

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2023
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NAME OF PROVIDER OR SUPPLIER AVENUES AT SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)3)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies</p> <p>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</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1 of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to report a resident's significant weight loss to the physician and worsening symptoms of mental illness disorders to Psychiatrist; failed to initiate appropriate interventions to maintain and/or improve nutritional status; and failed to assess, develop, and implement interventions to address the worsening symptoms of mental illness disorders for 1 of 4 residents (R29) reviewed for weight loss and behavioral health services in the sample of 65. The failure resulted in R29 having an insidious weight loss due to worsening and ongoing hallucinations telling him not to eat or drink of 14.5 pounds (lbs.), a 10% weight loss in the last six months.</p> <p>Findings include:</p> <p>R29's Face Sheet documents his diagnoses to include Schizophrenia, Major Depressive Disorder, Vitamin B Deficiency, Bipolar Disorder, Avoidant Personality Disorder, Panic Disorder and Anxiety Disorder.</p> <p>R29's Minimum Data Set (MDS) dated 4/18/23 documents he is alert and oriented and able to feed self independently with supervision and set up assist by staff.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>On 6/11/23 at 12:15 PM R29 was standing at the entrance to the dining room. He had not eaten any lunch or drank any of his fluids. He walked to the dining room and then turned around and went right back down to his room. He stated he was not going to eat lunch. His pants were so loose that he had to hold them up at the waist while he was walking. V7, Certified Nursing Assistant (CNA) stated, "He just doesn't feel good today." V7 did not encourage R29 to go back to the dining room to eat and did not offer him any substitutes or alternatives. R29 returned to his room and laid on his bed.</p> <p>On 6/12/23 at 12:25 PM R29 was lying in bed while the lunch meal was going on. He stated the voices are telling him not to eat or drink anything. R29 stated, "I haven't eaten or drank anything for four or five days. The voices told me if I eat or drink, they will make me take all my clothes off in public." V16, CNA was walking by in the hall and encouraged R29 to come to the dining room with her and she will help him eat and keep his clothes on. R29 was agreeable to this and went to the dining room with V16. V16 was assisting R29 to eat. R29's appearance is disheveled, frail, and extremely thin.</p> <p>R29's Electronic Medical Record (EMR) documents his weights over the last six months as: 6/9/23- 127.5 pounds (lbs.); 5/2/23- 135.5 lbs.; 4/4/23- 135 lbs.; 3/1/23- 138 lbs.; 2/1/23-143 lbs.; and 1/4/23-142 lbs. These weights document R29 has had significant weight loss in 1 month of 5%, in 3 months of 7.6%, and in 6 months of 10%.</p> <p>R29's Care Plan dated 6/12/23 documents: "The resident has unplanned/unexpected weight loss</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>r/t (related to) variety of meal intake". This Care Plan was entered after R29's significant weight loss was brought to the facility's attention by surveyor. Interventions for this care plan include: Offer substitutes as requested or indicated. If weight decline persists, contact physician and dietician immediately. Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss.</p> <p>R29's Physician Order dated 9/29/15 documents: Regular diet, regular texture, regular consistency, Med Pass (supplement drink) 120 milliliters (mls) three times a day, Vegetarian, and give milk with all meals.</p> <p>R29's Progress Notes were reviewed from 1/1/23 to 6/11/23 had no documentation of the physician being notified of R29's significant weight loss until 6/6/23 and no new interventions added until 6/13/23, when a new order was received to start Megestrol Acetate Oral Suspension 400 milligrams (mg)/10 ml; give 10 ml by mouth in the morning for appetite stimulant and Olanzapine 5 mg one tablet by mouth every six hours as needed for hallucinations.</p> <p>R29's Social Service Progress Note date 4/18/23 at 8:20 AM documents, "Resident experiences hallucinations. Resident experiences delusions. Behaviors, but not directed towards others, occurred daily during 7-day lookback. These behaviors put the resident at significant risk for physical illness. These behaviors interfere with the resident's care. Resident rejected care that was necessary to achieve the resident's goal for health and well-being daily during the 7-day lookback.</p> <p>R29's Social Service Progress Note dated</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>4/21/23 at 11:23 AM documents, "(R29) often refuses to take his medications and eating meals; he experiences hearing voices and hallucinations. PRSC (Psychosocial Rehab Coordinator) educated (R29) on the importance of taking his medications, eating and getting involved in social activities and sitting outside on the patio to help take his mind off negative thoughts." There was no documentation in the progress notes that this information was shared with the nursing staff, medical doctor, or psychiatrist.</p> <p>R29's Progress Note dated 6/6/23 at 11:02 AM documents, "Patient has noted weight loss and he is aware. (Medical Doctor (MD) notified of weight loss." This was the first documentation of physician being notified of R29's weight loss in past 6 months.</p> <p>R29's most recent Nutritional Assessment by dietician was dated 4/19/23 and documented he had no significant weight loss at that time. This assessment was not completed and signed until 6/12/23.</p> <p>On 6/12/23 at 1:45 PM V1, Administrator, stated V6, Regional Dietician for the company, entered a new care plan regarding R29's weight loss today. V1 stated V15, the facility's dietician, was notified and is finishing her nutritional note for R29 she initiated but had not completed on 4/18/23. V1 stated she would expect the dietician to address the weight loss and finish the assessment as soon as she is aware of R29's weight loss.</p> <p>On 6/12/23 at 2:38 PM V2, Director of Nursing (DON), stated she would expect if there were a significant weight loss the dietician and MD should be notified right away. V2 stated she</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>would expect this to be done as soon as the resident has a significant weight loss so appropriate interventions can be put into place.</p> <p>On 6/14/23 at 9:06 AM V22, Medical Doctor, returned call and acknowledged the facility did call him last week to notify him that R29 had a weight loss. V22 stated he would have expected the facility to notify him sooner, when R29 had a 3-5% weight loss and he would have put an intervention in place sooner, to promote R29 increased nutrition, before he got to the point, he had lost 10% of his weight.