STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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) 300.1210c)2)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 2) All treatments and procedures shall be administered as ordered by the physician. 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. (Section 2-107 of the Act) These Regulations are not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

Based on observation, interview, and record review, the Facility failed to provide timely assessessment and monitor for changes in condition for one resident (R10) reviewed for possible aspiration and pain. This failure resulted (R10) having a delay in hospitalization and treatment. R10 was admitted to a local emergency and subsequently to the Intensive Care Unit, with diagnoses of Hypotension, Sepsis, Hyperkalemia, Illeus, Vomiting, and Dehydration.

Findings include:

R10's Admission Sheet documents diagnoses in part of : History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

R10's Care Plan, dated 2/9/15, documents a Problem of "at risk for altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches / Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met."

The Care Plan - Pain, dated 2/9/15, documents; R10 is at risk for pain... Signs/ Symptoms of pain will be identified and pain interventions will be implemented immediately.

The Facility's Pain Management Monthly Flow Record documents on 4/13/2015 Day shift Pain Intensity = 8, Very Severe. Non - Verbal signs are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

#2, Tightly Closed, wide open, blinking eyes, #3, crying moaning, and #6, guarding an area of the body. Interventions included giving Vicodin 5/325, at 1:44 AM for "complaints of pain". Other interventions of turning and repositioning were documented as ineffective. For the day shift when pain was documented to be Very Severe, no other interventions drug or non-drug were documented. There is no documentation the Z3, (Physician) was notified of R10's pain.

On 4/14/2015 the Facility's Pain Management Monthly Flow Record documents Score = 6, Severe Pain. Non verbal signs of pain are #9, Irritability and #1, facial wrinkling, grimacing. Interventions included Ativan 0.5mg (milligrams) given for "constant yelling out / increased agitation." Non-drug interventions included turning and repositioning. There is no documentation of interventions on the day shift where it is documented R10 is in pain. There is no documentation Z3, (Physician), was notified of R10's pain.

On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10's gown. The green vomitus was on her bed linens, extending from R10's shoulder to her hip. During this time R10 smelled of feces. At 12:15pm, R10 remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown and she continued to smell of urine and stool. At 1:30pm, E6 (Certified Nurses Aide) was in her room and had just rolled her over and placed a mechanical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement.

On 4/16/15 the The Medication Administration record documents that R10 received Hydrocod/Acetaminophen 5/325 mg tablet at 1:10 PM for "complaints / hollering - "hurts". The pain management record does not document R10's having pain or the interventions.
Pain Management record and Nurse's notes for the day shift failed to document any information on R10's moaning / pain, or vomiting. The 4/16/15 Medication Administration Record has no documentation of medication given for R10's nausea and vomiting on this day.

On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10's feeding tube. The bottle was labeled "4/16/15, 2:30 AM, amount 5." R10's tube feeding pump was turned off until 5:05 PM with 850 cc remained in the bottle. Physicians orders dated 3/27/15 documented rate of 50 cc's per hour for 23 hours. Calculation of the flow rate from time of hanging at 2:30 AM, indicates there should have only been 300 cc's remaining in the bottle at 5:05 PM . At 5:05 PM, E18 turned on R10's tube feeding pump at a rate of 75 cc's per hour.

On 4/16/15 at 18:25 (6:25 PM), E3 (Assistant Director of Nursing) documented the discrepancy in the G-tube rates in her Nurses Notes. At this time she called Z3, to clarify orders, and documented "informed Z3, resident weight stable, no Nausea and Vomiting", orders received to resume tube feeding at rate prior to hospitalization, "that there is no harm done," will continue to monitor resident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 In a telephone interview on 4/28/15 at 3:22 PM, E36, Certified Nurses Assistant (CNA) stated "I did work with R10 on 4/16/15. R10 did have several, 2 -3 emesis of large amounts. I told E32, (Licensed Practical Nurse, LPN), about R10's emesis. I was told to keep the head of her bed elevated. At 1:30 I took R10 to the shower and cleaned her up. In a telephone interview on 4/28/15 at 3:50 PM, E32, (LPN), stated " I worked on day shift (6:30 Am to 2:30 PM) on 4/16/15, R10 did have 2 emesis. R10 has a history of vomiting (previously when she ate), and sometimes now with her G-Tube. I gave her the PRN (as needed) medication as ordered on her Medication Administration Record. No, I did not chart on this, as it was a busy day and I did not do it." A review of R10's PRN-Medication sign off record found no documentation that E32 on 4/16/15, had given any medication to R10 for her 2 episodes of vomiting. E32 also stated, "I did not tell anyone that R10 had vomited that day." In a previous interview on 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated R10's typical demeanor is she usually chats a sort of singing sound but no moaning nor groaning. E3 stated that on 4/16/15, she had not been told by E32 that R10 had vomited earlier on the day shift. Also, she (E3) had not assessed R10 when she wrote her Nurses Note that R10 "had not" vomited that day. E3, did not know if E18, (LPN/evening shift), had assessed R10, prior to her (E3's) calling Z3 on 4/16/15 and telling him E3 was "stable with no nausea/vomiting." E3, stated she would have expected the staff nurse to complete a physical assessment of the resident before calling the doctor, especially if vomiting was reported, but no nausea and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

