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
	IL6008817	A. BUILDING: ______ B. WING ______	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST ANNE CENTER	4405 HIGHCREST ROAD ROCKFORD, IL 61107

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S 000	Initial Comments	S 000		
	Complaint Investigation #1912488\IL 111162 and IRI of 4/2/19 #IL 111220			
S9999	Final Observations	S9999		

Statement of Licensure Violations:

1 of 2

300.1210 d) 3)
300.3240 a)

Section 300.1210 General Requirements for Nursing and Personal Care
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 regulations were not met as evidenced by:

Based on interview and record review, the facility failed to send a resident for evaluation after the resident exhibited change in vital signs and level of consciousness. R2's condition continued to

Attachment A
Statement of Licensure Violations

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decline and the facility was unable to start IV fluids. R2 was not sent out for a period of about 4 hours after the directive to send her out was given. This failure contributed to a delay in treatment, and unecessary pain. R2 was admitted to the hospital with an acute kidney injury, dehydration , and sepsis.

Findings include:

On March 28, 2019, at 1:02PM, V19 OT (Occupational Therapist) entered a note into R2's chart which showed, "took patient back to room and set patient up for a toilet transfer when she started reaching for things that were not there, therapist pulled the call light and nurse and CNA (Certified Nursing Assistant) arrived at that time patient's eyes rolled back but did not go completely unresponsive, assisted CNA to return patient to bed and left patient in care of nursing and CNA."

On March 29, 2019 at 3:55 PM, a nursing note by V5 LPN (Licensed Practical Nurse) showed at 8:00 AM, R2 was awakened to get a set of vital signs. R2's pulse was 108, and described as "bounding", with a blood pressure of 90/50 ... "lethargic this a.m., appetite poor, unable to stay awake to take meds (medications), noted coarse crackles right upper lobe, unable to get patient to eat or drink." The note showed V17 NP (Nurse Practitioner) was contacted at 10:30 AM, and new orders were received to start intravenous fluids, and if they are not able to get IV access to call the NP back, and "will probably send to ER (emergency room)". The same note showed at 11:00 AM an RN (Registered Nurse) tried three times to get the IV access it but was not successful ... " ... Dtr (daughter) called nurse informed unable to get IV in. dtr (daughter)

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stated, send her out. Placed call to NP message left to call facility. At 12:30PM NP returned call stated, will be coming within the hour. ADON wanting to give pt (patient) more oral fluids and try to keep pt here and do what we can for her here (at the facility). At 14:30 (2:30 PM) patients daughter POA here requesting mother be sent out NP here patient going to [acute hospital ER] for evaluation and treatment."

On April 17, 2019 at 2:35 PM, V17 NP (Nurse Practitioner On-Call) stated she received only one call from the facility on March 29, 2019 at approximately 11:00 AM. V17 said during that phone call, she gave new orders to start IV fluids and if they could not get the IV started they should send R2 to the emergency room for evaluation. V17 said when she arrived at the facility on March 29, 2019 at approximately 3:00 PM to see another resident, she was very confused to hear R2 was still in the facility since they were unable to start the IV fluids. V17 said the facility was supposed to send R2 to the hospital if they were unable to start the IV.

On April 16, 2019 at 1:10 PM, V5 (LPN) stated she was working R2's hall on March 29, 2019, and started her shift at 6:00 AM. V5 said R2 was "kind of lethargic and couldn't stay awake. This was a change for her." V5 said she does not remember if she assessed the patient again after the initial assessment or if she took another set of vital signs after the first set at 8:00 AM. On April 17, 2019, at 12:35 PM, V5 said she called the nurse practitioner on March 29, 2019, because her assessment of R2 at 8:00 AM was concerning because of R2's bounding pulse and lethargy. V5 said she reported to V3 ADON (Assistant Director of Nursing) that they were unable to get the IV started, and V3 said to try

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and keep her in the facility. V5 said R2 had been having behaviors of "playing possum" during which she would say she was really tired and would slump her head forward and close her eyes like she was sleeping. V5 said on March 28, 2019 (the day before she was sent to the hospital) during a therapy session, R2 had a behavior of closing her eyes and tipping her head back and then down, because she didn't want to do therapy and wanted to go to bed. V5 said it is possible that R2 was requesting to go to bed all the time and refusing therapy sessions because she was actually sick.

