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
	IL6008346	A. BUILDING: ______ B. WING ______	C 06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINE CARE NURSING & REHAB	120 SOUTH LAND STREET HARRISBURG, IL 62946

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S 000	Initial Comments Complaint Survey: 2354742/IL160718, 2354763/IL160751 & 2354812/IL160813	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.2040g) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.2040 Diet Orders

g) All oral liquid diets shall be reviewed by a physician or dietitian every 48 hours. Medical soft diets, sometimes known as transitional diets, shall be reviewed by a physician or dietitian every three weeks. All other therapeutic and mechanically altered diets, including commercially prepared formulas that are in liquid form and blenderized liquid diets, shall be reviewed by a physician or dietitian as needed, or at least every three months.

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 maintain acceptable nutritional and hydration parameters for a non-verbal resident with a diagnosis of dysphagia for 1 of 3 residents (R1) reviewed for nutrition and hydration in a sample of 12. This failure resulted in R1

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experiencing a significant weight loss of 5% in 1 week due to not receiving nutrition for 16 days, with subsequent hospitalization for malnutrition, critically low potassium levels, dehydration, and electrolyte imbalance. A reasonable person not being provided any form of nutrition for 16 days would react with feelings of emotional/psychological distress, weakness, anxiousness, as well as discomfort or cramping related to hunger pangs.

The findings include:

R1's Face Sheet in the medical record documents that R1 was admitted to the facility on 11/5/20 with diagnoses including hemiplegia, unspecified affecting unspecified side, dysphagia (oropharyngeal phase) following other cerebrovascular disease, aphasia, and Gastro-esophageal Reflux Disease.

R1's June 2023 Physician's Order Sheet (POS) documents an order dated 1/20/23 for a pureed diet with NTL (nectar thickened liquids) and assist with meals as needed.

R1's MDS assessment dated 1/13/23 in Section B, Hearing, Speech & Vision documents R1's speech clarity as "No speech - absence of spoken words." Subsequent MDS assessments dated 4/14/23 and 5/30/23 document R1's speech clarity as "Unclear Speech - slurred or mumbled words."

R1's MDS (Minimum Data Set) dated 5/30/23 documents in Section C, Cognitive Patterns, that R1 has a BIMS (Brief Interview of Mental Status) of 99, indicating R1 was unable to complete the interview. The same MDS assessment documents in Section G, Functional Status,

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documents that the self-performance and support provided under the section "Eating" as "Activity did not occur-activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 day period."

A Nurse's Note in R1's medical record authored by V30 (Licensed Practical Nurse) dated 5/20/23 at 1:54 PM documents in part "Resident (R1) started coughing during breakfast and lunch today that caused her to expel her food up both meals and for the past couple days she needed to be suctioned following 2 meals which she was and tolerated well. I called primary care today and talked to the Dr (doctor) on call which is (V35-Nurse Practitioner) she said to send to the emergency room. Ambulance called and was transported to (local hospital #1)."

R1's ED (Emergency Department) Discharge Instructions dated 5/21/23, authored by V24 (Emergency Room Physician) documents a final diagnosis of dysphagia, concern for aspiration. Discharge Instructions document that R1 is on 125 cc (cubic centimeters) of D5 (Dextrose 5%) 1/2 NS (Normal Saline) 20 KCl (Potassium Chloride), needs swallow evaluation, please contact the facility physician to order swallow evaluation, this needs to be done tomorrow morning, keep the patient NPO (nothing by mouth) until the swallow eval is done, check blood sugar, fingerstick, every 6 hours, and follow up with PCP (Primary Care Physician) in 24 hours. A "Miscellaneous Nursing Note" from the hospital records dated 5/21/23 documents "spoke with (name of facility). Nurse reports that they have the capability to do swallow evals in their facility Monday through Friday. (Name of facility) also, has the capability to give IV fluids. I spoke with provider and he is willing to send (R1) back

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to (name of facility) as long as they are comfortable with the IV fluids and NPO status. Attempting to return call to (name of the facility). The Nursing Note further documents "pt (patient) to be discharged back to the facility. Report called to (V18- Licensed Practical Nurse)."

