| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation #2160539/IL130464 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1010 h)<br>300.1210 b)<br>300.1210 d)3)<br>300.3240 a)<br><br>Section 300.1010 Medical Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>seven-day-a-week basis:<br>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.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These regulations are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to demonstrate timely effective actions to prevent and address a resident's significant change in condition for one of three residents (R1) reviewed for competent nursing staff in a sample of five. This failure resulted in R1 not receiving timely medical interventions or physician ordered laboratory work following symptoms of dehydration which included lethargy, not eating or drinking, and muscle twitching. These failures also resulted in R1 being sent emergently to the hospital where she was diagnosed with severe Dehydration with Hypernatremia (Elevated Sodium Levels), right lower lobe Pneumonia, and a small Subarachnoid Hemorrhage.<br><br>Findings include:<br><br>A Significant Change Condition & Notification policy (undated) states that a significant change in a resident's condition includes change in level of consciousness such as lethargy, other | S9999 | | |

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| S9999 | Continued From page 2<br>abnormal findings, or a need to significantly alter treatment.<br><br>According to an article from the National Institute of Health (Kim, 2006), "Hypernatremia reflects a net water loss." This article further states, "Severe symptoms are usually evident only with acute and large increases in plasma concentrations above 158-160 mmol/L (millimoles per liter). Importantly, the sensation of intense thirst that protects against severe Hypernatremia in health may be absent in patients with altered mental status," or in elderly people. This article also states that more serious signs of Hypernatremia include altered mental status and lethargy.<br><br>R1's meal intake log, dated 12/16/20 to 12/30/20, documents R1 had no meal intake, which includes fluids, for 34 out of 43 meals. Of the remaining nine meals, R1 consumed 51-75% (percent of a meal) five times, and 26-50% of a meal four times.<br><br>R1's Vital Signs Monitoring, dated 12/1/20 to 12/31/20, documents R1's blood pressure had usually ranged from 92/52 mmHg (millimeters of mercury) to 162/80mmHg, however, on 12/27/20 to 12/29/20 R1's blood pressure was lower than usual and was documented as 85/44 mmHg, 79/66 mmHg, and 78/57 mmHg on those days.<br><br>R1's nurse's note, dated 12/19/20, documented by V6 (Licensed Practical Nurse/LPN), documents R1 was noted to have, "green discharge from vagina along with dark color urine with foul odor." This nurse's note also indicates R1's physician (V11) was notified regarding R1's urine with no new treatment orders received and that nursing staff will continue to monitor R1's | S9999 | | |

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dark colored and foul-smelling urine. R1's nurses' notes, dated 12/20/20 to 12/30/20, do not document any additional assessment of R1's urine or vaginal discharge until 12/30/20.

R1's nurse's note, dated 12/28/20 at 4:28p.m., and entered by V5 (LPN), documents, " Writer faxed MD (V11) regarding lethargy and twitching on 12/28 and suggested labs and to run IV (Intravenous) fluids d/t (due to) s/s (signs and symptoms) of dehydration and MD only agreed to CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel). They will be drawn on 12/30/20."

A Non-Urgent Nursing Home Correspondence Fax sheet, dated 12/28/20, shows V5 sent a fax to V11's office on 12/28/20 at 10:21a.m., stating R1 was, "lethargic and twitching often. She (R1) is not drinking much the past couple of days or eating d/t (Due to) lethargy." The section on the fax sheet where R1's vital signs could have been entered was blank. On this fax under nurse recommendations V5 wrote she recommended, "labs and possible IV fluids." This fax further documents V11's office faxed back orders for R1 to have CBC and CMP lab work completed.

R1's nurse's note, dated 12/29/20 at 7:30a.m., and entered by V5, documents, " Res (R1) lethargic and unable to swallow medications." At 11:59p.m., R1's nurse's note documents, " Resident (R1) remained lethargic and unable to wake up. No intake including meds (medications) given. MD aware, POA (Power of Attorney) aware. Labs being drawn in AM (morning). Awaiting results for orders."

R1's medical record does not include a fax indicating R1's physician was notified that R1's

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symptoms of lethargy persisted, or R1 was unable to swallow medications and was unable to wake up.

R1's nurse's note, dated 12/30/20 at 9:11a.m., entered by V6, documents, "Aides told nurse resident (R1) felt warm and when nurse took res (R1) temp it was 101.5 (degrees Fahrenheit), res was very lethargic and still having green vaginal discharge along with (altered mental status). MD notified UA (urinalysis) ordered and CBC/CMP done this AM awaiting results." At 11:28a.m., V6 documented, "(V12, V11's nurse) called from (V11) office, wanted to know what was going on with resident, nurse let her know that she (R1) had a fever of 101.5 (F) and was very lethargic. V12 asked nurse to get blood sugar of resident, bs (blood sugar) was 181-V12 then asked if resident had been voiding and nurse let her know she (R1) has been dry since she (V6) got on shift today, V12 informed nurse that she has results from labs and resident had high sodium levels and was Hypernatremia and to go ahead and send her out."