R2's medical record showed no evidence of further assessments documented on R2 between the 8:00 AM assessment on March 29, 2019 and R2's transfer to the hospital at 3:55 PM.

On April 16, 2019, at 11:00 AM, V3 ADON (Assistant Director of Nursing) said on March 29, 2019, she was called down to R2's room because she was told R2 was lethargic, and unable to get out of bed. V3 said they were trying to start an IV when she arrived to the room but they could not get it started. V3 said, "I thought [R2] was out of it, but she was able to communicate yes and no." V3 said the nurses had tried to start the IV twice so she told them to, "maybe hydrate her first, give her water". V3 said after they tried the IV they wanted to send R2 to the hospital, but the nurse practitioner said to wait until she got there to send her out. V3 stated R2 should have been sent to the hospital when the change of condition was identified and the family requested.

On April 12, 2019, at 2:20 PM, V20 (R2's granddaughter) stated she had called the facility on March 29, 2019, to get a prescription for a wheelchair for R2's discharge home, when the

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nurse told her R2 was "unresponsive" because R2 is "just so tired." V20 said R2's daughter contacted the facility then, and requested R2 be sent to the acute care hospital for evaluation. V20 said the facility called back and said that R2 had "come to", so they thought she was going to be ok, at which time V20 said they requested again for R2 to go to the hospital. V20 said at about 3:30 PM, R2's Power of Attorney went to the facility and found R2 had still not been sent to the hospital, and did not have an IV. V20 said R2's Power of Attorney demanded a transport to the hospital at that time. V20 said when R2 was sent to the hospital they were told R2's kidneys had shut down due to sepsis.

R2's ambulance radio report dated March 29, 2019 at 4:15 PM, showed R2's chief complaint as fever and lethargy and R2's heart rate as 130 beats per minute. R2's acute care progress note entered by V24 (Hospitalist) on March 31, 2019, showed R2 was a skilled nursing home resident 6 weeks postoperative for a hip fracture admitted to the hospital with worsening confusion, acute kidney injury, dehydration, sepsis and a urinary tract infection who is moaning constantly and non-verbal. V24's assessment and plan with the same date of service of March 31, 2019, showed R2's active problems: acute kidney injury (baseline creatinine 0.8 - R2's creatinine 4 on admission), Sepsis on admission due to Urinary Tract Infection, Metabolic acidosis due to acute kidney injury, lactic acidosis and diarrhea, acute encephalopathy due to acute kidney injury, dehydration, and urinary tract infection.

R2's therapy note dated March 26, 2019 at 4:05 PM, entered by V19 (Occupational Therapist) showed, "attempted patient x 3 and patient stated she was ill and was not getting out of bed, nursing

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aware." R2's therapy note dated March 26, 2019 at 4:09 PM, entered by V21 PTA (Physical Therapy Assistant) showed, "attempted to see patient x 3. Patient was in bed every time she was checked on. Patient would be "whiny" and state she was not going to therapy." R2's therapy note entered on March 27, 2019 at 12:02PM entered by V19 showed, "Patient needed frequent rest breaks due to fatigue."

On April 17, 2019 at 12:00 PM, V19 (Occupational Therapist) said R2 was initially doing pretty well in therapy, but then she started wanting to stay in bed. R2 said on March 28, 2019 R2 had an episode during which her eyes rolled back and she appeared very dizzy. V19 said she knew that R2 was not feeling good for several days before the episode on March 28, 2019, because she was very tired, would verbalize she was not feeling well, and was coughing a lot.

R2's face sheet showed R2 was admitted on February 22, 2019, with diagnoses to include: displaced intertrochanteric fracture, hypertension, hypothyroidism, anxiety disorder, and pneumonia. R2's physical therapy plan of care dated February 22, 2019 showed under "Prior Residence and Living Arrangement, R2 "was independent with daily mobility and ADLS with no device and was driving."

