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
	IL6008106	A. BUILDING: ___ B. WING ___	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

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S 000	Initial Comments Complaint Investigation Survey 2110364/ IL 130274 2110377/ IL 130289	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 1) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)4)A) 300.1220b)2) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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S9999	Continued From page 1 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. 4)Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A)Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status,	S9999		

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discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 requirements were not met evidenced by:

Based on interview, and record review, the facility failed to assess, and provide necessary care and treatment for a dependent resident.
This failure contributed to R1 being sent to the hospital in respiratory distress with a foreign body lodged in her trachea and signs of severe dehydration on 1/18/2021. R1 expired in the hospital on 1/18/2021.The facility failed to notify the dietician, and put interventions in place for a resident experiencing weight loss, and dehydration while receiving enteral nutrition and water flushes. This failure contributed to R1 having an 18 lb weight loss in one month, being sent to the hospital with respiratory distress, being diagnosed with severe dehydration, and expiring on 1/18/21.

This applies to 1 of 3 residents(R1) reviewed for necessary care and services in a sample of 3.

The findings include:
R1's Physician's Progress Notes dated 11/23/20 show that R1 has diagnoses including Right Basal Ganglia Hemorrhage, Left Hemiparesis, Dysphagia, Status Post G-Tube Placement,

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S9999	Continued From page 3 Chronic Atrial Fibrillation, Hypertension, Anemia, and Peripheral Edema. The Nursing Progress Note dated 1/18/21 at 6:35AM states, "CNA called this nurse to resident room where respirations were noted at 38. Bilateral lower extremities dark purple up to calf with poor cap refill. MD gave orders to send to (Local Hospital- across the street from facility) for eval and treat..." (There are no other documented vital signs in R1's medical record) The Hospital Emergency Room Report states, "75 year old female with significant medical history presents from a nursing home. Patient was found to be unresponsive- minimal information available from nursing home staff. EMS was called for hypoxia and minimal responsiveness. Respiratory Failure- intubated with 7.5 tube, there was an airway obstruction which was removed, saturations improved. Hypernatremia- Greater than 170, Hyperkalemia- 5.7 and in renal failure, Fever- likely sepsis, source possibly urine. This document shows that resident arrived in the ER at 6:55AM with the following vital signs: Temperature 100.6, Pulse 136, Respirations 39 and Blood Pressure 95/48. The ER Report documents at 7:00AM, "EMS reports that the nurse came on shift this AM and has never seen this patient before and found the patient unresponsive and in respiratory distress. EMS reports other staff on site report that this is "normal" for the patient. Patient had shallow rapid breathing at approximately 36 per min, patient is responding to painful stimuli. Patient upon arrival	S9999		

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S9999	Continued From page 4 has stool in her fingernails, dried on her hands, her (Adult diaper) is overfull of urine and new plus old/dried stool. Patient has a feeding tube that is open with no gauze around and has a thick drainage around the tube and is red around the insertion site of the tube.... Patient toe nails are very long and her skin is very dry. Patient placed on non-rebreather via EMS and was on 15 liters non-rebreather on arrival. Patients saturation off the non-rebreather was 70% and is now up to 80%. " At 7:15AM the ER Report documents, "(V12- ER Physician) went to intubate and pulled a large foreign body from patient's throat and then patient was successfully intubated in 1 attempt. (V12) states patient still has foreign body in her throat however it is not obstructing his intubation. The foreign body was very hard and approximately 2 inches long by 1 inch wide. It was brown in color and had red in the center of it. " At 8:10AM the ER report documents, "Multiple attempts at oral gastric/nasal gastric (tube) however unsuccessful would not pass. Every attempt that came out had large amounts of brown sticky substance that had a foal smell on it." " Patient cleaned as she had had a bowel movement. Pericare provided. Thick white-brown pus came out of patient's vagina as patient was being cleaned and then a temp sensing foley was placed and a thick yellow pus came out into the foley... entire periarea including her buttocks is very red and excoriated." At 9:05 AM, "Life flight arrived at bedside." (Patient was transferred to another hospital for a higher level of care) On 1/20/21 at 2:30PM V9 (Emergency Room Nurse) stated, "(R1) was in respiratory distress.	S9999		

