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
	IL6004907	A. BUILDING: ______ B. WING ______	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 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 300.1210 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 are not met as evidenced by:

Based on interview and record review, the facility failed to perform a complete neurological assessment after a head injury for 1 of 3 residents (R11) reviewed for quality of care in the sample of 48.
This failure resulted in a delay in the diagnosis and treatment of a brain bleed for R11.

Findings includes:

R11's Resident Progress Note, dated 11/24/2019 at 4:00 AM, documents, "Resident was found on the floor sitting in water (not urine). Bruising noted to her left side, left side of her head from hitting it on the bedside table on the way down. Swelling is also noted to her left hand."

R11's resident post fall investigation form, dated 11/24/2019, documents, "Resident stated she did hit her head so neuro checks were started."

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R11's November 2019 Physician Order Sheet documents R11 takes the blood thinners: Plavix 75 milligram (mg) daily, Aspirin 81 mg daily, and Eliquis 2.5 mg twice daily.

R11's Neurological (Neuro) Assessment, dated 11/24/2019 from 4:00 AM to 1:00 PM, showed incomplete documentation. The facility did not follow the Neurological Assessment key to indicate the assessment of and changes in R11's neurological status. The Neuro assessment provided by the facility did not document R11's pupil size, reaction to light, and the extremity assessment. R11's scheduled 3:00 PM assessment was blank documenting, "Out to ER (Emergency Room)" although R11's Resident progress notes, dated 11/24/2019 at 4:50 PM, indicates that R11 was in the building.

R11's Resident Progress notes, dated 11/24/19 at 4:50 PM, documents, "Husband in doorway looking into hallway, needing help. Resident has to use the bathroom. Attempted to transfer resident with left side arm flaccid and left leg not responding. Went out and got help. Two CNA's (Certified Nursing Assistants) and writer assisted resident to toilet, resident unable to keep her balance on toilet. Right wrist noted to be bruised with knot on it. Call placed to primary physician with physician on call asking for x-ray, per family's request. Writer not familiar with this resident, but CNA states this is a change for her."

R11's Resident Progress Notes, dated 11/24/2019 at 9:15 PM, documents, "Spoke with staff at local hospital and (R11) was transferred to (a Metropolitan Hospital) with the diagnosis of Cerebral Hemorrhage (brain bleed)."

R11's Nursing Home Follow Up from the Hospital,

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dated 12/6/2019, documents "Patient suffered a fall early Sunday morning on 11/24/2019. Family visited her that day and noticed she was more lethargic and was not as talkative as usual. Her husband fed her dinner that day and noticed food was falling out of her mouth. A CT (Computed Tomography) scan of the head showed a right intraparenchymal hemorrhage. Patient was noted to have left sided weakness and left facial droop. Lists head injury with intracranial hemorrhage -with unconsciousness of unspecified duration as part of assessment. Patient states she isn't doing well and is sore all over. Patient complains of back pain, constipation and headaches mostly behind her ears."

R11's CT Scan of her head, performed at local hospital on 11/24/2019, showed large acute intracranial hemorrhage of the right basal ganglia region. Bleed measures at least 4.3 x 3.0 cm (centimeter) in size. There is approximately 1 cm right to left sided shift of the brain.

On 3/2/20 at 10:10 AM, V12, CNA, stated , "(R11) used to ambulate 1 assist with walker. Toilet 1 assist. Now she is a mechanical lift since coming back from the hospital. We put her on the bed pan now. We don't take her to the bathroom. Before, we didn't put her walker in reach because we didn't want her to fall."

On 3/2/2020 at 3:00 PM, V21, Medical Director, stated, "I would expect the nurses to perform a complete assessment including the pupil size and reaction and extremities and document it. As this would have caught a change in condition."

On 3/2/2020 at 3:45 PM, V27, R11's husband, stated, "She had a bad fall and since then she can't do anything for herself. Her left arm has a

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lot of pain when its moved. She uses the machine to get up now. She can't sit in her recliner like she used to. She really liked that. They feed her or I do when I'm here. That fall was really bad. She lays in the bed and sleeps more. We came here together and she has to stay."

On 3/2/2020 at 4:03 PM, V2, Director of Nursing (DON), stated, "The Neuro checks are incomplete. They should be totally completed showing the pupil size and reaction and extremity assessment. Its done that way to make sure there is no injury to the resident and (to) find any neurological change in conditions. If the nurses would have completed the Neuro checks per the instructions above, then they would have noticed the change in condition before the evening."