vomiting had been reported from either day or evening shift.

On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 the night of 4/16/2015 - 4/17/15. E34 stated it had been reported to her at 5:00-5:15 AM, by E35, (CNA) that R10 had two emesis. I documented it at "06:25 AM, two emesis". E34, (RN), said she noticed the vomitus was brown and had assessed R10's bowel sounds and skin. E34, (RN) stated R10 didn't respond or make eye contact, which R10 usually did respond to others and did make eye contact. E34, RN then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

On 4/29/15 at 2:45 PM, Z3, (Physician on Call), stated; on 416/15, stated that he had been called for orders for R10's G-Tube feeding. At that time he had not been told R10 had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know. Z3, stated if he does not know if sending R10 to the hospital sooner would have changed her outcome, due to her multiple medical problems, but had he known of the nausea and vomiting, he would have admitted R10 to the hospital for fluids and evaluation, earlier that day. As it was, Z3 stated he was not called until 4/17/14 and told R10 had vomited.

On 4/29/15 at 3:35 PM, a telephone interview was conducted with E1- (Administrator), E2 - (Director of Nursing), and E30, (Regional Nurse). E30 stated, "it was normal for R10 to have emesis, and staff would not have called the physician as it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

was not seen as a change in R10's condition. E1 stated, Z5 (Primary Physician), "would not" have wanted to be called for vomiting as it was normal for her to vomit at times. When informed of R10's observed condition on 4/16/15 of moaning, and laying in vomit, E1, E2 and E30 stated they were not aware of this, and would check with their staff. E1, E2, and E30 stated they were not aware of R10 having documented pain for 2 days prior to 4/16/15. E1, E2, E30 stated they were not aware E32 had not documented R10's episodes of vomiting or that she had given R10 PRN medications for vomiting. They stated that they were also not aware that on 4/16/15, E32 had not told any staff either verbally or in writing of R10's vomiting and moaning multiple times that day. E2 stated "we will have to address that internally." E1, E2, and E3 stated "they would review R10's record and talk to staff to find out why, (if R10 routinely vomited), there was no record of nursing staff giving PRN-anti-nausea medications documented in the Medication Administration Record of R10 for the months of March 2015 and April 2015."

On 4/29/15 at 4:20 PM, Z5, (Primary Physician of R10), stated "R10 did have a history of Nausea and Vomiting, but R10 also has a history of vomiting when she has a UTI (urinary tract infection) that is becoming septic. Z5, stated, the facility should have been aware of the history of R10's UTI's and vomiting. As R10 does have PRN (as needed) medications for vomiting, but it would only be normal if it was a one time spontaneous event. However, if she had vomited two or three times already I (Z5) would want to know she had vomitied to rule out possible issues of being septic or other problems due to her history of gastroparesis." Z5, stated, "because R10 had multiple medical issues, it is better if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 8 staff called the physician and informed them of the nausea, vomiting, and pain, and let the physician determine if this was something that needed to be addressed or not. If R10 was having nausea, vomiting, and pain, it would indicated something was wrong and probably needed to be seen by the physician. In the case of R10 on 4/16/15, she could have been sent to the hospital sooner, and treatments, surgical options or Hospice could have been discussed and offered to the family." The Facility policy Change in Condition / Notification dated 2/23/09, documented; It is the responsibility of licensed staff to contact the physician and resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definition: 1. A change in condition is any assessment finding, observance, or event that deviates or has the potential to cause a deviation in the resident's usual or expected physical, mental or psychosocial status. Policy: Upon identification of a change in condition licensed nursing personnel will contact the resident's physician to notify him / her of the change. All notifications should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. Examples of Changes in Condition: (include but not limited to) Emesis or Diarrhea, Symptoms of an Infectious Process with or without fever, Abnormal reports of Pain, Subjective reports made by the resident "I don't feel good, something is wrong", contact physician after thorough physical and mental assessment. (A)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 9	S9999		