R2's daily skilled note dated March 22, 2019, completed by V5 (LPN), showed R2 with frequent cough, fair appetite, and complaining of not feeling good today, wanting to go to bed. R2's daily skilled note dated March 23, 2019, and completed by V5, showed R2 was alert, had noted rhonchi in all lobes that clears with cough, good skin color, and a fair appetite. V5's March

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23, 2019 note showed R2 complained of frequent urination. R2's daily skilled note dated March 24, 2019, completed by V5, showed R2 on an antibiotic for upper respiratory infection, poor appetite, and resident with increased anxiety and confusion. R2's daily skilled note dated March 26, 2019, and completed by V5, showed R2 alert and confused, wanting to get into bed all the time. R2's occupational therapist progress and updated plan of care dated March 25, 2019 showed R2 was, "making slow progress in skilled OT (occupational therapy) however appears to be getting sick again with cough and weakness ..."

On April 17, 2019 at 1:00 PM, V2 DON (Director of Nursing) said she would expect any resident with a change of condition would be closely monitored with repeat vital signs and assessment. V2 said she does not know why R2 was not sent out either time the family requested, or when the order said to send to the hospital if the IV could not be started. V2 said the March 29, 2019 nursing note showed a concerning change of condition. V2 said after the 8:00 AM assessment of R2 there is no further assessments or vitals documented. V2 said when a resident has a change of condition, she would expect close monitoring, provider updates, and repeat vital signs. V2 said she would have expected to see further monitoring from the initial 8:00 AM assessment and the time that R2 was sent to the hospital at 3:55PM. V2 said she does not remember R2 having any behavioral concerns.

On April 17, 2019 at 10:18 AM, V16 RN (Registered Nurse) said when a resident experiences a change of condition, such as a change in vitals and change in level of mental status, we notify the nurse practitioner. V16 said

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they received an order to start an IV and were unable to get the IV started, he would call the provider back and see if they wanted the resident sent to the hospital.

On April 17, 2019 at 10:30 AM, V15 LPN (Licensed Practical Nurse) said a resident is considered to have a change of condition when they have a change to their level of consciousness, such as more confused or lethargic, or a change in a resident's vital signs.

The facility's Change in a Resident's Condition or Status policy with reviewed date of July 2018 showed the nurse will promptly notify the resident, his or her health care provider, and representative of changes in the resident's medical/mental condition and/or status. The same policy showed under the section Policy Interpretation and Implementation, "A. The nurse will notify the residents' health care provider or physician on call when there has been a ... 4. Significant change in the resident's physical/emotional/mental condition notify the residents' health care provider or physician on call when there has been a significant change in the resident's physical/emotional/mental condition ... 7. the need to transfer the resident to the hospital/treatment center ... B. A "significant change" of condition is a major decline or improvement in the resident's status that: 1. Will not normally resolve itself without intervention by associate or by implementing standard disease-related clinical interventions ..."

(B)

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300.1210 b)
300.1210 c)
300.1210 d) 6)
300.1220 b) 2)
300.1220 b) 3)
300.3240 a)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive

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assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow assessed safety needs for a resident when using a mechanical lift device, by not having two persons to assist with the transfer. This failure resulted in R1 sliding out of the mechanical lift sling, landing on the floor, hitting his head and breaking his neck on 4/2/19. R1 required hospitalization and subsequently expired.

Findings include:

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During this survey, R1 was unavailable for observation or interview, as R1 was discharged from the facility on 4/2/19, and died at the hospital on 4/5/19.

R1's undated Resident Care Guide was submitted by the Restorative Department as being his (R1's) current transfer plan. The document showed he requires a two assist with a mechanical lift.

The Nurse's Note dated 4/2/19 for R1 showed at 6:30 AM, the nurse was at the nurse's station by the medication cart and heard a call for help. The nurse went into the resident's room with two other nurses to find the resident on the floor at the base of the mechanical lift. V11, Certified Nursing Assistant (CNA), had the resident's head with pressure applied to the back of the head. The nurse noted a gash approximately 1 inch long. R1 was alert and talking to staff. V11 stayed with resident. At 6:40 AM, a call was placed to the ambulance company for transport to the emergency room (ER).