3/3/2020 at 1:20 PM, V1, Administrator, stated, "That performing the assessment and finding the brain bleed early would decrease the injury."

https://www.mayoclinic.org/diseases-conditions/intracranial-hematoma/symptoms-causes/syc-20356145 documents, "An intracranial hematoma is a collection of blood within the skull, most commonly caused by rupture of a blood vessel within the brain or from trauma such as a car accident or fall. The blood collection can be within the brain tissue or underneath the skull, pressing on the brain.
Although some head injuries - such as one that causes only a brief lapse of consciousness (concussion) - can be minor, an intracranial hematoma is potentially life-threatening. It usually requires immediate treatment, often surgery to remove the blood." It also documents,
Symptoms- "You might develop signs and symptoms of an intracranial hematoma right after a blow to your head, or they may take weeks or

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longer to appear. You might seem fine after a head injury, a period called the lucid interval. However, with time, pressure on your brain increases, producing some or all of the following signs and symptoms: Increasing headache, Vomiting, Drowsiness and progressive loss of consciousness, Dizziness, Confusion, Unequal pupil size, Slurred speech.
As more blood fills your brain or the narrow space between your brain and skull, other signs and symptoms may become apparent, such as: Lethargy, Seizures, Unconsciousness."
It further documents, "Seek immediate medical attention after a blow to the head if you: Lose consciousness, Have a persistent headache, Have difficulties such as vomiting, weakness, blurred vision, unsteadiness.
If signs and symptoms aren't immediately evident after a blow to the head, watch for physical, mental and emotional changes. For example, if someone seems fine after a blow to the head and can talk but later becomes unconscious, seek immediate medical care." It continues, "If you're an older adult - especially if you're taking an anticoagulant or an antiplatelet drug, such as aspirin - even mild head trauma can cause a hematoma."

The Facility Falls Management, dated 2017, documents "It is the policy to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. If a fall is unwitnessed or resident has evidence of head injury, complete neurological assessment per protocol."

(B)

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300.610 a)
300.1060 c)
300.1060 d)
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 300.1060 Vaccinations
c) A facility shall provide or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated.
d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated.

Section 300.3240 Abuse and Neglect

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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:

Deficiency at this level requires two deficient practice statements.

A. Based on interview and record review, the facility failed to offer, re-evaluate the need, and monitor and track when pneumococcal vaccines are and can be given for 3 or 27 residents (R62, R13, and R42) reviewed for the pneumococcal vaccine in the sample of 48. This failure resulted in R62 going to the Emergency Room and being diagnosed with pneumonia.

B. Based on interview and record review, the facility failed to administer pneumococcal vaccines to 24 for 27 residents (R4, R7, R8, R9, R12, R14, R17, R18, R20, R22, R23, R36, R39, R40, R43, R54, R55, R56, R58, R59, R71, R72, R76, R77) reviewed for the pneumococcal vaccine in the sample of 48.

A. 1. R62's Face Sheet, not dated, documents R62 was admitted to the facility on 3/1/2015 and has a birthdate of 8/26/1935. R62's Diagnosis includes Cerebralvascular Accident (CVA), Dysphasia, Seizures, Pneumonia, Hemiplegia, Hypertension.

R62's Pneumococcal Vaccine record, dated 3/31/2016, documents Pneumococcal Vaccine was administered on 3/31/2016. The facility was not able to provide documentation that R62 was offered or received Prevnar 13.

R62's nurses notes, dated 1/30/20 at 1:16 AM,

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document, in part, resident had a change in condition, not responding to staff and was sent out to the local ER for evaluation and treatment.

R62's nurses notes, dated 1/30/2020 at 10:51 AM, document, "Resident returned at 8 am this morning. With new orders of Levaquin 750mg IV every Q 24hrs x7 days. Check comprehensive metabolic panel (CMP) this afternoon. 22 gauge needle in left hand."

R62's ER discharge records, dated 1/30/20, documents, in part, diagnosis of Nontraumatic Cerebralvascular accident-hemorragic infarct involving an unknown intracranial artery. Bacterial pneumonia. Hyperkalemia. Mild Hypernatremia. Chest X-Ray results document IMPRESSION: Opacity at the left lung base reflects pleural effusion, atelectasis, consolidation/pneumonia.

On 2/27/20 at 12:15 PM, V3, Assistant Director Of Nursing (ADON), stated, "(R62) never received the prevnar 13, or if she did we cannot find it."