300.610a)
300.1010h)
300.1210b)
300.1210c)1)2)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 10 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 11 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 observation, interview, and record review, the Facility failed to provide timely monitoring and ensure food intake met the required amount as ordered by the physician for 4 residents (R3, R10, R12, & R19) with Gastrostomy Tubes (G-Tubes) observed for adequate hydration, nutrition and weight loss. This failure resulted in significant weight losses for R3, R19, and R10 and R19 being admitted to the hospital with a diagnoses in part of dehydration. Findings include: 1. The MDS dated 3/19/15 documents R19 was readmitted to the facility on 3/25/15 following a hospitalization for Dehydration, Dysphasia, Constipation and Urinary Tract infection in part. The MDS documents R19 to have moderate cognitive impairment and requires total assistance of staff for all activities of daily living. The care plan dated 3/3/15 identifies the tube feeding and includes interventions that all R19's calories and fluid needs will be met by 6/3/15 and staff are to monitor for signs/symptoms of dehydration, report problems to nurse.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 12	S9999		

The monthly weight record, documents R19's January 2015 weight was 157.6 pounds. Registered Dietician (RD) notes dated 2/24/15 document that R19 went from an oral feed and tube feeding to NPO (nothing by mouth.) R19 was totally dependent on his tube feeding to supply all his fluid and nutritional needs prior to his hospitalization in March.

An RD note dated 3/24/15 document for the month 3/2015 R19's weight was 148.2 pounds. This is 5% decrease in 1 month, 7% decrease in 3 months, 9% in 6 months. An order was given for Glucerna 1.2 to be given at 70cc/hour for 21 hours per day, at total of 1470cc/day.

The Nurses Notes of 4/09/15 at 2:15pm, document R19 weighed 142.4 pounds. This is a 5.2% weight loss despite the fact that he receives all his nutritional needs from his tube feeding. The Nurses Notes dated 4/9/15 document that the RD was called due to weight loss and the tube feeding was increased to Glucerna 1.5 70cc/hour with 200cc every 4 hours water flush.

The April Physician's Order Sheet (POS) includes a Gastrostomy Tube (G-tube) feeding dated 4/9/15 to be Glucerna 1.5 cal at 70cc (centimeter) an hour for 21 hours (1470cc total), and water flushes of 200cc every 4 hours. The POS also documents R19 takes Dilantin and has the tube feeding turned off one hour before and after the doses of Dilantin are given at 6:00 AM and 6:00 PM.

The Nurses Notes on 4/17/15 at 9:18 AM documents; R19 is up in the reclining chair with tube feeding infusing well. On 4/18/15 at 2:15PM, the nurse documents R19 to have an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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		

elevated temperature of 100.5 axillary with clear urine draining from his urinary catheter. At 3:55PM, the physician's office calls and a U/A (urinalysis) was ordered with a culture and sensitivity. At 5:50pm, the nurses notes document R19 having "no eye focusing, mouth breathing. Skin cool to touch. Facial perspirations noted. Moans out at intervals at this time" Blood pressure 102/58, Temperatures 101.4 axillary, pulse 116, and respirations 16. The physician was called again and R19 was sent to the emergency room. The Nurses Notes documents At 6:58PM, R19 was sent to the hospital. At 10:35PM, the hospital called and R19 was admitted to the Intensive Care Unit. Emergency Room hospital records dated 4/19/15 document R19 to have "pale and dry mucosa" with current problems listed as "Septic Shock, Acute Urinary Tract Infection, Dehydration, Acute/Chronic renal failure, Hyperkalemia, and Acute Hypernatremia."

