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	IL6007306	A. BUILDING: _____ B. WING _____	C 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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) 300.1210d)6) 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.	S9999		

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S9999	Continued From page 1 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: 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 300.3240 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 failed to notify the physician of a significant weight loss for one of three residents (R1) reviewed for hydration and weight loss in the sample of three. The facility knowingly failed to follow the plan of care and knowingly failed to follow their policy on	S9999		

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significant weight loss for one of three residents (R1) reviewed for falls and weight loss in the sample of three. R1 was not monitored according to the plan of care, fell, and subsequently developed a subdural hematoma. These failures resulted in R1 becoming acutely ill, and requiring hospitalization for Severe Dehydration and Hypernatremia (Increased Sodium Level).

Findings include:

The facility's Weight Policy dated 10-17-2014, documents a significant weight change is as follows: If being weighed weekly, a 2% (percent) in one week. 5% in one month. 7.5% or more in three months. 10% or more in six months. If a significant weight change persists, the doctor will be notified.

The facility's Change of Condition Policy and Procedure (date unknown) documents the nurse will notify the resident's attending physician or on-call physician when there has been a "significant change" in the resident's physical, emotional, or mental condition.

The Facility's Abuse Prevention Program policy dated 2012, documents that Neglect means the failure to provide, or willful withholding of, adequate medical care, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident.

The Facility's Quality Care Practice Fall policy dated 10-23-14, states, "To reduce the risk for resident falls, do not leave residents sitting in their rooms alone in a wheelchair or (high back)

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wheelchair."

R1's Physician Order Sheet (POS) dated 5-1-15 through 5-31-15, documents R1 has diagnoses of Subacute Dyskinesia and Protein-Calorie Malnutrition and receives a diet as NPO (nothing by mouth), Jevity 1.2 calorie supplement 360 ml (milliliter) five times a day via gastrostomy tube (g-tube), and flush the g-tube with 100 ml five times daily. R1's Physician Order Sheets from admission to the facility (2-17-15) through 5-8-15, do not include any new nutritional physician orders addressing R1's weight loss.

Clinical record for R1 documents that from 02/17/15 through 03/13/15 R1 experienced a 5%(percent) weight loss and from 02/17/15 through 04/09/15 R1 experienced a 7.5% weight loss. From 04/23/15 through 04/30/15 R1 experienced a 6.7% weight loss according to the same clinical record. This same record shows no documentation of R1 ' s attending physician being notified of the significant weight losses.

R1's Progress Notes dated 5-8-15 from 7:09 a.m. to 7:54 a.m., document R1's skin as pale and warm to touch, bowel sounds hypoactive, heart rate irregular, and a decreased pulse oximetry, requiring R1 to be sent to the emergency department.

R1's Hospital Emergency Department Notes dated 5-8-15 and signed by Z2 (R1's Emergency Department Attending Physician), document R1 was admitted to the Emergency Department with Severe Dehydration and Hypernatremia. R1's Complete Metabolic Panel lab dated 5-8-15, documents R1's sodium level at 147 (normal

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S9999	Continued From page 4 range 135-145). On 5-12-15 at 11:10 a.m., E2 (Director of Nursing) stated,"(R1's) significant weight loss of 134 pounds on 4-23-14 to 122 pounds on 5-17-15, has not been reported to the physician yet. We (facility staff) have our weight meetings monthly, but have not had a meeting this month. We (the facility) have not done any new nutritional interventions for (R1) since (R1's) admission in February." On 5-12-15 at 1:30 p.m., E3 (Dietary Manager) stated, "(R1) weighed 135 pounds in February and was 126.8 pounds in March. That was (R1's) first significant weight loss. On 5-7-15, (R1) had a significant weight loss of 10.3 percent from three months prior. I usually tell (E2/Director of Nursing) or (E7/Assistant Director of Nursing) when a resident has a significant weight loss, and they (E2 or E7) notify the physician. I have never notified the physician of (R1's) weight loss. (R1) has not had any new weight loss interventions since (R1's) significant weight losses in March 2015, and May 7th, 2015." On 5-12-15 at 2:15 p.m., E7 (Assistant Director of Nursing/ADON) stated, "I was off of work the week of 4-30-15, so I did not get (R1's) weight put into the computer system that week. (R1's) weight went from 134 pounds (week of 4-23-15) to 125 pounds (week of 4-30-15) in one week. If the weekly weight of 125 pounds was put into the computer on 4-30-15, we (facility staff) would have known (R1) had a significant weight loss in one week, and the physician, dietician, and family would have been notified, but were not. (R1's) weight the week of 4-23-15 of 134 pounds was a	S9999		

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re-admission weight from (R1) being in the hospital."

