon, E2 confirmed that R1 had not had seizures previously, and had returned from the hospital on Keppra.	F 309		