The facility's Final Report of Incident for R1 dated 4/5/19, showed R1 was alert with some confusion. R1 was dependent on staff for all activities of daily living, care, transfers, and used the full mechanical lift with assist of 1-2 for transfers. On 4/2/19, the CNA was assisting R1 out of bed to the chair with a full mechanical lift, and during the transfer R1 slid out of the sling to the floor. During the fall, he hit his head on the leg of the lift. R1 was sent to the ER and had a fracture of C4 & C5.

The Neurosurgeon Consult Note dated 4/2/19 for R1 showed, "Diagnostic data: Review of the

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computerized tomography scan of the cervical spine shows that he had a previous fusion at C3-4. There is a fracture at the level of the C4-5 interspace with displacement posteriorly of 8 mm, this is a highly unstable injury. Impression: The patient suffered a C4-5 fracture at the fall. This is in the context of extensive ankylosis of his spine and fracture dislocation is highly unstable. The family does not wish to have any aggressive treatment as this would usually be a surgical stabilization situation. The patient does not want to have surgery and he appears to have at least enough insight to make this determination. We will palliatively treat him in a collar, understanding that this may not heal and he could suffer additional neurologic injury."

The Trauma Surgeon's Summary of History and Hospital Course for R1 dated 4/5/19 showed, "The patient was admitted after a fall at his nursing facility. He sustained unstable fractures of the neck and was seen by trauma service and was admitted. The patient did not pass a swallow evaluation, due to wearing the hard collar to protect him from his neck injury. Patent had difficulty swallowing his own saliva and was intubated due to significant buildup of secretions. This was done at the direction of the son, who was temporarily out of the country. After the son returned to the country and evaluated his father's condition, the choice was made to proceed to place the patient under comfort measures and perform compassionate extubation. The extubation was performed and the patient was calmed (died)on 4/5/19 shortly after 5:00 PM. The patient's case was reviewed by the coroner, and the body released."

On 4/17/19 at 9:00AM, V14 (Trauma Surgeon) stated, "A hard collar was placed because of the

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C4-C5 fracture (neck fractures). The fractures to his neck were unstable at C4 & C5. The subsequent events like being unable to manage secretions, neck fractures and the collar led to him deteriorating and he needed to be intubated." V14 was asked if the fall lead to R1's death. V14 stated, "Yes, the fall resulted in a C4-C5 fracture. His death at that time could have been prevented if he had not fallen and had neck fractures. From what I understand he was in a mechanical lift in the nursing home; they are supposed to have ample people performing the lift because this is what could happen. In theory if there were enough people monitoring the lift and the patient then he would not have fallen out of the lift."

On 4/16/19 at 9:00AM, V2 (Director of Nursing - DON) stated, "R1 expired at the hospital from fall related issues. R1 used a full mechanical lift. Our policy says to use a lift per manufacturer's guidelines. I understand why it is strange for him to fall out if everything is right. R1 moved slowly because he is so stiff that sometimes his movements would not be noticed. The CNA was V11. The sling was not the one that comes up between his (R1's) legs. It was the one that covered him from head to mid thighs." V2 stated she did not do R1's assessment, so she was unsure if 1 person was appropriate for the transfer with the mechanical lift.

On 4/16/19 at 10:14AM, V4 (RN - Registered Nurse/Restorative Nurse) stated, "I came here in August, 2018, and have been restorative certified since 2015. R1 was contracted at the hip joints, knees, elbows, and shoulders. R1 was a total assist of two people for transfers; it was more appropriate to do with 2 people because he was contracted and it is safer. They use a mechanical lift that uses slings with loops; a full mechanical

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	IL6008817	A. BUILDING: ______ B. WING ______	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST ANNE CENTER	4405 HIGHCREST ROAD ROCKFORD, IL 61107

(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) COMPLETE DATE
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lift sling. Two people are needed to transfer R1 safely. R1 was assessed for two people before I even came here. I do and update the resident care guide and it shows the residents functional status. R1's current care guide shows that he (R1) was a transfer of two people and using a mechanical lift. I don't know where it is (Resident Care Guide); it was here in the restorative book. V13 (Restorative Aide) will have a copy. I would never have changed him to a 1 person assist no matter what; he was a two person assist with a mechanical lift. The resident care guide in a resident's room is the final restorative assessment. It's hard to get a sling under someone that is contracted; you need two people to do it correctly. If a resident is placed in a mechanical lift correctly then the resident should not fall out. This is what happens if it is not done safely; he fell out and now he is dead. V4 stated there are some reasons a resident can fall out of a mechanical lift. V4 stated it can happen if a sling loop is not hooked securely, if the sling is not centered under the resident. The sling needs to be at least under the resident to their knees because the sling can scoot up; it should never be just to the thigh area."

