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
	IL6008718	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN REHAB & HCC	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS

300.610a)
300.1210b)
300.1220b)3)
300.3220f)
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 300.1210 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.

Attachment A
Statement of Licensure Violations

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Section 300.1220 Supervision of Nursing Services

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

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 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review, the facility

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failed to implement nutritional interventions recommended by the dietitian, failed to follow the facility policy for updating the nutritional care plan and failed to monitor a resident 's oral intake. This failure resulted in R1 sustaining a 12.25% weight loss over 6 months, and requiring hospitalization for dehydration, and protein-calorie malnutrition.
This applies to 1 of 3 (R1) residents reviewed for weight loss.
The findings include:

R1 is no longer in the facility. The physician's order sheet (POS) dated March 2015 showed R1 was a 72 year old woman with diagnoses of Parkinson's Disease, Psychosis and Dementia. R1's Minimum Data Set (MDS) dated 1/26/2015 showed R1 had unclear speech and sometimes understood others. R1's MDS also showed R1 required limited assistance with walking and eating. R1 required extensive assistance with bed mobility, transferring between surfaces, dressing, toileting, hygiene and bathing. R1 was incontinent of bladder and bowel.

The facility's Nursing Progress Review, dated 2/10/2015, showed R1 ate 50-74% of her meals and snacks in the last 7 days, and drank 50-74% of her fluids. The nursing progress review also showed R1 required her meals to be set up by staff and was able to eat with supervision only.

On 3/24/2015 at 2:05 p.m., E8 (CNA-Certified Nursing Assistant) said she sometimes fed R1 her meals if she was having trouble eating.

The facility's "Report of Monthly Weight" for R1 showed the following weights:

September 2014: 106 pounds (lbs.)

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October 2014: 106 lbs.
November 2014: 105 lbs.
December 2014: 101 lbs.
January 2015: 99 lbs.
February 2015: 97 lbs.
March 2015: 93 lbs.

R1 had a severe weight loss of 7.92% for the three month period of December 2014 to March 2015, and a severe weight loss of 12.25% for the six month period of September 2014 to March 2015.

Z2's (RD-Registered Dietician) dietary notes dated 12/28/2014 showed R1's weight of 101 lbs. and a body mass index of 18, "below standards." Z2 recommended "super cereal and whole milk." On 3/24/2015 at 2:00 p.m., E7 (Dietary Manager) said R1 never received the recommended super cereal or whole milk.

On 1/20/2015, Z2's dietary notes showed R1's weight of 99 lbs. Z2 recommended "60 milliliters (ml.) of MedPass (dietary supplement) three times a day." Z3 approved and signed the dietary order. R1's medication administration record and treatment records for the months of January, February and March 2015 showed R1 never received MedPass as ordered.

On 2/13/2015, Z2's dietary notes showed R1's ideal body weight was 110 lbs. and R1's weight was 97 lbs. Z2 again recommended "super cereal and whole milk." Z3 approved and signed the dietary order for super cereal at breakfast and changing menu milk to whole milk. On 3/24/2015 at 2:00 p.m., E7 (Dietary Manager) said R1 never received the recommended super cereal or whole milk. "Maybe it just skipped my mind. I have so much work to do and I forgot about it. Now I

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won't."

On 3/19/2015, Z2's dietary notes showed R1's weight of 93 lbs, and a body mass index of 17, "below standards." Z2 again recommended "60 ml. of MedPass three times a day." At the time the communication was written, R1 was in the hospital.

On 3/24/2015 at 11:42 a.m., Z2 (RD) said she was not aware her dietary recommendations had never been put in place. Z2 said each month she met with E1 (Administrator), E2 (DON-Director of Nursing) and E7 (Dietary Supervisor) to discuss her dietary recommendations. Z2 said it was her understanding the facility was ensuring all dietary recommendations were being initiated unless the physician declined the recommendations. Z2 said it was also her understanding the facility was following through on dietary recommendations that physicians never returned or signed.

The facility's Diet Listing sheets for the months of October 2014 through March 2015 showed residents' diet needs and supplements. R1's name was not on any of the Diet Listing sheets. R1's MedPass supplement, and super cereal and whole milk was not listed on any of the Diet Listing sheets for the aforementioned period. On 3/24/2015 at 12:38 p.m., E7 (Dietary Supervisor) said if the resident's name was not on the sheets, then the diet recommendations were never put in place.