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S9999	Continued From page 5 The paramedics had O2 on her and her O2 levels were still low. She was unresponsive. She did respond to painful stimuli but would not open her eyes. The paramedics that brought her told us that the nurse at the facility told them that she did not know this patient at all. It was a rough day. He adult diaper was saturated with urine and there was dry and fresh stool in it. She had poop caked under her fingernails and dried on her hands. She had bruises on her lower body in various stages of healing, from dime to quarter size. And later we noticed her hands and legs were mottled. She had a feeding tube but there was no dressing around it- it was actually a foley catheter that had been placed in our ER a few days to a week prior. The feeding tube site was draining a thick brownish red discharge and it had an odor. The doctor tried to insert a breathing tube and he found a significant foreign body in her trachea. We didn't have time or the ability to measure it but it was about 2 in x 1 in, firm but not hard and it was brown with a dark red center. We all looked at it but no one could figure out what it was. He got most of it out and was able to pass the tube but stated there was still some in there. Even more significant than that was when we went to do pericare. We turned her on her side and at least a quarter of a cup of tannish- brown pus just poured out of her vagina. It had a very strong odor. Then we inserted the foley catheter and got a very thick uroseptic, pudding consistency substance from her bladder. About 10cc and that is all she urinated the whole time. He skin was so dry and her mouth was so dry. Her sodium level was 176 and creatinine was 4.5. She was so dehydrated and she has a tube feeding. It was awful. " On 1/22/21 at 8:45AM, V13 (R1's Physician) stated, "I remember before that day, they thought	S9999		

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she had thrush. I'm sure renal failure is what finally finished her off. She was a true failure to thrive. On Sunday I got a message from an agency nurse and she told me (R1) was not looking good and she said she thought she had thrush. I told them she needs aggressive mouth care and we draw some labs. I didn't see the labs until after she was already gone to the hospital. Something else was happening to her. Then I got the call on Monday and I told them to send her out. That is the problem with COVID- we are not able to get into see our patients as much as we would like so we have to depend on them to tell us what is going on.
On 1/21/21 at 3:00PM, V6 (LPN) stated, "I walked in at 6:00AM and the CNA came to the desk and said (R1's) O2 saturation was in the 50's. I went down there and her respirations were 38 and her feet were purple. I sent a message to (V13- R1's Physician) and he said to send her out. When I checked her O2 saturation it was 94%. She was non-responsive. (V7- LPN) told me at 4:00AM (R1) seemed fine. I had not worked with (R1) before. When I found she was a full code- I sent her out. I gave report to the paramedics but not to the hospital."

On 1/25/21 at 10:40AM, V1 (Administrator) stated, "1/25/21- 10:40AM , "We do weekly weights so I will look at the weights and send you what we have. The dietician was going to see her on 1/18/21 but (R1) was already gone."

On 1/25/21 at 3:40PM V7 stated, "(R1) was pretty much the same as she had been. Moaning in the bed, turning self, would throw her legs over the side of the bed. I would put them back in when I went in there. Nothing too unusual for her. Sometimes she spoke a few words, sometimes she didn't. It was not a rapid decline. I was told

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she had a foreign body in her trachea but I have no idea what that was. There was no coughing (while she was here). Her room is right by the Nurse's Station and I never heard her coughing. When the CNA went in to do her vitals her O2 saturation was low but then (V6) went in and did the assessment. I was in the room but did not have any hands on. The CNA told us her toes were dark and she was having trouble breathing so we assessed her and decided to send her out. We did not put O2 on her. I know she was soiled when I was in there and the CNAs were changing her. She tends to pull at her brief and put her hands in her poop so I am not surprised if her hands had poop on them. We try to keep her clean but it may not get cleaned every time. I have never seen her put her hands or anything in her mouth. I don't recall if I charted on her that night or not. I know we are supposed to do Medicare charting but sometimes I do it later. I know that is not right. "

On 1/26/21 at 3:45PM V14 (LPN) stated, "I had not been there in about 3 weeks. So when I saw her on Sunday her mouth looked horrible. It was full of dried, caked on debris. It literally took me an hour to clean out her mouth and I had to keep on the CNAs to keep doing oral care to keep her mouth clean. It had looked bad when I was there before and I was wondering why no one had done anything about it before then. I didn't know if she had thrush or what was going on so I contacted the doctor. He ordered Diflucan (Antifungal) and labs. The labs are usually drawn on Monday morning. Sometimes they come in about 4AM. Before when I was there she seemed like she was doing better and this time she seemed so declined. Once I cleaned out her mouth she thanked me for it and I didn't see anything else. No temp, her respirations were normal. I did not

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do a full set of vitals. I did not see a reason to."