On 4/16/19 at 10:27AM, V13 (Restorative Aide) was asked by V4 (Restorative Nurse) if she had a copy of R1's Resident Care Guide. V13 stated, "Yes, I took the one off his door in his room." V13 pulled out R1's care guide and showed it to the surveyor. A copy was made and given to the surveyor. V4 and V13 confirmed it was the resident care guide that was current and being used for R1 prior to his hospitalization. The resident care guide for R1 showed he was a 2 assist with a mechanical lift.

On 4/16/19 at 2:34PM, V11 (CNA) stated, "It was

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a busy morning. There is a care plan on the inside of his closet door; I don't know what the care card for R1 said. He has been there since I started and I just go off of what I was trained to do. I am not aware of R1 being a two person assist. I transferred him; I mechanically lifted him up, the chair was under him. He had a padded wheelchair. I lowered R1 and he slid out of the front of the sling. I tried to catch him; he hit his head on the lift. He is always stiff and always in pain with everything. R1 said he just had pain. I held his head and neck and yelled for help."

On 4/16/19 at 12:58PM, V8 (CNA) stated, "There is a resident care guide form posted in the resident's closet. It shows everything on the patient like how they ambulate, transfer, continence, diet, and repositioning. I look at it when I go into a resident's room. When I use a mechanical lift I usually have someone with me in case something happens."

On 4/16/19 at 1:19PM, V9 (Licensed Practical Nurse - LPN/Nurse Manager) stated, "Staff come in and are oriented to all of the mechanical lifts. We tell them where to find the information on the care for the resident which is the resident care guide. They also have assignment sheets for the residents they are taking care of. Everyone should have a resident care guide to show how to provide care."

The facility's Mechanical Lift policy dated 11/2020 showed, "The use of mechanical equipment should be according to manufactures recommendations."

The undated mechanical lift manufacturer recommendations showed, "Make certain the patient you are about to lift has been assessed by

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the professional staff and approved to be lifted by the lift; Make sure you have sufficient staff to accomplish the procedure. Usually one person can perform the lift procedure with the lift. Certain patients; however, require the support of one or more additional staff members. This requirement must be recorded during the patient's assessment and communicated to the lifting staff."

R1's MDS dated 1/7/19 showed extensive assist of 1 person for transfers; this assessment conflicted with the resident care guide the staff were currently using for instruction this residents care.

R1's Care Plan dated 1/21/19, showed he was a full mechanical lift for transfers with the assist of 1-2 people; his care plan was changed on 4/2/19 and showed he should be a 2 assist for all transfers.

On 4/17/19 at 8:22AM, V22 (Registered Nurse - RN/MDS Care Plan Coordinator) stated, "A score for a resident under transfers that uses a mechanical lift should be a 4 - total dependence. The staff are being re-educated on completing the documentation and ensuring it is accurate. To do the care plan I look at the nurse's notes and minimum data set. I look at assessments by the restorative nurse and base the care plan on that and the MDS. I didn't look at R1's restorative assessment; I didn't know he was a 2 person assist. I didn't look at R1's care guide (restorative assessment) to see what the restorative nurse put in place. I didn't know the resident's care guide was part of the restorative assessment."

On 4/24/19, V4 (RN/Restorative Nurse) stated, "I did not have a quarterly restorative assessment

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for R1. I thought I had one but I can't find it. The resident care guide is what the CNA's follow and the resident care guide is a reflection of what the care plan should say. If activities of daily living don't capture the appropriate charting in a seven day look back period, you can't change the charting. The MDS is based on charting so it's not always an accurate reflection of the resident or for example of how they transfer. The accurate assessment of the resident is on the resident care guide; it's a reflection of my accurate assessment of the resident. I didn't update R1's care plan to show a 2 person assist. It said a 1-2 person assist on the care plan at the time this happened and it should have been a 2 person assist. I think the sling for him was too small."

(AA)