On 5-12-15 at 2:10 p.m., E6 (Certified Nursing Assistant/CNA) stated, "I took care of (R1) frequently. (R1) was very weak one week prior to hospitalization. (R1) seemed dehydrated. (R1) was always asking for food and water. (R1's) lips were cracking. (R1's) mouth was very dry. (R1's) tongue was very dry and had white film on it."

On 5-13-15 at 11:00 a.m., E9 (Licensed Practical Nurse) stated, "We (facility staff) would have to clean (R1's) tongue a lot, because it was so dry. (R1) always asked for drinks. (R1) was very pale."

On 5-13-15 at 11:30 a.m., Z2 (R1's Emergency Department Physician) stated, "When (R1) came to the emergency department on 5-8-15, (R1) looked like (R1) received poor care in general. (R1's) mouth was dry with lots of dried mucus. The staff (emergency department staff) had to remove lots of dried mucous from (R1's) mouth. (R1) had not been getting enough fluids. (R1's) sodium level was high even after getting fluids in the ambulance. I felt like (R1) was neglected, so I had the hospital make a report of elder neglect."

On 5-13-15 at 1:20 p.m., E7 (Assistant Director of Nursing) stated, "Weight meeting are held once a month, and this is when the physician is notified of weight loss. Whoever does the weight charting is responsible for notifying the physician. I did not do (R1's) weight charting or notify (R1's) physician of (R1's) weight loss."

On 5-14-15 at 10:40 a.m., Z4 (R1's Primary

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Physician) stated, "I have not been notified of (R1) having significant weight losses. I would have expected to be notified. Had I been notified, I would have increased (R1's) caloric intake and fluids. (R1's) dehydration could have been prevented. There is no reason a resident fed by a g-tube (gastrostomy tube) should become dehydrated or have a weight loss. Now that weights are on the facility's computer, I no longer see the residents' weight logs when I make rounds."

On 5-14-15 at 2:30 p.m., Z5 (Registered Dietician) stated, "(R1) had a significant weight loss from 4-23-15 to 4-30-15. The physician should be notified within 24 to 48 hours of the facility knowing of a weight loss."

On 5-14-15 at 1:00 p.m., E1 (Administrator) verified the facility should notify the physician immediately when a resident has a significant weight loss.

R1's Fall Plan of Care dated 2-19-15, documents a fall intervention dated 3-18-15 that staff are to try to keep R1 in an area to be monitored and supervised.

R1's Accident/Incident Report dated 3-30-15 at 8:33 p.m., documents R1 was observed on the floor in R1's room, with bleeding and a left eyebrow laceration measuring approximately two cm (centimeters) long. This same report documents that there were no witnesses to the fall, and R1 was sent to the hospital emergency department for evaluation where R1 was admitted with a diagnosis of a subdural hematoma.

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R1's Final Report Investigation dated 3-31-15 and signed by E2 (Director of Nursing), documents on 3-30-15 that E8 (Licensed Practical Nurse) had given E10 (Certified Nursing Assistant/CNA) instructions to place R1 at the nurses' station where R1 could be directly observed by the nursing staff due to R1's risk of falls. This same report documents E10 then took R1 to R1's room and placed R1 in a wheelchair with R1's feet propped up on the bed, resulting in R1's fall. This same report documents E10 was suspended from work on 3-31-15 to 4-2-15 due to E10's unsatisfactory performance.

R1's Emergency Department Notes dated 3-30-15 and signed by Z3 (Hospital Emergency Department Physician), documents R1 fell from a seated position in R1's wheelchair, at the facility, resulting in a left eyebrow laceration and a moderate sized subdural hematoma.

