STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014674	A. BUILDING: _____ B. WING _____	C 01/25/2022

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CALHOUN NURSING & REHAB CENTER	#1 MYRTLE LANE HARDIN, IL 62047

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S 000	Initial Comments Complaint 224042/IL142516	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999		

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S9999	Continued From page 2 following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to assess, monitor, and provide timely treatment for a change of condition to maintain a resident's highest practical physical well-being for 1 resident (R2) reviewed for quality of care. This failure resulted in R2 not being sent to the hospital for evaluation of nausea and vomiting until 12 hours after onset of symptoms. R2 expired the next day in the hospital with diagnosis of aspiration pneumonia. Finding include: R2's Face Sheet documents he was admitted to the facility on 11/5/21 and was discharged on 1/12/22. His Face Sheet documents his diagnoses as Hyperlipidemia, Benign Neoplasm of Cranial Nerves, Gastro-esophageal Reflux	S9999		

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S9999	Continued From page 3 Disease without Esophagitis and Slow Transit Constipation. R2's Physician Order dated 1/4/22 documented, "VS (vital signs) every 4 hours while on precautions." R2's Progress Note dated 1/11/22 at 11:33 PM documents, "Resident remains on droplet precautions due to observation/assessment of status due to COVID-19 Public Health Emergency with adherence to CDC/CMS Isolation Guidance. Resident had one episode of emesis. No complaint of upset stomach or discomfort. Abdomen soft and non-tender to touch. Bowel sounds (BS) active x 4. Lungs clear and equal bilaterally. Continues on Mucinex with no adverse side effects (ASE) noted. Will continue to monitor." This progress note was signed by V13, Unlicensed Staff. There were no other progress notes documented in R2's medical record until the next morning at 6:57 AM. R2's Progress Note dated 1/12/22 at 6:57 AM documents, "Nurse called to room because resident moaning and not responding per normal for resident. Resident awake and making moaning noises, will not answer staff with words. Resident is hard of hearing but will normally answer staff appropriately. Decreased LOC (Level of Consciousness). Respirations 24 but does have short periods of apnea, sats vary 84% to 94% on room air. O2 (oxygen) applied per nursing measure and head of bed (HOB) elevated. Lungs clear. Blood pressure 99/46, heart rate 85, BS+4. Reported resident did have an emesis through the night. Family notified of decline and need to transfer to ER (Emergency Room). Ambulance notified. Transfer papers completed. No POLST in chart; full code status."	S9999		

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S9999	Continued From page 4 The last vital signs documented for R2 in his medical record before he was assessed and sent to the hospital on 1/12/22 at 6:57 AM were documented on 1/11/22 at 3:29 PM in his Progress Notes as 154/86, 97.6, 86, 16 and 96 %. R2's Resident Transfer Form, untimed, dated 1/12/22 documents, under, "Events or change in condition leading up to request for ER evaluation/ reason for ER visit or reason for consult", "emesis; decreased sats (oxygen levels) and decreased LOC". The transfer form documents R2's usual cognition was "alert and oriented, confused at times." R2's Medication Administration Record (MAR) dated January 2022, documents an order, dated 1/5/22, "Zofran 4mg one tablet by mouth every 6 hours as needed for nausea and vomiting." This medication was not documented as being given during the month of January. R2's Hospital Records dated 1/12/22 document his clinical impression as: New onset atrial fibrillation with uncontrolled rate, aspiration pneumonia and moderate acute renal failure. R2's Death Certificate dated 1/19/22 documents R2's date of death as 1/13/22, and lists his cause of death as Sepsis, Atrial Fibrillation with Rapid Ventricular Response, and COVID Pneumonia with Aspiration Pneumonia. On 1/14/22 at 6:00 PM V3, Registered Nurse (RN) stated she was the nurse who sent R2 out to the hospital on 1/12/22 because he was not acting like himself. V3 stated R2 was usually able to make his needs known but, on that morning,	S9999		

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he would not answer simple questions. She stated his pulse ox was in the 80's and his blood pressure was low. V3 stated R2 was sent to the local hospital and admitted with Aspiration Pneumonia and Atrial Fibrillation. V3 stated on the report sheet from the night before, it documented R2 had been stating he felt ill but did not have any specific complaints. She stated the nurse giving her report was V13, who reported R2 had vomited the night before, but didn't have any problems through the night. V3 stated when she had last taken care of R2 a couple of days earlier, he was doing good through his illness with COVID-19.

On 1/20/22 at 1:10 PM during phone interview with V13, unlicensed staff, she stated she did take care of R2 on 1/11/22 and stated R2 had an emesis and stated she does not do very well with vomit, but it appeared to be undigested food. V13 stated R2 was sitting up at the end of his bed and had vomited onto the floor. She stated she listened to his lungs and they were clear, and his bowel sounds were good. V13 stated she had another nurse who was working that night, V25, Licensed Practical Nurse (LPN), also listen to R2's lungs and she said they were clear too. V13 stated she gave him a Zofran for nausea but stated she does not remember if she charted it or not and stated R2 didn't have any more complaints that night. V13 stated she gave him medications around 6:00 AM and he was his usual self but stated he was moaning and said he didn't feel good but did not have any specific complaints. V13 stated she found out the next night when she came to work that he had been sent out to the hospital.