A Nurse's Note dated 5/21/23 at 11:52 AM documents in part that "(R1) returned from (local hospital #1) at 2050. New orders for IV fluids."

A Nurse's Note dated 5/22/23 at 2:00 AM documents in part "Resting in bed at this time. HOB (head of bed) elevated 30 degrees. #20 gauge IV patent in left hand. No redness or swelling noted, flushes without difficulty. N.O. (new order) from (local Hospital #1) to start D5 ½ NS 20KCl at 125 mL (milliliters) per hr (hour) until morning. IV fluids running per orders. Keep NPO until swallow eval ordered and done."

R1's June 2023 POS documents orders dated 5/22/23 for a swallow eval next available Dx (diagnosis): dysphagia, keep NPO until swallow eval is done, and check blood glucose Q (every) 6 hours and an order dated 5/23/23 for Dextrose 5%- 0.45%NaCl (Sodium Chloride) IV (Intravenous) solution at 125mL/ hour.

On 6/21/23 at 8:30 AM, V18 (Licensed Practical Nurse) said that she admitted R1 back to the facility after the 5/21/23 trip to the emergency room. V18 said she was specifically told a swallow exam by the hospital. V18 said that she told them that they could do a bedside swallow test but could not do a barium swallow or a video test. V18 said that she put R1 on the doctors list for rounds. V18 said that R1 was ordered to be NPO at that time. V18 said the doctor does rounds on Wednesdays and Fridays and

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sometimes the weekend and they usually clip the hospital orders on the list and put them in a folder labeled MD (Medical Doctor) rounds. V18 said that R1 came back on IV fluids and the hospital sent a bag of fluids with her. V18 said the fluids were D5 1/2 NS. V18 said that when she hears swallow evaluation to her that means to have a speech therapy evaluation not video or barium swallow test. V18 said when she received report from the hospital, a video or barium swallow test was never mentioned. V18 said the folder for physician rounds, that included R1's hospital records, was left at the nurse's station. V18 said that on 5/18/23 she had to suction R1. V18 said that there was no food in what she suctioned. V18 said it was clear frothy phlegm.

Nurse's Notes dated 5/21/23, 5/22/23, 5/23/23, 5/24/23, 5/25/23, 5/26/23 and 5/27/23 all document that R1 continues to be NPO until the swallow evaluation is completed.

A Nurse's Note dated 5/30/23 at 9:26 AM, documents that R1 has left the facility to have a swallow eval done.

A hospital Fluoroscopy Esophagram Report (from local hospital #2) documents the reason for the exam as "dysphagia" with an order dated 5/22/23 by V21 (Physician). The Fluoroscopy Esophagram results dated 5/30/23 at 9:48 AM, documents under "findings" that "the patient was unable to swallow barium. There is a history of aspiration. This is a non-diagnostic exam. Is suggested that the patient be scheduled for a video swallow with speech pathologist to evaluate which consistencies the patient can tolerate without aspiration."

On 6/14/23 at 7:00am, V3 (DON/Director of

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Nurses) said that they tried to get a barium swallow done for R1 but the 2 local hospitals could not do it. V3 said they did get an appointment for 5/30 but that R1 would not swallow the barium so it could not be completed. V3 said that V21 saw R1 at the facility on 5/31/23 in the morning and was unsure what the family's choice would be- hospice or feeding tube and then the family made the decision to get a feeding tube that same afternoon. V3 said they were following physician orders by keeping R1 NPO since that is what he ordered.

A Nurse's Note by V3 dated 5/31/23 at 12:56 AM documents "(R1) remains NPO. She was unable to complete swallow eval today. (V21) is aware of study failure. Awaiting further orders. IV site to left upper arm patent and clear without evidence of infiltration. D5 0.45%NS infusing at 125mL per hour. Glucose readings wnl (within normal limits). Oral care provided."

A facility Progress Note dated 5/31/23 by V21 (Physician) documents under "plan" that "Orders reviewed and signed and continue current regimen. Patient (R1) has been in and out of the hospital emergency room several times over the last couple weeks. (R1) was diagnosed with progressively worsening dysphagia to the point that she is been kept NPO due to constant aspiration. We would attempt esophagram and she was unable to do due to dysphagia. Staff has been in contact with (V36 Power of Attorney-POA/ Family). (V36) is contemplating hospice versus PEG (percutaneous endoscopic gastrostomy) tube feeding. Patient has been on IV fluids. Patient is non-verbal but does not show any signs of discomfort or pain. As soon as the family decides we will proceed with orders."

