STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015879	A. BUILDING: _____ B. WING _____	C 10/19/2022

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S 000	Initial Comments Complaint Investigation: 2268278/IL152335	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010h) 300.1210a) 300.1210b) 300.1210d)1)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the facility failed to assess and seek medical intervention for a significant change in condition for one resident (R1) of three residents reviewed for condition change in a sample list of three residents. This failure resulted in R1 being hospitalized with a blood glucose level of 1200 (milligrams per deciliter) and Diabetic	S9999		

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S9999	Continued From page 2 Ketoacidosis. B. Based on record review and interview the facility failed to administer blood glucose monitoring and sliding scale insulin as ordered on six occasions for one of three residents (R1) reviewed for medication administration in a sample list of three residents Findings include: A. R1's Continuity of Care Document printed 10/18/22 includes the following diagnoses: Malignant Neoplasm of the Right Kidney, Abnormal Weight Loss, Difficulty Walking, and History of Polio. The Diagnosis Diabetes was not added until 10/18/22. R1's Minimum Data Set (MDS) dated 9/14/22 documents R1 was completely cognitively intact. R1's Brief Interview of Mental Status (BIMS) dated 9/14/22 documents R1 scored a score of 15 out of 15. R1's Care Plan includes a problem initiated 9/19/22 which documents "(R1) has been displaying verbal behaviors such as yelling/cursing at staff telling them to leave him alone, he has also been displaying rejection of care behaviors such as not allowing CNAs (Certified Nurse Assistants) provide him with daily ADL cares, telling staff that he will let them know when he needs help and that he was not going to allow them to touch him. (R1) has also been displaying more confusion than usual and has been making false accusations toward staff with no truth to the accusations being made." R1's Progress Note dated 9/17/22 at 8:53PM documents "(R1) refused to be changed and	S9999		

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S9999	Continued From page 3	S9999		

refused to go to bed. (V6 Licensed Practical Nurse/LPN) encouraged (R1) to let CNAs at least provide peri care to prevent sores and infection. (R1) stated, 'I will not let them. I do not need to be changed right now. They always want to show me disrespect and think they know what's best for me when they don't. I'm my own boss.' (V6) asked (R1) what was wrong and if the CNAs did anything to make him upset. Resident stated, 'No they aren't going to tell me what to do or when to be changed. I am my own person and have been taking care of myself for many years and I don't need them now.' (V6) asked (R1) are you sure you don't want changed. That it would be best to get changed out of wet underwear. (R1) stated, 'No! I will let you know when I need your help.' " There is no documentation to support this change in mental status was reported to the physician or a physical assessment was completed by the nurse.

R1's Progress Note dated 9/17/22 at 11:58PM documents "(V6) was informed by CNA on hall that resident was making statements at him by telling him to go sit on a railroad and let the train hit him. Resident seemed to be confused and started stating, 'You think your "sic" a bad A** (expletive) and a boss because you have your bike. I do not want care from you.' Writer and another CNA went into resident room and asked (R1) what was the matter and (R1) stated, 'Well I haven't been checked on since after dinner time and this guy thinks he knows it all. I will not let him touch me. I don't like him. He thinks he is the boss, and he is always late to work.' (V6) informed (R1) that (V6) is sorry (R1) feels that way, but the CNA is truly trying his best and told resident the reason he hasn't been changed since after dinner is because (R1) has been refusing care. (R1) stated, 'You can change me

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S9999	Continued From page 4	S9999		

now, but he is not to touch me.' Writer and other CNA provided care and transferred resident to bed. Resident is lying in bed now calm and cooperative." There is no documentation to support this change in mental status was reported to the physician or a physical assessment was completed by the nurse.

R1's Progress Note dated 9/18/22 at 1:56PM documents "(R1's) POA (Power of Attorney) was notified of incident that happen 9/17/22. (POA) stated that (R1) normally doesn't act in that manner."

R1's Progress Note dated 10/2/22 at 4:49PM documents "(R1) did have a slight increase in confusion earlier in the shift. Resident was noted yelling out and being incoherent." There is no documentation to support this change in mental status was reported to the physician or a physical assessment was completed by the nurse.