A. 2. R13's hospital notes, dated 9/1/2019, documents that R13 's diagnosis of HCAP Healthcare Acquire Pneumonia (HCAP) was ruled out. R13's Patient Transfer Form, dated 9/6/2019, documents that R13 was administered Prevnar 13 vaccine 0.5cc conjugated on 9/2/2019 while at the hospital. The facility has no documentation in regards to R13's Pneumococcal vaccinations. The facility did not offer any pneumococcal vaccines.

R13's Face sheet, dated 9/6/2019, documents that R13 is 91 years old. R13's Face sheet documents that R13 primary admission to the facility due to pneumonia.

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A. 3. R42's Face Sheets documents that R42 was admitted to the facility on 1/8/2020. R42's records does not document that R42 was offered the pneumococcal immunization. R42's Face Sheet documents that R42 is 78 years old.

B. 23 residents (R4, R7, R8, R9, R12, R14, R17, R18, R20, R22, R23, R36, R39, R40, R43, R54, R56, R58, R59, R71, R72, R76, R77) or their guardians, signed consents to receive the pneumococcal pneumonia vaccine, of which, not one of the residents received the pneumococcal vaccine deemed appropriate for them depending on their immunization history.

On 2/26/2020 at 12:15PM, V2, DON, stated that she had delegated the immunizations to someone else. V2 stated that for any new admissions the consents were to be included in admission packet. V2 stated this process did not occur for new admissions.

On 3/02/2020 at 8:30AM, V2, Director of Nurses (DON), stated, "I am in charge of the immunization program at the facility. We ask resident, family, or if the resident came from the hospital, what pneumonia shot they got. We don't have a Vaccination Log at this time, but we are trying to get on track now. The past administrator, (V22) sent out a mass mailing of consents and vaccine information sheets (VIS) for the flu, and 02/03/2020 the consents came back. (V23, Secretary), just highlighted the residents who needed the flu vaccine and gave it to (V24, License Practical Nurse) who works night shift and she was going to start giving the flu shots. This is how the pneumonia vaccines got missed. Prior to that when there is a new resident being admitted, I assumed the floor nurses or

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admissions were asking if they (the resident) had received the flu and pneumonia vaccines and if the hadn't received it was offered." V2, DON, continued to state, "The education part for the pneumonia vaccine is on the consent form that they had received it."

On 03/03/2020 at 7:55 AM, V25, License Practical Nurse (LPN), stated that she does not know who or when residents need the pneumonia vaccine and has no idea on who takes care of it.

On 03/03/2020 at 8:00 AM, V26, LPN, stated, "The admission note should have it (pneumonia vaccine information) in it. Usually, when the paperwork is given to the department heads and they will let us know who needs the (pneumonia) vaccine."

The facility's Pneumococcal Vaccine Policy, dated 12/2016, documents, "It is the policy of Helia Healthcare that all residents are protected from incident of pneumonia by obtaining pneumococcal vaccines, if desired, per CDC (Centers for Disease Control and Prevention) guidelines." It continues to document, "Procedure: 1. Upon admission, the facility will attempt to determine when the last pneumococcal vaccine was received by the resident, if at all and whether the vaccine was a PCV13 (Prevnar) or a PPSV23 (Pneumovax). PCV13 is recommended for all adults 65 years or older, and people 6 years or older with certain risk factor. PPSV23 is recommended for all adults who are 65 years or older and for people 2 through 64 years old who are at high risk for pneumococcal disease. 2. Immunization information will be recorded on the Vaccination Log. 3. Before offering the resident pneumococcal vaccination, the resident or their

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legal guardian shall receive education about the benefits and potential side effects of the vaccination. 4. Each resident will be offered vaccination unless the immunization is medically contraindicated, has been refused or the resident has already been immunized. If the resident desires vaccination they must sign a Vaccination Authorization Form. 5. If the resident has never had a pneumococcal vaccine, and desires one, it will be administered by the nursing department and recorded on the Vaccination Log according to the schedule listed below. 6. If the resident cannot recall when they received the last dose and the facility is unable to determine this information from other sources, (medical records, family, etc.) and the resident desires the pneumococcal vaccine, it will be administered by the nursing department and recorded on the Vaccination Log according to the schedule below. 7. Documentation in the medical record shall include that the resident or the legal guardian was provided education regarding the benefits and potential side effects of the vaccination and that the resident received the immunization, it was medically contraindicated or refused."

According to CDC's Advisory Committee on Immunization Practices (ACIP), the following new recommendations were released June 26, 2019. PCV13 is a shared decision between residents and their provider, for all immunocompetent adults> 65 who have not previously received the vaccine. All adults > 65 should receive a dose of PPSV23 (Pneumovax 23). The two vaccines should not be co-administered but should be given at least 1 year apart."

