STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 1	S9999		

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. Restorative measures shall include, at a minimum, the following procedures:

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 were not met as evidenced by:
Based on record review and interview the facility neglected to follow their policy on fluid watch, intake and output, physician notification of change in condition, and neglected to address a known swallowing difficulty for one of seven residents (R1) reviewed for hydration in the sample of seven. R1 became acutely ill with a decrease in appetite and fluid intake along with a diminished swallow over a nine day period and subsequently died. This failure has the potential to affect 30 residents (R2, and R5 - R33) identified as currently having acute illness with the potential for dehydration.

Findings include:
R1's Admission Record face sheet documents R1 was admitted to the facility on 12/12/14.
R1's local hospital Laboratory Report dated 1/31/15 documents R1's stool tested positive for C-diff (clostridium difficile) on 1/31/15.

The facility's Fluid Watch Policy dated 7/2/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 2	S9999		

documents the following: "...A resident will be assessed for dehydration by using the dehydration assessment form upon admission, with quarterly MDS (Minimum Data Set) assessments, and acute illness. If a resident is found to be at risk for dehydration they will placed on a fluid watch...the nurse is to assess the resident every shift to determine if hydration is adequate...Draw a Basic Metabolic Panel (BMP) in 5 days after fluid watch is initiated. Call physician with update after results of BMP is received..."

The facility's Intake and Output (I&O) Measurement Policy dated October 2010 documents the following: "If a resident is observed having very poor intake, place on I&O. If intake is less than 500 milliliters in a 24 hour period for 3 days, draw a Basic Metabolic Panel and notify the physician. Give a condition report, lab values, and document accordingly. Intake and Output is to be evaluated every 72 hours to determine adequacy. If not adequate or if output is greater that intake, the physician is to be notified and corrective action taken...Document physician's notification in the nurse's notes of the medical record..."

The facility's undated Significant Change policy documents, "...Nursing responsibility for a significant change: Notify family; Notify physician; Notify Director of Nursing..."

R1's dehydration care plan dated 12/31/14 documents the following, "(R1) at risk for dehydration..." This same care plan documents the intervention, "Complete dehydration assessment upon admission, readmission, quarterly, and when acute illness and/or signs and symptoms of dehydration are present..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 3	S9999		

R1's Dehydration Assessment form dated 12/24/14 documents that R1 had only one dehydration assessment completed, and this was completed on 12/24/14.

R1's Daily Skilled Nurses Notes document the following: On 2/9/15, "Remains on contact isolation for C-diff...appetite poor at lunch..." On 2/11/15, "...Appetite poor times two..." On 2/13/15, "...Administered 2 Tylenol...for fever...appetite remains poor...appetite poor. Resident encouraged to eat...Pale with sunken in cheeks and eyes..." On 2/14/15, "Refused breakfast and lunch...continues to refuse to eat states, 'I'm not hungry'..." On 2/15/15, "...Appetite poor at breakfast...Eating poor with minimal fluid intake. Skin pale, sunken in cheeks and eyes..." On 2/16/15, "...fluids encouraged. Appetite poor..." On 2/17/15, "(R1) refused to take morning medication...poor appetite...large liquid brown and foul-smelling stool. Involuntary. Poor appetite and fluid intake...poor appetite..." On 2/18/15, "...(R1) refused to eat supper or drink (R1's) supplement. Wants to stay in bed all the time..." On 2/19/15, nine days after onset of R1's symptoms, "...Condition report called to (Z1, R1's Physician) showing signs and symptoms of dehydration: skin tenting, dry flaky skin, weak, loose stools, poor food/fluid intake, complaining (R1) is 'sick'...requesting orders for labs, waiting for return call...(Z1) returned call. Orders received to send to (local Emergency Room) for evaluation..."

E2, Director of Nursing, verified that R1 was not monitored for I&O's from 2/1/15 - 2/16/15, although R1's Nurses Notes document decreased food and fluid intake during this time, and stated, "They (R1's I&O's) should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 4	S9999		

(monitored.)" E2 then verified that if the facility's I&O Policy was followed and a Basic Metabolic Panel was drawn as instructed in the policy, Z1, R1's Physician, would have been made aware of R1's change in condition at an earlier date, and could have addressed R1's condition more timely.