R1's Progress Note dated 10/3/22 at 10:08AM documents "(V7 Registered Nurse/RN) assessed (R1) at approximately 08:30AM and noted (R1) to be calling out in pain. Abdomen noted to be distended. Lower abdomen firm. Bowel sounds audible in all quadrants but hypoactive. (R1) having difficulty following commands. (V7) received report from staff members that the resident has been experiencing decline in mental status over the weekend. (V7) re-assessed (R1) at approximately 09:30AM. (R1's) condition not improved. (R1) not following commands or answering questions. POA and (family member) called and notified. Family requests resident to go to emergency department for evaluation."

R1's hospital discharge summary dated 10/12/22 documents R1 was hospitalized from 10/3/22 to

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S9999	Continued From page 5 10/12/22 with a new diagnosis of Type II Diabetes with Ketoacidosis. R1's Blood Glucose during that time is recorded as high as 963 mg/dl (milligrams per deciliter) with the normal Blood glucose being 80-120 mg/dl. R1's Hemoglobin A1C (measures average blood glucose over three months) on 10/3/22 is recorded as 14 with the normal levels being under 7. On 10/17/22 at 4:00PM V9 (R1's POA) stated "(R1) went to the (local hospital) 10/3/22. (R1's) blood glucose at that time was 1200. (R1) was then transferred to (a hospital with a higher level of care). (R1) was in ICU (Intensive Care Unit) for several days with an insulin drip. (R1's) blood pressure was also very low. (Family members) visited (Nursing home) on Sunday 10/2/22 and they knew something was wrong. (R1) was lethargic and very confused which is nothing like (R1) had been before. On 10/18/22 V2 (Director of Nursing/DON) stated "We do use a lot of agency nurses and they are not always aware of the residents baseline cognition and behavior. Any time a resident has a sudden change in cognitive ability or behavior it should be documented and if necessary, the resident should be sent to the emergency room for assessment. (R1) was not ever diabetic before the recent hospitalization." V1 (Administrator) denied having a specific facility policy for notification of a change in condition. On 10/18/22 V1 (Administrator) stated "It is our responsibility to make sure when a resident has a change in cognition they are seen by a physician or taken to the emergency room."	S9999		

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S9999	Continued From page 6 B. R1's Care Plan updated 10/12/22 documents "Problem: (R1) has a diagnosis of Diabetes. Goal: Reduce the risk for hypoglycemia or hyperglycemia. Approaches: Administer medication per Dr orders. Monitor for effectiveness/adverse side effects. Diet per Dr orders. Monitor blood glucose per Dr orders. Notify Dr with any changes/concerns. Monitor for signs of hyperglycemia such as blood glucose above 140 milligrams/deciliter; increased thirst; increased urination; increased appetite followed by lack of appetite; nausea, vomiting. Monitor for signs of hypoglycemia such as blood glucose below 60 milligrams/deciliter; sweating; cold, clammy skin; numbness of fingers, toes, mouth; rapid heartbeat; nervousness, tremors; faintness, dizziness. Administer medication per Dr orders. Monitor for effectiveness/adverse side effects. Monitor blood glucose per Dr orders. Notify Dr with any changes/concerns." R1's hospital discharge orders dated 10/12/22 includes a physician's order for "Check blood sugars before meals and at bedtime. If greater than 150 milliliters/deciliter give extra Novolog insulin using the following sliding scale: Blood Glucose 150-200 give 2 extra units. 201-250 give 4 extra units. 251-300 give 6 extra units. 301-350 give 8 extra units. greater that 350 give 10 extra units." R1's Medication Administration Record (MAR) for 10/12/22 to 10/17/22 documents that while the order for blood glucose checks and sliding scale was followed before meals it was not administered at bedtime on 10/12/22, 10/13/22, 10/14/22, 10/15/22,10/16/22, and 10/17/22. On 10/18/22 at 10:30 am V2 (Director of Nursing) stated "I do see where the blood glucose checks	S9999		

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S9999	Continued From page 7 and sliding scale insulin were missed 10/12/22-10/17/22 at bedtime for (R1). This will be corrected. It is important physician's orders are followed especially for insulin." "A"	S9999		