STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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
S 000	Initial Comments Complaint Investigation: 2170909/IL130876 2170974/IL130954	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)4) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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	S9999		

decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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		

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 requirements were not met as evidenced by:

Based on interview and record review, the facility failed to identify and inform the physician of a resident's decreased intake and urinary output. This failure resulted in a change of mental status and the resident being hospitalized in the intensive care unit with severe dehydration and malnutrition. This applies to 1 of 3 residents (R1) reviewed for dehydration and malnutrition in a total sample of 13 residents.

The findings include:

According to the Electronic Health Record (EHR) R1 had diagnoses including orthopedic aftercare, displaced intertrochanteric fracture of left femur, severe intellectual disabilities, urinary incontinence, gastroesophageal reflux disease, chronic cystitis, thrombocytopenia, pulmonary nodule, developmental disorder, urinary tract infection, weakness, assistance with personal care, difficulty walking, and anxiety disorder. R1 was admitted to the facility on 01/13/2021.

The admission Minimum Data Set (MDS) dated 01/20/2021 showed R1 needed extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use, and hygiene. R1 had impaired range of motion of one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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		

lower extremity and used a walker and a wheelchair. R1 was always incontinent of bowel and bladder. R1 was five feet six inches tall and weighed 110 pounds. The MDS showed R1's cognition was severely impaired. The MDS did not show any swallowing disorder. The MDS care area assessment (CAA) showed R1 was at risk for dehydration and nutrition deficiency. The CAA showed R1 had a body mass index (BMI) of 17.75, below ideal body weight.

A baseline care plan dated 01/13/2021 showed R1 may need assistance with eating and drinking with interventions including spending a lot or the entire time with R1 during meals.

Hospital Records dated 01/11/2021 just prior to R1's admission to the facility showed the following laboratory blood work:
White Blood Cells count (WBC) 5.4 [normal WBC is 4-11];
Sodium 138 milliequivalents (mEq) [normal Sodium levels are 133-144 mEq];
Potassium 3.6 mEq [normal Potassium levels are 3.4-5.1 mEq];
Chloride 106 mEq [normal Chloride levels are 98-107 mEq];
Blood Urea Nitrogen (BUN) 18.6 milligrams per deciliter (mg/dL) [normal BUN is 7 to 25 mg/dL];
Creatinine 0.59 mg/dL [normal Creatinine 0.6 to 1.2 mg/dL]; and
Glomerular Filtration Rate (GFR) 155 milliliters per minute (ml/min) [normal GFR greater than 60 ml/min].

An Emergency Department Physician Report dated 01/30/2021 at 4:17 PM showed on arrival the paramedics had difficulty obtaining intravenous access for R1 and an intraosseous line was placed in the left tibia. R1 was admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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		

to the hospital with Acute Kidney Injury, Possible sepsis, and severe dehydration. Hospital Laboratory blood work dated 01/30/2021 at 5:27 PM showed:
White Blood Cells count (WBC) 14.8 [normal WBC is 4-11];
Sodium 177 milliequivalents (mEq) [normal Sodium levels are 133-144 mEq];
Potassium 5.4 mEq [normal Potassium levels are 3.4-5.1 mEq];
Chloride 135 mEq [normal Chloride levels are 98-107 mEq];
Blood Urea Nitrogen (BUN) 219 milligrams per deciliter (mg/dL) [normal BUN is 7 to 25 mg/dL];
Creatinine 6.66 mg/dL [normal Creatinine 0.6 to 1.2 mg/dL]; and
Estimated Glomerular Filtration Rate (GFR) 9 milliliters per minute (ml/min) [normal GFR greater than 60 ml/min].

On 02/11/2021 at 12:12 PM, V6 (agency Certified Nursing Assistant/CNA) said she worked double shifts (16 hours) each day with R1 on 01/27/2021, 01/28/2021, and 01/29/2021. V6 said R1 liked some "sweet stuff" to be mixed with his food but he wouldn't eat the food, he would just suck the yogurt off the food. V6 was told by an unknown CNA to make sure R1 ate his yogurt because he didn't eat much. V6 didn't report anything to the nurse since she assumed they knew. On Friday 01/29/2021 V6 said R1 hardly had any urine output during the 16 hours shift she had worked. V6 stated she reported to V8 (Licensed Practical Nurse/LPN) about R1 not urinating very much during the shifts.

On 02/11/2021 at 1:51 PM, V7 (agency CNA) said it was the first time she had cared for R1 on 01/30/2021 on the day shift. R1 "absolutely needed 100 % assistance for eating." V7 said he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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 was R1 was not alert and oriented or would not respond to his name at all. V7 stated, "As far as I know that's how he was." The nurse (V8) had asked V7 if R1 ate anything and V7 stated he did not. When V7 tried to feed R1, he would let the food and liquids just drain out of his mouth. R1 did not try chewing or swallowing. V7 said R1 did not void or have a bowel movement during the day shift on 01/30/2021 and V7 notified V8 (LPN). On 02/11/2021 at 2:58 PM, V8 (LPN) said she was told by the night shift nurse during morning report on 01/30/2021, R1 had not really urinated during the night shift. V8 said she tried to encourage fluids during morning medication pass. V8 said R1 only took about 100 ml of water before he started spitting it out. V8 also had attempted to give R1 the med pass supplement but he drank a little bit and spit it out. V8 instructed V7 (CNA) to watch R1 for his intake and urinating. V8 was informed by V7 that R1 hadn't eaten anything. V8 attempted to feed R1 lunch around 12:30 PM or 1:00 PM, after V7 had attempted to feed him but he had refused to eat for her as well. V8 said she had not called the physician until after 2:30 PM when she found he wasn't responding to his name and his oxygen saturation levels were in the 80's. V8 said she was told to send R1 to the hospital for evaluation and called 911. On 02/17/2021 at 12:58 PM, V2 (Director of Nursing/DON) said R1 always needed a staff member present for feeding. V2 said R1 was a messy eater and would grab the food and put it in his mouth quickly. V2 said the staff needed to encourage R1 to take liquids as well. V2 stated R1's decreased meal intake and decreased urine output was not brought to her attention, but it should have been.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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		