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A Nurse's Note dated 5/31/23 at 11:43 AM documents "TC (telephone call) to (V36) in regards to being placed on hospice service or have a feeding tube placed. (V36) said she wants a feeding tube placed and doesn't want her on hospice care."

A Wound/ Weight Meeting Note authored by V32 (Licensed Practical Nurse) dated 6/1/23 at 10:34 AM documents in part "Current weight 113.6 lbs (pounds) which is 6.2 lbs loss since being placed on NPO status with IV D5 1/2NS continuous at 125 mL/hr, pending swallow study, which she failed. Call placed to (V36) regarding options of feeding tube placement or hospice care. (V36) has opted for feeding tube. MD notified and PEG tube placement is pending..."

A Nurse's Note dated 6/1/23 at 2:06 PM documents "June 8th at 2 PM (local hospital #3) for G (gastrostomy) tube placement."

On 6/25/23 at 9:00am, V3 (DON) said that they were able to get another appointment at another local hospital for G tube placement on 6/8/23. V3 said that V21 was able to find a surgeon to place the feeding tube and sent R1 to the hospital on 6/6/23.

R1's Admission History and Physical (from local hospital #3) dated 6/6/23 under the section "HPI (history of present illness)/ Subjective" documents in part that R1 presents with "traumatic brain injury, aphasia, dysphagia, spastic right hemiparesis was brought into ER (Emergency Room) today from the nursing home for possible PEG tube placement ...(V36) stated that (R1) has been without food for 2 weeks since an episode of aspiration. She has been awaiting evaluation by speech therapist ...Routine labs

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obtained today show severe hypokalemia 1.8. UA (urinalysis) is pending. Chest X-rays unremarkable for cardiopulmonary pathology." Under the section "Plan" it documents "traumatic brain injury with spastic right hemiparesis, aphasia, dysphagia on puree with inconsistent swallow and history of aspiration with poor oral intake, anorexia and dehydration with severe electrolyte derangement, hypokalemia, monitor on telemetry, check magnesium as well and replete all electrolytes, Speech and Swallow eval, NPO, D5NS with KCL (potassium) at 100 mL/hr. General surgery consulted for a PEG tube placement."

A document titled "ST (Speech Therapy) Bedside Swallow Evaluation" from the hospital records dated 6/7/23 by V14 (Hospital Speech Therapist at local hospital #3) document an impression of "moderate oral dysphagia and pharyngeal dysphagia suspected. A pureed diet with nectar thickened liquids was recommended and a goal of R1 participating in dysphagia treatment in order to further determine safest and least restrictive diet level. An inpatient speech therapy note by V14 dated 6/12/23 documents that R1 swallowed nectar thickened liquids and pureed consistencies with no overt signs and symptoms of aspiration and speech therapy was not needed at this time due to R1's goals were met and a recommendation was made for discharge to a skilled nursing facility.

A Nutritional Assessment in the hospital records dated 6/9/23 document that R1 meets ASPEN (American Society for Parental and Enteral Nutrition) criteria for severe protein calorie malnutrition related to inability to consume adequate nutrition as evidenced by patient with aspiration two weeks ago and reportedly