R1's Nurses Notes dated 2/4/15 document, "(R1) continues with clear phlegm and not swallowing, letting it run out of (R1's) mouth...(Z1) notified that it sounded like (R1) may have something caught in (R1's) throat..."

On 3/19/15 at 9:45 a.m., E5, Licensed Practical Nurse, stated that on 2/4/15, "It was like (R1) was drowning in (R1's) own saliva...(E5) thought that (E5) was going to have to suction (R1). (E5) thought that (R1) needed to go to the hospital. Typically, after an incident like this, speech therapy does an evaluation..."

On 3/18/15 at 12:33 p.m., E2, Director of Nursing, verified that R1 was not evaluated by speech therapy after the above incident occurred because, "it was a one time fluke episode that never happened before or after the incident..." On 3/19/15 at 1:00 p.m., E2, Director of Nursing, stated that the facility does not have a policy specific to when residents need to be evaluated by speech therapy. E2 then stated the facility has a referral form that the nurses fill out to refer a resident to be evaluated by therapy.

The facility's undated Nursing to Rehabilitation Notification Change in Functional Status form (undated) documents that a resident should be referred to be screened by therapy for the following change in conditions: "...Recent weight loss/diet change, and decline in eating ability..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 5	S9999		

R1's local hospital records dated 2/20/15 document the following: "...A bedside swallow was done which (R1) failed and had a video swallow which also showed poor initiation and aspiration...(R1) is very malnourished and dehydrated...Unfortunately, (R1) failed a swallow evaluation and so (R1) cannot have any oral intake at this time..."

On 3/19/15 at 10:20 a.m., E2, Director of Nursing, stated E2 would have expected the facility's nursing staff to notify (Z1, R1's Physician) of R1's decrease in food and fluid intake as documented on R1's Daily Skilled Nurses Notes dated 2/9/15 - 2/19/15.

On 3/17/15 at 3:06 p.m., E4, Licensed Practical Nurse, stated that R1 wasn't eating, drinking or taking medications like (R1) should, which began a few days after being placed in contact isolation precautions for C-diff, and E4 felt that R1 should have been sent to the hospital sooner.

R1's Local Hospital Records dated 2/19/15 document the following: "Disposition: Admit to (local hospital). Primary impression: Acute Renal Failure. Additional impressions: Dehydration, Acute Hypokalemia...History of Present Illness: (R1) is a pleasant 88-year-old female...who per (Z3, R1's family member)...has had a diagnosis of C-diff for approximately two weeks. (Z3) states that (R1) was being treated at the nursing home but was not getting better. (Z3) states that (R1's) oral intake got worse over the last two weeks... (Z3) states that (R1) continues to have diarrhea regardless of treatment and (R1) was sent to (local hospital) after (R1's) condition deteriorated significantly. On (R1's) arrival in the emergency room, (R1) was found to be cachectic, weak, dehydrated, and complaining that (R1's) mouth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 6	S9999		

hurts...Workup showed acute kidney injury. Creatinine of 2.9 and (R1's) baseline is between 1.0 and 1.3 and on 1/29/15, less than a month ago, (R1's) creatinine was actually 1.0..." These same records also document the following: "(R1) has dry mucous membranes...Assessment and Plan...Acute Kidney Injury. (R1's) baseline Creatinine is 1.0 and now close to 3.0 likely due to prolonged dehydration...normal range for blood urea nitrogen 7-18...normal range for creatinine 0.6-1.3..."

On 3/17/15 at 12:32 p.m., Z3, R1's family member, stated that R1 expired on 3/4/15, shortly after being discharged to another facility from (local hospital), and the cause of death was Acute Renal Failure. R1's Certificate of Death dated 3/4/15 documents R1's primary causes of death are as follows: "Acute Renal Failure, Deep Vein Thrombosis, and Clostridium Difficile infection."

On 3/20/15 at 11:00 a.m., E14, Medical Director, stated the facility's policies and procedures were not followed for R1, and E14 had no explanation why. E14 then stated that R1 had decreased fluid intake and was incontinent multiple times while at the facility, and the facility should have notified (Z1, R1's Physician) but E14 doesn't believe they did.