On 1/21/22 at 2:40 PM V25, LPN, stated she was working the evening/night shift (6:00 PM to 6:30

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S9999	Continued From page 6	S9999		

AM) on 1/11/22 and heard R2's bed alarm sounding at about 7:30 PM. She stated she remembers the time because she was just passing her 8:00 PM medications. V25 stated R2 was on the COVID unit, and V13 was his nurse, but when nobody responded to his alarm, she (V25) went down to check on him. V25 stated just as she walked into his room, R2 was sitting on the end of his bed and he vomited. V25 stated there were some undigested pills in the vomit so she assumed he had just taken his medication. V25 stated she yelled for V13 to come to R2's room, but as soon as V13 got to R2's doorway, V13 stated "I don't do puke" and she refused to come in and assess R2 until it was all cleaned up. V25 stated she assessed R2 and his lungs sounded clear, but he was complaining of being nauseated. V25 stated she does not know if V13 gave R2 anything for nausea because after the UA (unit assistant) and the CNA (Certified Nursing Assistant) got the floor and R2 cleaned up, V13 went into R2's room to assess him, and V25 stated she heard R2 tell V13, "I don't feel good. I feel nauseous." V25 stated, during the rest of the shift, while they were at the nurses' desk, she heard the CNA and UA report to V13 that R2 had vomited again around 11:30 PM, and early in the morning the UA told V13 that R2's legs didn't look right. V25 stated she does not know if V13 assessed R2 anymore that night, but she did not see her go into his room again.

On 1/21/22 at 3:23 PM V26, UA, stated she was working with V27, CNA, on 1/11/22 from 9:30 PM to 5:00 AM on the COVID unit. She stated V25 went into R2's room just as he was throwing up. V26 said V25 informed R2's nurse, V13, that she needed her to come to R2's room because he had vomited, but V13 told her that she does not do vomit, and V13 would not enter R2's room until

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V26 and V27 got R2, and his floor cleaned up. V26 stated V25 did check R2's lungs when V13 would not come in his room. V26 stated R2 did vomit again through the night, and he was not acting like himself. V26 stated when they would walk by his room, R2 would be hanging part way out of his bed and they had to go in and position him safely in his bed several times. V26 stated R2 was mumbling and not making sense. She stated he became delusional and was talking about a washing machine, but she could not understand what he was saying. She stated she and V27 went to V13 several times with concerns about how R2 was acting and let her know when he vomited again, but stated V13 told them, "His lungs are clear...there is nothing I can do about it." V26 stated they continued to report R2's condition to V13, but V13 did not go down and assess R2 when he got sick again. V26 stated she did tell V13 that R2's legs turned a funny color the first time they went in to clean him up; skin tone, purple and pink that looked like a spider web pattern, and V13 told her that was probably because he was sitting up on the side of the bed. V26 stated she and V27 reported to the oncoming staff that R2 had vomited twice during the night, and the oncoming CNAs stated they would let their nurse know. V26 stated she did not know what happened after that because she leaves at 5:00 AM.

On 1/21/22 at 3:30 PM V1, Administrator, confirmed she could not find any documentation of assessments for R2 for 1/12/22 on night shift to assess for his change in condition after he had emesis earlier on the evening shift. She stated she would have expected the staff to reassess him to ensure he did not continue to have emesis and stated he should have had at least two sets of vital signs, including checking his oxygen

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levels, on the night shift, because he was on the COVID unit.

On 1/24/22 at 1:47 PM during phone interview, V14, Medical Doctor (MD) stated he had checked with the answering service regarding 1/11/22 and 1/12/22 and they did not receive any calls from the facility about R2 having a change of condition on the night shift on those dates. V14 stated if R2 had only had one emesis, and this was not out of the ordinary for him, he would not necessarily expect the facility to call and report that in the middle of the night, but if R2 had continued to have another emesis, and this was not normal for him, they should have called and reported it. V14 stated if R2 was continuing to have s/s (signs and symptoms) that were abnormal for him, or if he was requiring more oxygen and more care due to a change in his condition from his normal baseline, he would expect to be notified. V14 stated he could not say without any doubt that R2's outcome would have been different had the facility called and reported his change in condition sooner, but if he had been sent to the ER earlier when he first had changes in his condition, the sooner he would have received a higher level of care, and the better the outcome he would have expected, quite possibly with a better outcome overall.

The facility's policy, "Notification of a Change In a Resident's Status" revised 11/17, documents, "The attending physician/physician extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations. Procedure: 1. Guideline for notification of physician/responsible party (not all inclusive): a. Significant change in /

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S9999	Continued From page 9 or unstable vital signs (Temperature, B/P, Pulse, Respiration); b. Emesis/diarrhea; e. Symptoms of any infectious process; k. unusual behavior." (A)	S9999		