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S9999	Continued From page 9 uncooperative with previous SLP (Speech and Language Pathologist) evaluation who has been without food for two weeks and presents with critical hypokalemia 1.8 and critical hypophosphatemia 0.7 as well as (by mouth) intake 0% of estimated needs for 2 weeks, significant fat wasting noted per NFPE (Nutrition Focused Physical Exam): moderate orbital pad, significant muscle wasting per NFPE: moderate clavicular, moderate dorsal hand/interosseous. Under the section "Evaluation" it documents that R1 is tolerating diet order of pureed diet and nectar thickened liquids as recommended by SLP (Speech-Language Pathologist) based on bedside evaluation, ate 75% of lunch and dinner yesterday (6/8/23), and ate 100% of breakfast this morning (6/9/23). On 6/15/23 at 10:46 AM, V14 (Hospital Speech Therapist at local hospital #3) said that speech therapy makes the recommendation for a resident to be NPO (nothing by mouth). V14 said you cannot leave someone without eating for that long. V14 said she did a bedside swallow evaluation on R1 when she was admitted to the hospital and that R1 was safe for PO (by mouth) intake and could have eaten if R1 was seen by speech therapy. V14 said she is not sure why R1 was not seen at the facility. V14 said they were going to put a feeding tube in a lady that did not need it. V14 said that R1 is still in the hospital and is on a full pureed diet and is doing great and has had no feeding tube. On 6/15/23 at 10:30 AM, V12 (Contracted Speech Therapist for facility) said that she could have done a bedside swallow evaluation on R1 if it was ordered by the Physician but that she never received any order or information for R1.	S9999		

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On 6/15/23 at 10:35 AM, V13 (Director of Rehabilitation/COTA/Certified Occupational Therapist) said a bedside swallow evaluation could have been done but was not ordered by the physician.

On 6/20/23 at 11:35am, V3 said that the Dietician saw R1 at the facility on 5/19/23. V3 said that the dietician was not here while R1 was NPO, therefore did not see R1. V3 also said that R1 received her medications crushed in applesauce and did not receive any of them while she was NPO. V3 said that V21 was aware.

A facility document labeled "Vital Signs Grid" documents that R1 weighed 119.8 on 5/24/23 and 113.6 on 5/29/23, a weight loss 6.2 pounds (5.2%), in 5 days. There were no interventions or dietary notes documented in R1's medical record to address this weight loss.

On 6/20/23 at 2:06 PM, V23 (RD/Registered Dietician) said she was not aware of R1's weight loss during that time. V23 said unfortunately she was not made aware that R1 was NPO for 16 days. V23 said she saw R1 on 5/19/23 and she was eating. V23 said she would have expected to have been notified that R1 was going that long without eating since R1 needed a liquid nutrition rather than just IV fluids for hydration.

On 6/20/23 at 8:25am, V21 (Physician) said that R1 had had 2-3 episodes of aspiration. V21 said he sent R1 to a local hospital emergency room and doesn't understand if they were unable to do any kind of swallow testing, then why did they not send her to a facility where it could be done. V21 said he tried and tried to find someone to place a feeding tube with no success and finally found one and that is why they sent R1 out on 6/6/23.

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V21 said he did not realize that R1 went 16 days without eating and said he is not surprised about the weight loss. V21 said he doesn't know what else he could have done. V21 said that as soon as V36 made the choice of putting in the feeding tube, they called all over southern Illinois trying to get someone to put the tube in. V21 said no one from the facility asked about a bedside swallow eval to be done at the facility. V21 said he was aware the facility had Speech Therapy but did not know what their hours were.

A letter dated 6/19/23 provided by V22 (Director of Operations) from V21's office and signed by V21, documents "In my medical opinion, the risk of aspiration posed by conducting a bedside swallowing evaluation was greater than the risk of remaining NPO pending the swallowing study that was originally ordered. R1 was monitored while NPO for dehydration and glucose readings remained within parameters. Given her history of aspiration with resultant pneumonia maintaining her NPO status and IV therapy pending definitive evaluation and treatment of her dysphagia was deemed the safest course of action.

On 6/15/23 at 9:00 AM, V22 said that they did what the physician ordered. V22 said the physician (V21) ordered R1 to be NPO. V22 said they scheduled R1 for a barium swallow on 5/30/23 but R1 did not swallow the barium. V22 said they then had an appointment for 6/8/23 and that is the soonest they could get an appointment then sent R1 out on 6/6/23. V22 said he does not know what else they could have done.

R1's Care Plan documents a Care Plan Description of "Nutritional Risk difficulty swallowing" with a Goal of "Maintain or improve weight and health status" with a start date of

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(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 12	S9999		

5/22/23. Documented interventions include: diet as ordered (start date 5/22/23), provide adaptive equipment as needed (start date of 5/22/23), weight as ordered (start date of 5/22/23), swallow eval as ordered by physician (start date of 5/22/23), NPO until swallow eval completed (start date 5/22/23), IV fluids per orders (start date of 5/23/23), transfer to (local hospital) for PEG tube placement (start date 6/6/23), and fortified pudding per orders once clearance after swallow study (start date 5/24/23).