E10's Employee Warning Notice dated 3-31-15 and signed by E2, documents the following: E10 stated E10 left R1 alone in R1's room with R1's legs propped up on the bed. R1 fell and suffered a serious injury. R1 is a high risk for falls and had safety measures in place that were not followed. E10 is suspended from work from 3-31-15 to 4-2-15.

On 5-13-15 at 2:20 p.m., E10 (CNA) stated,"They (the facility) suspended me for taking (R1) to (R1's) room where (R1) sustained a fall on 3-30-15. The nurse had told me to leave (R1) at the nurses' station so the nurse could watch (R1), but the nurse was not there, so I took

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(R1) to (R1's) room. I propped (R1's) feet up on the bed. (R1) was antsy, fidgety, and wanted to get up prior to the fall. I was unable to calm (R1). I went up the hall from (R1), when (R1) fell in (R1's) room."

On 5-12-15 at 11:10 a.m., E2 (Director of Nursing) stated, "When (R1) fell on 3-18-15, the interventions were to keep (R1) some place where (R1) could be supervised and remind (R1) not to get up. (R1) should be somewhere we (the facility) can supervise (R1), anytime (R1) is up in the wheelchair. When (R1) fell on 3-30-15, (R1) was taken to (R1's) room. That is not what (E10/CNA) was suppose to do. (E10) had been given strict instructions per (E8/Licensed Practical Nurse) to put (R1) at the nurses' station, but (E10) took (R1) to (R1's) room unsupervised, and propped (R1's) feet up on the bed. That is not what (E10) was suppose to do. This resulted in (R1) falling in (R1's) room and sustaining a serious injury of a subdural hematoma. (E10) was suspended for an unsatisfactory performance. (E10) did not follow the direction of the nurse. (E10) knew (R1) was suppose to be placed at the nurses' desk, and was just told prior to (R1's) fall."

On 5-14-15 at 10:40 a.m., Z4 (R1's Primary Care Physician) verified that the facility should not have left R1 in R1's room unsupervised. Z4 stated, "I am big about safety of the residents."

On 5-12-15 at 2:10 p.m., E6 (Certified Nursing Assistant/CNA) stated, "I took care of (R1) frequently. (R1) was very weak one week prior to hospitalization. (R1) seemed dehydrated. (R1) was always asking for food and water. (R1's) lips

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were cracking. (R1's) mouth was very dry. (R1's) tongue was very dry and had white film on it."

On 5-13-15 at 11:00 a.m., E9 (Licensed Practical Nurse) stated, "We (facility staff) would have to clean (R1's) tongue a lot, because it was so dry. (R1) always asked for drinks. (R1) was very pale."

On 5-13-15 at 11:30 a.m., Z2 (R1's Emergency Department Physician) stated, "When (R1) came to the emergency department on 5-8-15, (R1) looked like (R1) received poor care in general. (R1's) mouth was dry with lots of dried mucus. The staff (emergency department staff) had to remove lots of dried mucous from (R1's) mouth. (R1) had not been getting enough fluids. (R1's) sodium level was high even after getting fluids in the ambulance. I felt like (R1) was neglected, so I had the hospital make a report of elder neglect."

On 5-14-15 at 10:40 a.m., Z4 (R1's Primary Physician) stated, "I have not been notified of (R1) having significant weight losses. I would have expected to be notified. Had I been notified, I would have increased (R1's) caloric intake and fluids. (R1's) dehydration could have been prevented. There is no reason a resident fed by a g-tube (gastrostomy tube) should become dehydrated or have a weight loss. That is neglectful. Now that weights are on the facility's computer, I no longer see the residents' weight logs when I make rounds."

(B)

300.610a)
300.1210b)

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S9999	Continued From page 10 300.3240a) 300.3240b) 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. 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) b) A facility employee or agent who becomes	S9999		

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aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview, and record review, the facility failed to notify the Administrator and investigate bruises of unknown origin, for one of three residents (R1) reviewed for abuse in the sample of three.