R1's Food/Fluid Intake Sheets did not show any oral intake for supper or bedtime snack/fluids for the months of January 2015 and March 2015. After this investigation started and the facility provided the incomplete March 2015 Food/Fluid Intake Sheet, E3 (RN-MDS Coordinator) asked a

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nursing assistant on 3/24/2015 at 3:00 p.m., to fill out the food/fluid intake sheet. An unknown nursing assistant completed the form "from her memory" E3 said.

R1's care plan entitled "Potential risk for altered nutritional status and/or weight loss" was dated 1/29/2014 with a goal that R1 "will gain 1 pound per month for the next 90 days." R1's care plan showed: encourage self feeding, assist/feed at meal times as needed to complete meal, "follow recommendations of RD/LDN-notify RD/LDN of discrepancy of recommendation with Resident's preferences or care goals." R1's care plan was never updated to reflect her severe weight loss or any of the dietary recommendations.

On 3/24/2015 at 11:42 a.m., Z2 (RD) said she does not update the resident's care plans. Z2 said E7 (Dietary Manager) is responsible for updating the care plans regarding weights or interventions.

On 3/24/2014 at 12:38 p.m., E7 (Dietary Manager) said he does not update the resident's care plans. "It is not my job to update care plans, it is E3's (RN-MDS coordinator) responsibility."

On 3/24/2014 at 1:25 p.m., E3 (RN) said E7 (Dietary Manager) should be updating the resident's care plans with any dietary or weight issues.

Section K Swallowing/Nutritional Status of R1's Annual MDS dated 1/26/2015 was coded incorrectly. R1's MDS showed no weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, when, in fact, R1's weight in July 2014 was 111 pounds and R1's weight in January 2015 was 99 pounds, which

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was a 10.81% weight loss for the 6 month period.

On 3/12/2015 at 5:15 p.m., R1 was transferred to a local hospital. E5's (RN-Registered Nurse) Nursing Transfer/Discharge Assessment dated 3/12/2015 showed R1 "continued with fever 100.4 F (Fahrenheit) to 100.9 F since this A.M. Has poor appetite and not taking fluids at this time. Lethargic, but arousable to verbal and tactile stimuli."

Z4's (Hospital physician) consultation report dated 3/13/2015 showed R1 was admitted to the hospital with "severe dehydration, suspected urinary tract infection with fever and positive urine analysis, poor oral intake, hypernatremia, likely free water deficit, and protein-calorie malnutrition with a total protein of 5.9." R1 had a nasogastric tube placed in the emergency room, in order to "start free water at 200 ml. per hour, and tube feeding."

On 3/18/2015, Z3 (physician) documented R1 had a percutaneous gastrostomy tube inserted on 3/17/2015 to supplement oral nutrition.

On 3/24/2015 at 3:28 p.m., Z3 (physician) said he expected the facility to follow his orders for the MedPass, super cereal and whole milk. "It would be my expectation that the orders would be carried out." Z3 said he expected the facility to accurately document oral intake and urine output, and that the oral intake the facility staff tried to recall for the month of March would not be an accurate assessment of R1's actual intake. Z3 said R1 improved with hydration at the hospital.

The facility's policy entitled "Intake and Output" revised 12/2001 showed "C. After meals, CNA's document the amount of liquids, Jell-O, ice cream

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or liquids from soup, which the resident consumed in cc's on the daily assignment sheet, and/or report the total intake for your shift to your Charge Nurse.... D. The Charge Nurse will total all intakes for his/her shift and place in the separate columns on the Intake and Output record."

The facility's policy entitled "Resident Weight Monitoring" revised 10/2013 showed "11. Significant weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any trends of gradual weight loss or gain. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed."

300.610a)
300.1010h)
300.1210b)
300.1210d)3)
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.

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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 and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

On 3/30/2015 at 10:15 a.m., E2 (DON-Director of Nursing) said the last documented temperature for R1, prior to 3/12/2015, "was 96.8 F (Fahrenheit), sometime at the end of February 2015."

The facility's nurse's notes for R1 dated 3/12/2015 at 6:00 a.m., showed R1 was "noted to be lethargic and weak with a body temperature of 100.5 F", for which R1's physician was notified.

On 3/12/2015 at 7:00 a.m. the nurse's notes showed "cooling measures done. Resident remains lethargic, but responsive to verbal and tactile stimuli."

On 3/12/2015 at 12:00 p.m., the nurse's notes showed "Medical Doctor (MD) paged, awaiting reply. Will endorse for next shift to monitor and follow up."