On 1/27/21 at 10:06a.m. and at 2:00p.m., V5 (LPN) stated she was R1's nurse on the 6:00a.m to 6:00p.m. shift on 12/28/20. V5 stated R1 had a significant change in her condition. V5 stated on that date, R1 was lethargic and was having muscle twitching. V5 stated R1's lethargy and muscle twitching can be the result of dehydration. V5 stated, "It was obvious she was dehydrated because of the lethargy and twitching." V5 stated the nursing staff tried to get R1 to drink fluids but R1 refused. V5 stated R1's condition change was serious enough that she notified V11, R1's physician. V5 stated she did not call V11 but instead notified V11's office by fax. V5 stated V11's office sent a return fax with orders to have

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the lab draw a complete blood count and a comprehensive metabolic panel for R1. V5 stated she didn't think the orders meant the labs needed to be drawn immediately so she entered them into the computer for the next scheduled lab technician visit which was for 12/30/20. V5 stated the fax she sent to V1's office on 12/28/21 was the only communication V5 had with V11's office.

On 1/27/21 at 10:31a.m., V6 stated she starts work at 6:00a.m. for the day shift. V6 stated she was R1's nurse on 12/19/20 when she noted R1 had a green discharge from her vaginal area and that her urine appeared darker than usual and with a foul odor. V6 stated since R1 did not have other symptoms of a Urinary Tract Infection such as a fever, V11 did not order a Urinalysis, but instead, instructed V6 to encourage R1 to drink more fluids. V6 stated on 12/30/20, V6 worked the day shift as R1's nurse after having been off work for several days. V6 stated when she began her shift, R1's condition was different than usual. V5 stated normally R1 did not stay in bed and was more active, however, on 12/30/20, R1 was in bed, lethargic, had a temperature, and the CNA staff reported to her R1 had not had any urine output in her incontinence brief. V6 stated she knew R1 was scheduled for labs that morning plus she sent a fax to V11's office detailing R1's symptoms. V6 stated she also knew she needed to send R1 to the hospital, but waited for V11's office to respond. V6 stated V11's office responded they had received R1's lab results and R1's sodium was abnormal, and she should be sent to the emergency room for evaluation and treatment.

R1's laboratory (lab) report, dated 12/30/20, documents that R1's White Blood Cell Count (WBC) was 23/mcL (microliters). This same lab

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report documents a normal WBC is no greater than 11mcL. This report also documents that R1's Sodium was 177 mmol/L (millimoles per liter) which is categorized as High Panic. This report indicates the normal range for sodium is 133-145mmol/L. In addition, R1's BUN (Blood Urea Nitrogen) was 94ml/dl (milligrams per deciliter) with normal range being 6-19mg/dl, blood creatinine was 2.30mg/dl with the normal range being 0.40-1.10 mg/dl.

R1's hospital Physician's progress notes, dated 12/31/20, documents R1 presented to the hospital on 12/30/20 with altered mental status, severe Hypernatremia, acute kidney injury, and severe dehydration which required IV fluids and IV antibiotics. This same progress note documents R1's prognoses was considered poor. R1's hospital physician discharge summary note, dated 1/7/21, documents R1 was admitted to the hospital for altered mental status. This same progress note documents that R1, "was severely dehydrated on presentation with Hypernatremia." In addition, this progress note documents R1 was also admitted with right lower lobe Pneumonia, a small Subarachnoid Hemorrhage, and Acute Kidney Failure. This progress note further documents R1 was placed on hospice comfort care and was deceased on 1/7/21.

R1's death certificate, dated 1/15/21, documents R1 was deceased on 1/7/21 from a Cardiopulmonary Arrest due to Pneumonia, Hypernatremia, Intracranial Bleed, and Severe Dementia.

On 1/27/21 at 11:16a.m., 12:17p.m., 1:50p.m., 2:30p.m., V2 (Director of Nurses) stated V5 did not notify her on 12/28/20 that R1 had a change in condition with symptoms of lethargy, muscle

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| S9999 | Continued From page 7<br>twitching, and was not drinking any fluids. V2 stated this was a serious situation. V2 stated V5 should have asked V11 if R1's CBC and CMP should be ordered stat instead of V5 placing the order for R1's lab draw on the next schedule lab day, which was 12/30/20. V2 stated if she had been R1's nurse on 12/28/20 when R1 developed lethargy and muscle twitching, she would have called V11 to ask for stat labs and she would have also called 911 to send R1 to the emergency room because R1's symptoms could have indicated severe dehydration.<br><br>On 1/29/21 at 10:05a.m., V11 stated he was R1's physician. V11 stated he expects the facility to call him when residents have a change in condition instead of sending a non-urgent fax. V11 stated when his office ordered for R1 to have the CBC and CMP to be drawn when R1 was exhibiting the symptoms of lethargy and twitching, he would have expected V5 to order those labs for that day and not for two days later. V11 stated when R1's symptoms persisted into the next day, 12/29/20, he would have expected the facility to notify him that R1's symptoms had not improved. V11 stated he would have expected nursing staff to report R1's abnormal blood pressures such as those on 12/27/20-12/29/20. V11 stated facility nursing staff should monitor residents for changes in blood pressure, poor food and fluid intake, over what time frame and then report those details when reporting changes in residents' condition. V11 stated if R1's labs had been drawn as ordered on 12/28/21, or if R1's persistent symptoms had been reported on 12/29/20, R1's significant change in condition could have been treated sooner.<br><br>(A) | S9999 | | |