Findings include:

On 5-13-15 at 9:00 a.m., R1 was lying in a hospital bed. R1 had multiple bruises, measured by Z1 (Hospital Registered Nurse), in the following locations: Light purple bruising measuring approximately 4 cm (centimeters) by 2 cm under the right eye. Three purple/red bruises measuring 2 cm round to the right upper arm. Two purple/red bruises with one measuring 6.5 inches by 1 inch and one measuring 1 cm round to the left outer arm. Scattered purple/red bruises measuring approximately 1 cm round to the bilateral lower extremities.

On 5-13-15 at 9:00 a.m., R1 stated, "They (the facility staff) were rough with me there. I do not want to go back there (the facility)." R1 was unable to name the staff that was rough.

On 5-13-15 at 9:15 a.m., Z1 (Hospital Registered Nurse) stated, "I have worked with (R1) since the first night (5-8-15). When (R1) first came to the hospital, (R1) was non-verbal, tearful, and

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flinched when we (hospital staff) would go near (R1). (R1) had multiple bruises on admission. Since being at the hospital, (R1) had become better with caregivers."

On 5-13-15 at 11:30 a.m., Z2 (R1's Emergency Department Physician) stated, "(R1) came to the emergency room on 5-8-15 with bruising on the arms, legs, and shins. I am not sure what the cause of the bruising was from."

On 5-12-15 at 2:10 p.m., E6 (Certified Nursing Assistant) stated, "I took care of (R1) frequently. (R1) had bruises everywhere. (R1) had purple bruises on the chest area, arms, and legs. I reported the bruises to (E8/Licensed Practical Nurse). I am unsure how (R1) got the bruises. (R1) always had new bruises. I did not report any of the bruises to the Administrator, because I thought (E8) would do that."

On 5-12-15 at 2:35 p.m., E8 (Licensed Practical Nurse) stated, "I was never informed of (R1) having bruising to the chest or legs."

On 5-13-15 at 11:00 a.m., E9 (Licensed Practical Nurse) stated, "The bruise to (R1's) right eye was not real big. I am not sure what it was caused from. I did not notify the administrator or director of nursing of (R1) having a bruised eye. I just assumed (E2/Director of Nursing) knew about the bruised eye. (R1) always had bruising somewhere. I probably should have documented the bruises in the nurse's notes and notified (E2) of (R1's) bruises, but did not."

On 5-13-15 at 2:20 p.m., E10 (Certified Nursing Assistant) stated, "I worked with (R1) on 5-7-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007306	A. BUILDING: _____ B. WING _____	C 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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 13	S9999		

or 5-8-15. (R1) had a bruise on the right arm and right leg. I told the nurse (E8/Licensed Practical Nurse) and (E8) said, 'I am not sure where those came from?' I am unsure how (R1) got bruises. We (facility staff) report bruises to the nurses. We (facility staff) only document bruises if the nurse tells us to. They (the bruises) looked like fingertip bruises."

On 5-12-15 at 2:40 p.m., E1 (Administrator) stated, "If staff find bruises and there was not a fall, then we (the facility) should look at a possible allegation of abuse. (R1) could have had bruises from falls. The only bruises I see documented from (R1) falling are bruises to (R1's) head. Bruising should be documented in the nurse's notes. Bruises to the chest or legs should be investigated immediately, and an incident report should be done. No one has reported to me that (R1) had bruises within the last week that (R1) was here, so an abuse investigation has not been done." E1 verified that E1 has not done any bruise investigations regarding R1's bruises, since R1 was admitted to the facility on 2-17-15.

R1's Accident/Incident Reports from R1's admission to the facility on 2-17-15 to 5-8-15, indicate R1 has had 11 falls since admission on 2-17-15, with no documentation of (R1) receiving injuries/bruises from the falls to anywhere except the head.

The Facility's Abuse Prevention Program Policy dated 2012, documents the nursing staff is responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations, or other abnormalities as they occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the administrator. All incidents will be documented, whether or not abuse occurred. For any other incident or pattern involving "reasonable cause to suspect abuse, neglect, or misappropriation," the administrator will appoint a person to gather further facts prior to making a determination to conduct an abuse investigation. (B)	S9999		