On 3/12/2015 at 5:00 p.m., E5's (RN-registered nurse) nurse's notes for R1 showed "Resident continues with fever 100.4 - 100.9. Refusing to drink fluids. Lethargic but responsive. Z3 (physician) informed with new order to send out to local hospital. Temperature 100.5 F (axillary)." At 5:15 p.m., resident was transported to a local hospital via ambulance transport company.

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R1's "ADL (Activities of Daily Living) Flow Record" for 3/12/2015 lacked documentation to show R1 had any urine output for two consecutive nursing shifts.

On 3/12/2015 at 5:15 p.m., R1 was transferred to a local hospital. E5's (RN-Registered Nurse) Nursing Transfer/Discharge Assessment dated 3/12/2015 showed R1 "continued with fever 100.4 F (Fahrenheit) to 100.9 F since this A.M. Has poor appetite and not taking fluids at this time. Lethargic, but arousable to verbal and tactile stimuli."

Z4's (Hospital physician) consultation report dated 3/13/2015 showed R1 was admitted to the hospital with "severe dehydration, suspected urinary tract infection with fever and positive urine analysis, poor oral intake, hypernatremia, likely free water deficit." R1 had a nasogastric tube placed in the emergency room, to "start free water at 200 ml. per hour."

R1's CMP (blood chemistry) on admission to the hospital on 3/12/2015 showed an elevated BUN of 28 (normal 6-20 mg/dL), an elevated sodium level of 154 (normal range 136-145 mEq/L), and a potassium level of 3.4 (normal range (normal range 3.5-5.1 mEq/L).

On 3/24/2015 at 3:28 p.m., Z3 (physician) said R1 improved with hydration at the hospital. Z3 said he was not notified R1 had no urine output for two consecutive nursing shifts, and his expectation was that he be notified for any resident not urinating. Z3 said he expected the facility to promptly document oral intake after meals, and urine output each shift. Z3 said any oral intake or urine output documented at a later date could not be considered accurate.

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On 3/30/2015 at 11:15 a.m., E10 (CNA-Certified Nursing Assistant) said she cared for R1 on 3/12/2015 beginning at 2:00 p.m. E10 said R1's temperature was 100.3 F at 2:00 p.m., and R1 "was sweaty and barely moved during my shift." E10 said she only changed R1's diaper one time, close to the time of her transfer at 5:00 p.m., and the diaper had a scant amount of urine in it.

Z2's (RD-Registered Dietician) nutritional assessment dated 2/13/2015 showed R1's fluid needs were "1323 milliliters (ml.) daily. R1's current diet order was general diet with thin liquids.

Food/fluid intake sheets were reviewed for January 2015 through March 2015. Logs for January and March 2015 had spotty documentation. There was no documentation for oral/fluid intake for all evening meals and snacks for both January and March 2015. Documentation on R1's food/fluid intake sheet for the period of March 1 to March 11, 2015 showed R1 received between 360 ml. to 780 ml. of fluids daily.

R1's care plan entitled "Fluid Volume Deficit concern for Resident" dated 1/29/2014 showed the following interventions: "Monitor for signs of elevated temperature, observe for signs and symptoms of dehydration such as dry, cracked lips, tenting of skin, increased confusion, decreased urinary output, etc., monitor for fluids loss from fever, vomiting, diarrhea."

2.) During mealtime observation on 3/24/2015 at 12:15 p.m., R2 was being fed by E9 (CNA-Certified Nursing Assistant) in his room. R2 had one 180 ml. cup of water on his tray, covered with a clear plastic wrap. The diet card

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on R2's tray showed R2 was to receive 2% milk and apple juice with all meals. E9 said she did not know why there was no juice or milk on R2's lunch tray. R2 said it was not her job to put the milk and juice on R2's lunch tray prior to serving his meal, and she would not be obtaining any milk or juice for R2.

On 3/24/2015 at 12:38 p.m., E7 (Dietary Manager) said the kitchen is supposed to follow the diet card and R2 should receive 2% milk and apple juice with each meal. "I will have to talk to them about that."

The facility's policy entitled "Hydration Program", revised 2/2008, showed "4. Record the amount of fluids resident consumes at meals and any other specified times, on meal/fluid intake log."

The facility's policy entitled "Intake and Output" revised 12/2001 showed "C. After meals, CNA's document the amount of liquids, Jell-O, ice cream or liquids from soup, which the resident consumed in cc's on the daily assignment sheet, and/or report the total intake for your shift to your Charge Nurse.... D. The Charge Nurse will total all intakes for his/her shift and place in the separate columns on the Intake and Output record."

(B)