The April 2015 Medication Administration Record (MAR) shows all flushes and feedings initialed by nursing staff for all three shifts. However, the Fluid Intake and Output Record which documents the G-tube feeding amounts actually administered are incomplete for the month of April, 2015. No 24 hour amount was calculated to ensure that R19 is receiving the ordered amount of feeding. Based on 70cc/hour for 21 hours, R19 should be receiving 490cc per shift or 1470cc per 21 hours. The Intake records document on 4/18/15 for day shift (6:30am-2:30pm) that R19 received 477 cc of tube feeding and on 2nd shift (2:30pm to 10:30pm), he was documented as receiving 376cc. Nothing is recorded for the night shift, for a total of 853cc/24 hours. On 4/17/15, day shift is blank, 2nd shift - 417, and 3rd shift, 329cc, totaling 746cc/24 hours. On 4/15, 1st shift is documented as 560cc, 2nd as 420, and 3rd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 14	S9999		

914cc for a total of 1894cc. The facility was unable to provide the week prior to 4/15/15 and only three weeks of intake records for March were provided and those were incomplete. There is no evidence that the facility assessed R19 to determine a causative factor as to why R19 would present to the hospital with dehydration on his readmission to the hospital in April. There is no documentation in regards to any assessments being done or evidence that nurses closely monitored R19's feeding to ensure his nutritional and hydration needs were met.

On 4/22/15 at 11am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. E2 stated she was unable to determine why R19 would have dehydration if he received all his feedings and flushes. E20 when asked if she expected the nurses to follow orders and administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them."

2. The MDS dated 2/9/15 identifies R3, as being admitted to the facility on 1/31/15 with diagnoses in part of; Pagets Disease and Reflux. The MDS documents R3 requires extensive assist of one staff for most activities of daily living and has severe cognitive impairment.

According to the February 2015 POS, R3's tube feeding was Jevity 1.5, given Bolus 300cc every 4 hours via enteral syringe, with a 120cc water flush every 6 hours. At that time, R3 was also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 15	S9999		

receiving an oral diet of puree food. The 2015 March Medication Administration Record, MAR, show nursing staff initials documented the tube feeding being given every 4 hours around the clock with the water flushes every 6 hours.

Dietary History and Initial Screening dated 1/30/15 have R3's weight as 152.8 pounds. The RD documents R3 consumes approximately 25-50% of his meals and that the tube feeding provided 51% or more of Kcal and greater than 51% of fluid needs per day. Rd note dated 3/23/15, documents R3's March 2015, weight was 145 pounds, a 7.8 pound weight loss with the tube feeding every four hours and an oral tray. R3's weight on 4/2/15 was recorded as 136.6 pounds, an additional 9 pound weight loss. R3 has lost a total of 9.43% of her body weight in 63 days (from 1/30/15 to 4/2/15). There is no indication the facility staff assessed R3's weight loss to determine what could be contributing to R3's weight loss, although feedings were recorded as given.

E33's, (Dietary Manager), note, dated 4/14/15 documents "resident is now NPO (nothing by mouth) status as of 4/13/15. Will update order when received. Weight for April is 136.6 and March 145, resident has had a 9 # (pound) weight loss in 30 days (5.8%). RD will assess upon next visit. E33's note did not document the total overall weight decline of 9.43% since 1/30/15.

On 4/20/15, R3's tube feeding was changed due to weight loss with an order for Jevity 1.5cc Bolus 300cc every 3 hours while awake and NPO. There is no corresponding RD note with this change. The MAR documents the every three hour feeding and shows that on average, R3 gets his feeding 7 times a day or approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 16	S9999		

2100cc of feeding with some days recorded as little as 4 times/day, and some as much as 8 times/day. The information on the MAR conflicts with the Intake and Output records. Examples include: On 4/20 and 4/21/15, the 3rd shift nurses initialed R3 getting 300cc at 12am, 3am and 6am (900cc) but on the intake record, wrote in only 600cc. On 4/19/15, day shift initialed R3 getting 300cc at 9:00AM, 12:00pm and 3:00pm but only documented 600cc on the intake record.

On 4/17/15 at 2:30pm, (R3's wife), Z1 stated she always questioned whether R3 was getting enough feeding when he was first admitted because she donated cases of Jevity and with the order being 300cc, nurses would have to use one whole can and about 60cc from a second can. Z1 stated she observed the nurses giving just one can and then in the most recent past, observed a nurse "shooting his feeding in using a syringe" because she said she was in a "hurry." Z1 stated she also felt staff didn't spend enough time feeding him when he could eat. Z1 stated she talked to facility staff about it but was unable to give names of who she spoke with. Z1 stated R3 has lost a great deal of weight since admission and she was concerned that he wasn't getting enough.

On 4/21/15 at 12:00 noon, E16 Licensed Practical Nurse (LPN) checked placement and flushed R3's g-tube before giving him 300 cc of Jevity per gravity with a syringe.