On 3/18/15 at 10:00 a.m., E2, Director of Nursing, stated, "(E2) called (Z1, R1's Physician) because (Z3, R1's family member) said that Z1 said that we (facility) were negligent, so (E2) called (Z1) and asked if (Z1) had said this and (Z1) said 'yes'. (Z1) said that (Z1) felt that nurses didn't know what they were looking at in regards to labs, monitoring intake, weight, and communicating amongst the nurses. (Z1) said that the nurses did not communicate to (Z1) a clear picture (of R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY NURSING	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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
S9999	Continued From page 7	S9999		

condition)...(Z1) said that when (R1) got to the hospital, (R1) had 'death labs' and (Z1) was surprised that (R1) was still alive..."

On 3/18/15 at 9:15 a.m., Z1, R1's Physician, verified that R1 was admitted to a local hospital on 2/19/15 with the following diagnoses: Acute Renal Failure and Dehydration. Z1 then stated, "(R1) could not swallow. (R1) was weak and never did recover...things were not going well for (R1) and it didn't necessarily have to happen this way...(Z1) spoke with (E2, Director of Nursing) about consistency with staff and better identifying when someone is getting sicker...(Z1) don't think they (facility staff) understood or recognized how sick (R1) was...the failure came from lack of consistent staff taking care of (R1). That is one thing that could have made a difference...(R1) was just too weak to swallow..." Z1 stated that Z1 was initially notified of R1's potential dehydration issues on 2/19/15, and gave an order for R1 to be transported to (local hospital) for evaluation. Z1 then stated that R1 had outpatient lab work obtained on 1/29/15 and at that time, R1's blood urea nitrogen level was 26, and creatinine was 1.0. Z1 then confirmed that R1's blood urea nitrogen level was 89, and creatinine was 2.9 upon arrival to the local emergency room on 2/19/15, indicative of acute renal failure and dehydration (normal range for blood urea nitrogen 7-18. ..normal range for creatinine 0.6-1.3).

On 3/20/15, E2, Director of Nursing, provided a list of residents identified as currently having acute illness and the potential for dehydration. This list includes the following residents: R2, and R5 - R33.

(AA)

POC F224 Prohibit Mistreatment/Neglect/Misappropriation

Corrective actions will be accomplished for those affected by the deficiency:

R2 and R5-R33 were found to be a high risk for dehydration because of acute illness. The nursing staff was in-serviced on signs and symptoms of dehydration. Each resident was determined to be low risk, moderate risk, or high risk for dehydration. Each resident will be assessed according to their level of risk.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents will have a dehydration assessment done using the revised dehydration risk assessment form. Each resident will be determined to be a low risk, moderate risk, or high risk for dehydration. Each resident will be assessed according to their level of risk for dehydration according to the newly revised intake and output policy.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.

The Intake and Output Policy was revised. The fluid watch was discontinued. All employees were in-serviced on dehydration and what their specific responsibilities were according to their job description. The Dehydration Risk Assessment form was revised and implemented. Intake and output sheets were revised. The nurses were in-serviced on assessment skills, the new forms, notifying families and physicians. A notification form for a physician was developed and implemented.

Quality Assurance Plans to monitor facility performance to make sure the corrections are achieved and permanent.

Quality Assurance is performed weekly on the hydration assessments and intake and output.

Quality Assurance will be performed weekly to monitor physician and family notification regarding a change in condition.

Dates when corrective action will be completed:

Completion date April 26, 2015

accepted

Attachment B
Imposed Plan of Correction

POC F327 Sufficient Fluid to Maintain Hydration

Corrective actions will be accomplished for those residents affected by the deficiency:

R1 was transferred to the hospital on February 19, 2015.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents that develop an acute illness will be placed on intake and output. These residents will be assessed every shift for signs and symptoms of dehydration. Physician will be notified and the family will be notified.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.

The Intake and output policy reviewed and revised. The fluid watch policy discontinued. All staff was in-serviced on their specific responsibilities regarding dehydration. Nursing was in-serviced on dehydration assessment and documentation. Dehydration risk assessment reviewed and revised. Intake and output documentation sheets reviewed and revised.

Quality Assurance Plans to monitor facility performance to make sure that the corrections are achieved and permanent.

Quality assurance for Intake and Output is performed weekly for 3 months

QA on all new admissions for Dehydration Risk Assessment will be on each new admission

QA will be performed on all quarterly dehydration assessments.

Dates when corrective action will be completed:

Completion date April 26, 2015

accepted

Attachment B
Imposed Plan of Correction