On 1/28/21 at 12:15PM, V17 (Dietician) stated, "No I was not notified of her (R1's) weight loss, and absolutely I should have been. Especially when someone is receiving a tube feeding. I know they were without a Director of Nurse (DON) for a little while so they had a lack of leadership but I should have been notified. I was not aware of her weight loss. "

On 1/29/21 at 9:30AM V12 (ER Physician) stated, " (Re: Foreign Body) It was like what a dried up piece of fruit would look like. Or a huge chunk of thick mucus- very dry. It really didn't resemble anything. It wasn't like something that was manufactured. It was just so dry- like it had been there a long time. I don't know what her level of awareness or ability to communicate was like before she came to us but she was just so systemically ill when she came in. I don't know if she was starting to get ill and then got more ill and whatever this thing was just moved and she was it longer able to protect her own airway and it became a complete obstruction. Plus I gave her medications to paralyze her trachea so I could intubate her and that may have caused it to move. Her sodium level was so high- like in the 170's and since she is completely dependent- I don't know if she just wasn't getting the proper amount of fluid or if the tube was not the proper tube for nutrition/hydration. I mean if the water is going in, it has to be going somewhere. She was just so dehydrated."

The hospital documentation from the hospital R1 was transferred to dated 1/18/21 states, "Acute hypoxic respiratory failure secondary to septic shock, inability to protect airway and suspected food impaction per transferring physician, Acute

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S9999	Continued From page 9 kidney injury suspected secondary to septic shock and dehydration, Hypernatremia (elevated sodium): Sodium was significantly elevated at outside facility at 176, it is thought to be severe dehydration." Review of R1's medical record shows no nursing assessment or documentation from 1/17/21(6:00AM- 2:00PM) written by V14, until 1/18/21 at 6:35AM when R1 was sent to the hospital in respiratory distress. R1's current care plan states, "Alteration in consistancy of fluids nothing orally she is NPO at time of admission, Resident dental status total assist with oral care, Resident specific information new admission, do not feed or give fluids orally, all meds and feeding is through a PEG (Percutaneous Endoscopic Gastrostostomy) tube feeding and only by nurse, Alteration in bladder elimination as related to incontinence- total assist with pericare. " R1's Nutritional Assessment dated 12/5/20 states, "Weight 240 lbs" Initial Assessment- Resident NPO (Nothing by mouth). Receiving Jevity 1.2 @70ml x 24 hrs with 200 ml water flush every 4 hours via PEG (Percutaneous Endoscopic Gastrostomy). Per nursing resident is currently tolerating feeding. Skin intact Continuing to meet needs and continue with weekly weights. Goal: Weight maintenance and G-tube tolerance. RD (Registered Dietician) available PRN (as needed)." R1's Weekly Weight Meeting Report shows her weight on 11/20/20 was 240lbs (hospital). On 11/27/20 this report states that resident refused to be weighed. On 12/4/20 R1 weighed 212.6 lbs, 12/11/20- Refused, 12/18/20- 200.2lbs (Down 12.4 lbs), 12/26/20- 200.5 lbs., 1/1/21- 200.5lbs,	S9999		

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S9999	Continued From page 10 1/8/21- 194.7 lbs (Down 5.8 lbs), 1/15/21- refused. R1's Hydration Assessment dated 11/19/20 shows Potential Signs/Symptoms as decline in ADLs, Dry Mucus Membranes and Elevated BUN (Blood Urea Nitrogen) lab value. The assessment does not show any risk factors for R1 and is not complete. Handwritten at the bottom of the page is GTF (Gastrostomy Tube Feeding) NPO (Nothing by Mouth). A Quality Improvement Review dated 12/18/20 states, "QA weekly weights. Current weight is 200.2lbs. Weight loss of 12.4 lbs. Will continue to monitor. " "AA"	S9999		