On 4/22/15 at 11:40am, E20 (RD) was asked about the discrepancies between the MAR and the intake record and R3's overall weight loss while getting a Jevity around the clock. E20 stated she did not routinely look at the intake records or the MAR and that she relies on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 17	S9999		

charge nurse to tell her about residents. E20 stated the order for 300cc when awake was not her order but agreed that it leaves some question as to whether or not he's getting what he needs daily in his tube feeding. E20 stated she also does not routinely observed residents eating or tube feedings but evaluates the resident monthly and is called all the time with questions.

3. The Admission Record identifies R12 as admitted to the facility on 9/30/13 with diagnoses of Pneumonia, Respiratory Failure, Pleural effusions, and Right sided Cerebral Vascular Accident in part. The MDS documents R12 to be dependent on staff for all activities of daily living and have cognitive impairment.

The April 2015, Physician's Order Sheet, POS, includes an order for a puree diet, honey thick fluids at noon meal only - NPO (nothing by mouth) otherwise and Jevity 1.2 @ (at) 60cc/hour for 23 hours continuous, flush with 150cc of water every 4 hours, 30cc with medications. The 23 hour total amount for Jevity should be 1380cc or approximately 460cc/shift.

R12's weight record documents her weights as 4/3/15 - 134 pounds and on 4/14/15 as - 131 pounds.

On 4/17/15 at 8:05am, R12 was in bed, slouched down with her tube feeding running at 60cc/hour per pump. The 1000cc bottle of Jevity 1.2 had 675cc left in it and was labeled as being hung on 4/16/15 at 2200 (10pm) which is approximately 10 hours. The bottle of 1000cc had 675cc left in it at 8:05am. Calculating the feeding at 60cc an hour for 10 hours results in 600cc should have infused. R12's feeding showed a deficit of 275cc, that R10 did not receive for the 10 hours .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 18	S9999		

On 4/21/15, at 4:00pm, R12's tube feeding was running at 60cc/hour per pump. The 1000cc bottle of Jevity 1.2 had 400cc left in it and was labeled as being hung at 1:30am on 4/21. Calculating 14.5 hours times 60cc equals 870cc. R12's feeding was again 270cc less than should have infused since the time the bottle was hung.

The Intake and Output Sheets from 4/16/15 have 3rd shift documenting 293cc, daily shift 582cc and no amount documented for 2nd shift (a total of 875cc for day). On 4/17/15, 3rd shift recorded 617cc/shift, day shift 330cc/shift and nothing recorded for 2nd shift (at total of 947cc for day). On 4/18/15, only day shift documented 854cc for 24 hours. On 4/19/15 only 3rd shift documented 483cc (no other for day). On 4/20/15, 3rd shift recorded 580cc and day shift - 321cc with nothing recorded on 2nd (a total of 901 for day). On 4/21/15, the nurses have documented an intake of 305cc/night shift and 405cc per day shift and again, none recorded for 2nd shift (a total of 710cc). All of the above days documentation indicated R12 failed to meet her required intake of 1480cc/day.

On 4/22/15 at 8:15am, E30, (Corporate Nurse) stated the facility had identified an issue with tube feedings and weight loss and had been working on it recently the past couple months. E30 agreed that nurses should be aware of what feeding amount is to be given during their shift and a 24 hour amount should be calculated especially if weight loss is occurring.

The Facility's Policies, Standards, Protocols, and Procedures Manual Enteral Feeding Delivery Policy dated 12/06/12, documents; "Adequate nutritional support through enteral feeding will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 19	S9999		

provided to residents that are unable to meet their dietary needs through the oral intake of food. Enteral feedings will be administered in a manner that promotes resident dignity, safety and function.."
Policy Guidelines and Interpretation #2, A physicians's order specifying type of solution, rate and frequency is required. #4, The nurse will confirm that there are appropriate, by mouth (PO) or nothing by mouth (NPO), orders for all residents with tube feedings. The decision to allow or disallow PO will be made in conjunction with the physician, Registered Dietitian and the Speech Therapist, as appropriate, given resident diagnosis and status. #8, The following procedure is contraindicated if the resident's tube is obstructed, improperly positioned, the resident is vomiting, bowel sound are absent, or if the resident appears to be in respiratory distress. Procedures / Pump #4, Monitor resident for signs and symptoms of aspiration and/or feeding intolerance." #5, On the formula label document resident's name, date and time formula was hung/administered, formula type, if using a feeding bag, and rate/amount to be infused and initials of person performing procedure. #6, Flush tube as ordered by physician.