Pneumococcal Pneumonia Guide, undated, documents, "NO vaccinations received. (Then) Adults 65 years of age or older who have not

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S9999	Continued From page 12 previously received any pneumococcal vaccines should receive PCV13 followed by a dose of PPSV23greater or equal to twelve months later. If a dose of PPSV23 cannot be given during this time window, it should be administered later. PCV13 and PPSV23 should not be administered on the same day. For some immunocompromised residents (See High Risk Pneumococcal Revaccination Guide) the PPSV23 should be given greater than 8 weeks after receiving the PCV13. UNCERTAIN if any vaccination was received. (Then) Adults 65 years of age or older who have not previously received any pneumococcal vaccines or whose previous history is unknown should receive a dose of PPSV23 greater or equal to twelve months later. For some immunocompromised residents (See High Risk Pneumococcal Revaccination Guide) the Pneumovax 23 should be given greater or equal to 8 weeks after receiving the Prevnar13. UNABLE TO DETERMINE if PCV13 or PPSV23 was received. (Then) Adults 65 years of age or older whose previous history of obtaining PCV13 or PPSV23 is unable to be determined should receive a dose of PCV 13 first, followed later by a dose of PPSV23 greater or equal to twelve months later. For some immunocompromised residents (See High Risk Pneumococcal Revaccination Guide) the Pneumovax 23 should be given greater or equal to 8 weeks after receiving the Prevnar13. RECEIVED PCV13 (Then) Adults 65 years of age or older that received a dose of PCV13 may receive a dose of PPSV23 greater or equal to twelve months later. If a dose of PPSV23 cannot be given during this time window, it should be administered later. RECEIVED PPSV23. (Then) Adults 65 years of age or older who have not received PCV13 and who have previously received one or more doses of PPSV23 should receive a dose of PCV13. The	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: ______ B. WING ______	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 dose of PCV13 should be given greater or equal to 1 year after receipt of the most recent PPSV23 dose. RECEIVED BOTH PCV13 & PPSV23. (Then) See attached table for those that meet the requirement for an additional vaccine. PCV13 = Prevnar13 PPSV23 = Pneumovax 23. Above are the recommendations of the Center for Disease Control (CDC) for all adults 65 years of age or older. For revaccination recommendations in high risk residents see table attached." Review of the Centers for Disease Control and Prevention (CDC) publication with a review date of 9/18/19 titled "Adults: Protect Yourself with Pneumococcal Vaccines" specified "Many adults may be at increased risk for pneumococcal disease...Two vaccines provide protection against this serious and sometimes deadly disease...Each year in the United States, pneumococcal disease kills thousands of adults. Thousands more end up in the hospital because of pneumococcal disease. It can cause severe infections of the lungs (pneumonia) blood steam (bacteremia) and lining of the brain and spinal cord (meningitis)...However, some can be deadly, especially for adults 65 years or older: Pneumococcal pneumonia kills about 1 in 20 older adults who get it (and) pneumococcal bacteremia kills about 1 in 6 older adults who get it. Vaccines are the best way to prevent pneumococcal disease...When the bacteria spread into other parts of the body, it can lead to (pneumonia, bacteremia, and meningitis). These illnesses can be deadly, especially for: Adults 65 years or older, people with chronic health conditions (and) people whose immune systems are weakened by disease or medicine (immunocompromised) ...Pneumococcal disease is contagious...Pneumococcal bacteria spread from person to person through coughing, sneezing, and close contact. People can carry the	S9999		

Illinois Department of Public Health

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S9999	Continued From page 14	S9999		

bacteria in their nose and throat without being sick and spread the bacteria to others..."

Review of the new immunization guidelines dated June 2019 TABLE 2. Policy options* for use of pneumococcal vaccines in adults aged 65 years presented for a vote and considerations by the Advisory Committee on Immunization Practices (ACIP), June 2019 revealed..." BOX. Considerations for shared clinical decision-making regarding use of 13- valent pneumococcal conjugate vaccine (PCV13) in adults aged 65 years PCV13 is a safe and effective vaccine for older adults...The remaining risk is a function of each individual patient's risk for exposure to PCV13 serotypes and the influence of underlying medical conditions on the patient's risk for developing pneumococcal disease if exposure occurs. The following adults aged 65 years are potentially at increased risk for exposure to PCV13 serotypes and might attain higher than average benefit from PCV13 vaccination, and providers/practices caring for many patients in these groups may consider regularly offering PCV13 to their patients aged 65 years who have not previously received PCV13: Persons residing in nursing homes or other long-term care facilities..."

(B)