There were no orders, interventions, nor documentation in R1's medical record for a referral to the dietician, speech therapy, or orders for blood work to monitor R1's electrolytes during the 16 days that R1 was on NPO status. There is no documentation in R1's medical record that R1 received any nutrition, orally or parentally, from 5/20/23 until R1's hospitalization on 6/6/23.

The facility policy titled "Abuse Prevention Policy and Procedures" (dated 8/16/19) documents the "facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents." Under the section titled "Definitions", neglect is defined as "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008346	A. BUILDING: ______ B. WING ______	C 06/30/2023

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S9999	Continued From page 13 b). R2's face sheet documents R2 was admitted to the facility on 2/11/22 with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, hallucinations, unspecified, Essential (primary) hypertension, bilateral transient visual loss, bradycardia, unspecified. R2's MDS (Minimum Data Set) assessment dated 4/14/23 documents in section C, Cognitive Patterns, a (Brief Interview for Mental Status) score of 99, indicating that an interview could not be conducted due to resident is rarely/never understood. The IDPH (Illinois Department of Public Health) Incident report labeled Final report dated 5/31/23 documents that on 5/26/23 at 11pm, V2 (Administrator) received a call from a CNA (Certified Nurse Assistant) reporting an allegation of abuse that took place between the nurse in charge and R2. V19 (LPN/Licensed Practical Nurse) was removed from the floor by V2 and asked to write a statement. Immediate assessment of residents was given by V3 (DON/Director of Nurses) with no injuries noted. Police were called and two officers arrived and interviewed V19, then viewed video footage along with the owner (V1) and interviewed R2. The nurse (V19) was suspended pending outcome of investigation. Physician, POA (Power of Attorney), Ombudsman, and police were notified. Head to toe assessment completed on R2 with no injuries noted. R2 did not recall anything happening tonight. V19 was interviewed by V1 (Owner) Administrator and police. V19 stated she was trying to keep R2 from getting all the snacks. V19 said she was following training that she had been given at a psychiatric hospital. It was explained to V19 that we do not put our arms around residents	S9999		

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S9999	Continued From page 14	S9999		

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and escort them down hallways. V19 was suspended pending the investigation. The investigation determined R2 was seeking snacks from the snack cart and V19 told her to stop because she was taking all the snacks. V19 moved R2 away from the snack cart and then started to argue with R2. V19 then escorted R2 to a chair, had her sit down. R2 then attempted to obtain snacks from the nurse's cart. V19 then took R2 by the arms with her (V19) around her and led her (R2) to hallway leading to resident's room. Resident interviews were conducted with no resident reporting knowledge of incident or that they witnessed incident. Staff interviews indicate witnessing V19 arguing and escorting R2 to her hallway leading to R2's room with her arms around her. Based on employee statements, V19 interacted with R2 in an inappropriate manner, along with a direct violation of training provided to her as an employee, and facility protocols. Due to the outcome of this investigation, her (V19) employment will be terminated.

On 6/14/23 at 5:45 AM, V1 (Owner) said that V19 (LPN) was holding R2 from behind with her arms around her. V1 said that V19 took R2 away from the area the snacks were in and then shoved R2 on her shoulders and walked away. V1 said that they have video footage of the incident, but cannot go back that far to view it now. V1 said that V19 was immediately fired.

On 6/14/23 at 5:50 AM, V26 (CNA) said she witnessed V19 put arms around R2 and push her up the hall and was yelling at her. V26 said another staff had reported it to the Administrator.

On 6/14/23 at 6:05 AM, V27 (CNA) said she was there for the incident between V19 and R2. V27 said she saw V19 put her arms around R2 and

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take her up the hall and was yelling at her. V27 said she felt this was wrong and she called the Administrator and reported it.

The facility policy titled "Abuse Prevention Policy and Procedures" (dated 8/16/19) documents under the section titled "Definitions", abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."

(A)