4. R10's Admission Sheet documents diagnoses in part of : History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

R10's Care Plan, dated 2/9/15, documents a Problem of "at risk or altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches / Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 20	S9999		

Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met." Monitor for incontinence frequently. Monitor and document bowel movements (BM), report diarrhea, constipation or no BM in 3 days. G-Tube Flushes and care as ordered. Diet as ordered water flushes.

R10's Physician Order Sheet, dated 3/27/15, documents an order for "Glucerna 1.2 at 50 cubic centimeters (cc) per hour for 23 hours continuously, via infusion kit and pump with IV (intravenous) Pole. Flush PEG (Percutaneous Endoscopic Gastrostomy) tube with 150 cc's Q-4 hours (every) via enteral syringe. Flush 150 cc every 4 hours (with water)."

From 3/27/15 through 4/7/15 the Interdisciplinary Progress notes indicate R10 received Glucerna 1.2 at 50cc/hr X 23 hours. However, on 4/8/15 the nurses notes document G-tube patent infusing at 75 cc per hour flushed without difficulty.

Per Physician's order of 3/27/15, at a rate of 50cc / hour X 23 hours, R10 should receive 1150cc/day of feeding. Review of R10's Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 during this time. R10's intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15 - 1236cc, 4/3/15 -790cc, 4/4/15 - 1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 - 1511cc, 4/10/15 - 1632cc, 4/11/15 - 1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 21	S9999		

1872cc.
On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 received 200cc to 400cc less feeding than required. And the rest of the days received between 100cc and 900cc more per day than ordered by the physician. No information was given for these discrepancies in R10's intake.

On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10's gown. The green vomitus was on her bed linens, extending from R10's shoulder to her hip. R10 smelled strongly of feces.

On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10's feeding tube. The bottle was labeled "4/16/15, 2:30 AM, amount 5 (?)." R10's tube feeding pump was turned off from 1:30 PM until 5:05 PM with 850 cc remained in the bottle. Calculation of the flow rate from time of hanging at 2:30 AM to 5:05 PM, indicates there should have only been 275 cc's remaining in the bottle (not 850cc).

On 4/16/15 at 5:05 PM, E18, Licensed Practical Nurse (LPN), stated "she checked for R10's tube feeding order on the current monthly Medication Administration Record (MAR) dated 4/2015 which documents "Glucerna 1.2 at 75 cc's per hour from 7:00 PM to 7:00 AM ." (order is inconsistent with current MD order of 50cc/hour for 23 hours.) E18 stated she then turned on R10's tube feeding pump at a rate of 75 cc's per hour.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 22	S9999		

On 4/22/15 at 11am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. E2 stated she was unable to determine why R19 would have dehydration if he received all his feedings and flushes. E20 when asked if she expected the nurses to follow orders and administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them." E2 stated that she though R10 was doing fine, but was not aware R10 had been hospitalized.

On 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated "On 4/16/15 I spoke to Z3, (Physician on call). He told me to write for the Glucerna to be given per the previous admission order. I wrote the order on 4/16/15 for R10's Glucerna to run 75cc / hour for 23 hours. I was not aware the G-Tube feeding should be from 7:00 PM to 7:00 AM only. I did not verify the order against the original in the chart." Additionally, E3 stated she had not been told by E37 that R10 had vomited earlier on the day shift.

On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 the night of 4/16/2015". She stated she had documented at "06:25 two emesis". The emesis had been reported to her at 5:00-5:15 AM when the E35, (CNA) showed her the linens with emesis. E34, (RN) noticed the vomitus was brown and had assessed R10's bowel sounds and skin. E34, (RN) stated R10 didn't respond or make eye contact, which R10 usually did respond to others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(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 23	S9999		

and make eye contact. E34, (RN) then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

R10 was transferred from the Facility to the local hospital Emergency Room (ER) on 04/17/15. The local hospital ER report documents R10 diagnoses Primary Impression: Hypotension, Additional Impressions: UTI (lower urinary tract infection), Sepsis, Illeus, Vomiting, Hyperkalemia, and Dehydration. R10 was treated with bolus fluids and admitted to the hospital.

On 4/29/15 at 2:45 PM, Z3, (Physician on Call), during interview stated; on 4/16/15, stated that he had been called for orders for R10's G-Tube feeding. At that time he had not been told R10 had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know and had he known of the nausea and vomiting, he would have admitted R10 to the hospital for fluids and evaluation, earlier that day.

(B)