The meal intake record provided by the facility showed R1's meal intake between 01/19/2021 and 01/30/2021. Only 23 out of 35 possible meals (65.7 percent) were documented. R1's documented meal intake during this time period was:
3 of the 23 meals R1 ate 76 to 100 percent;
7 of the 23 meals R1 ate 51 to 75 percent;
4 of the 23 meals R1 ate 26 to 50 percent; and
9 of the 23 meals R1 ate 0 to 25 percent.
The seven meals on 01/28/2021, 01/29/2021, and 01/30/2021 were documented R1 took zero to 25 percent of the meal.

On 02/17/2021 at 3:07 PM, V2 (DON) said after checking with V6 (CNA) about R1's food intake between 01/28/2021 and 01/29/2021, V6 said R1 ate only 10 to 15 percent of his meals on 01/28/2021 and 01/29/2021.

On 02/16/2021 at 5:10 PM, V11 (agency RN) said she worked Friday night shift 01/29/2021 to 01/30/2021 as a CNA because the facility was short one Certified Nursing Assistant. . V11 said R1 did not have any urine output for her during the shift, even after encouraging fluids. V11 said she asked V18 (RN) to check R1's incontinence brief when she was busy with another resident.

On 02/18/2021 at 8:56 AM, V18 (Registered Nurse/RN) said she worked the night shift on Friday 01/29/2021 into Saturday 01/30/2021 morning. V18 said, during report, the evening shift nurse had said (R1) hadn't had much of a urine output and to watch him. V18 denied anyone mentioning anything about (R1's) eating "They would only mention it if he wasn't eating and it wasn't mentioned." V18 said she assisted changing R1's incontinence brief midway through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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		

the shift for a small to moderate amount of urine. V18 said, during morning report on 01/30/2021, she told the day shift nurse both verbally and written on the 24 hour report sheet, to watch R1's urine output since it was decreased since the day prior.

On 02/16/2021 at 9:39 AM, V13 (RN) said "Definitely the CNAs should be telling me if a resident doesn't eat much for a meal so we can monitor and watch them."

On 02/16/2021 at 3:01 PM, V12 (Registered Dietitian/RD) said she did R1's admission nutritional assessment. V12 said R1 was eating adequately prior to admission and there wasn't any recent bloodwork laboratory results while at the facility. V12 said R1's food intake had varied mostly between 26 and 75 percent which meant he was not meeting 100 percent of his needs. V12 said he had a low BMI, weighed only 112 pounds and was 66 inches tall he would need extra calories from a supplement. V12 determined his calorie intake to be 30-35 calories per kilogram for a total of 1500-1750 calories per day and a fluid intake 30 ml/kg for a total of 1500 ml/day. When asked how does the facility ensure a resident was receiving adequate food and fluids, V12 said she would look at the resident's intake record, and in the case of R1, would speak with the nurse managers since R1 was non-verbal. V12 would also look at the weekly weight records. V12 said if a resident was not eating or drinking, the staff should call the doctor. V12 said she was only in the facility one day per week and if a resident needed fluids intravenously, she would not have anything to do with that.

On 02/11/2021 at 4:22 PM, V8 (MD Hospital ICU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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	S9999		

Intensivist) said he was getting reports from the nursing home that didn't correlate with the clinical signs of what we were seeing. V8 said "Someone doesn't go from eating one day to being dehydrated that severely the next." On exam, V8 stated it did not look like (R1) was getting any nutrition.

On 02/17/2021 at 1:54 PM, V17 (Medical Doctor/MD) said he had not seen previous medical records but felt R1 may have had nutritional deficiencies prior to being admitted to the facility. V17 said "Seeing his output had diminished and he was admitted (to the hospital) with severe dehydration, shows me they were not successful in improving his nutrition." V17 stated " It certainly didn't look good that the facility had not called the physician when his intake and output had decreased for three days."

On 02/17/2021 at 9:32 AM, V9 (Attending MD) said he was not aware or notified R1 was not eating or drinking or had little urine output. V9 said if he had been notified he probably would have acted sooner and done some blood work. V9 would have ordered a basic metabolic panel (BMP), complete blood Count (CBC), urinalysis and a urine culture and sensitivity to determine R1's hydration status and come up with a plan. If R1 had a decrease in intake and a decrease in output "Certain protocols would call for notification" and V9's expectation would have been a call or some kind of notification from the facility, which did not happen.

The facility's Standards and Guidelines Change of Condition policy dated 11/01/2016 included to observe resident during routine care to identify significant changes in physical or mental conditions, orientation, change in vital signs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIVER REHAB & HEALTHCARE	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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 weights, etc. Contact the primary physician to update him/her to the change in condition. (A)	S9999		