</p> <p>On 6/14/23 at 10:15 AM V15, Dietician stated she usually receives the facility's monthly weights by the 5th or 7th of the month. V15 stated that usually the weight summary in the EMR documents in the right column if there is a significant change in a resident's weight at 1 month, 3 months or 6 months, but for some reason, R29's did not show this. V15 stated R29 had significant weight loss at 1, 3 and 6 months, but V15 had to manually calculate it. V15 stated when the facility called her on Monday, she manually calculated R29's weights and R29 had lost 6% in one month, 7.7% in 3 months and over 10% in 6 months. V15 stated, that doesn't usually happen, with the system not flagging the significant weight losses. V15 stated as soon as they made her aware, she manually calculated everyone's in the facility weights. V15 stated the usual procedure if a resident flags a weight loss in 1, 3 or 6 months is that she is notified, and she makes a recommendation. V15 stated if the reason for the weight loss is related to the resident's mental illness, she would send the psychiatrist a recommendation, if appropriate. V15 stated she would first consult with the facility to try to find out why the weight loss occurred.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>V15 stated normally she would like the MDS Coordinator, or some other staff let her know if a resident has significant weight loss when she is due for a visit so she can review them and make appropriate recommendations before she does the other nutritional assessments that are due that month. V15 stated she has not had any reports from staff with monthly weight concerns. V15 stated the bottom line is that for whatever reason, (R29's) EMR did not flag his significant weight loss like it usually does, and she was not aware of his weight loss until the facility called her on Monday. V15 stated R29's weight loss is very concerning because he is under his recommended BMI (body mass index) and ideal body weight. V15 stated she recommended an appetite stimulant to his MD. V15 stated ideally, she should have been notified of his weight loss when he had a 5% weight loss, and it would have been addressed sooner.</p> <p>R29's Progress Note dated 6/13/23 at 8:19 AM, documented by V21, Psychiatrist, documents, "Received a call from staff, made aware about patient's worsening symptoms. They communicate the failure of non-pharmacological interventions. Started Olanzapine 5 mg po (by mouth) q6hr (every 6 hours) PRN (as needed) x 14 days. Diagnosis Schizophrenia. Indication: Per staff, patient having increasing hallucinations. Voices are telling him not to eat and he has been losing weight. We will keep low threshold for hospitalization should patient become aggressive. Will evaluate patient at next visit." This was first documentation of notification of psychiatrist regarding R29's refusal to eat related to his increased hallucinations.</p> <p>On 6/14/23 at 10:00 AM V1, Administrator, stated</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>there is no policy specifically for notifying the psychiatrist of changes in resident's behaviors. V1 stated this would be covered by the facility's policy for notification of change in condition.</p> <p>On 6/14/23 at 10:50 AM V21, Psychiatrist, stated he received a call from the facility on Monday, (6/12/23) and was told R29 was hallucinating and hearing voices telling R29 not to eat. V21 stated he started R29 on prn Olanzapine to help with his hallucinations. V21 stated that is the only communication V21 had received regarding R29 since the facility had notified him in April that another practitioner had ordered Haldol. R29 was allergic to Haldol, so it was discontinued. V21 stated the facility is aware they can email concerns or call the office if needing to talk to the psychiatrist or their nurse practitioners. V21 stated he prefers they call the office because the office keeps track of every call or message that comes in, so he can track who called, from where and why they called. V21 stated if the facility had informed him of R29's complaint of voices telling him not to eat, and his significant weight loss related to that, he would be able to retrieve those messages and see exactly when and what time he received the notification. V21 stated he was never contacted of any changes with R29 since the call regarding his Haldol on 4/10/23. V21 stated it is very important for any changes in the resident's condition related to their behaviors to be reported to him, the nurse practitioner, or the office so it can be addressed right away. V21 stated he will have the nurse practitioner who goes to this facility to call, and she may know more about what is going on with R29.</p> <p>On 6/14/23 at 11:37 AM V23, Psychiatric Nurse Practitioner, stated no staff from the facility told her anything about R29 having significant weight</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>loss or complaining that the voices were telling him not to eat. V23 stated she usually talks to V3, Assistant Director of Nursing (ADON), when she first gets to the facility, but V3 never reported any concerns about R29's weight loss or him not eating. V23 stated the only thing that was ever reported to her about R29 was that R29 was having increased anxiety and V23 refilled his Ativan. V23 stated that information came from a floor nurse, not V3. V23 stated when she talked to R29 during his visits, R29 would report that he was hearing voices, but R29 never told V23 the voices were telling him not to eat. V23 stated it would be important for the facility to let V23 know if R29 was having any changes so V23 could assess R29 while she is there and address it before it significantly affects his health or well-being. V23 stated staff in the facility are aware they can call or email concerns to the office and the office forwards those concerns to V23 as soon as they get them. V23 stated any abnormal resident behaviors should be reported and addressed.</p> <p>The facility's policy, Weight Assessment, and Intervention dated 2020 documents, "Guideline: Weights are monitored monthly or more often as recommended by the interdisciplinary care team. The goal is to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight loss. Weight data will be used as one step in determining if changes to the nutritional plan of care are needed to prevent or slow unintentional weight loss within the limits of the resident's clinical condition. 4. Any weight change of 5% or more since the previous weight assessment shall be re-taken to confirm. If the weight is verified, nursing will notify the</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>appropriate designated individuals such as the physician, Registered Dietician, Dining Services Manager, or other members of the interdisciplinary team. 5. The Registered Dietician will review the weight log each month to follow individual weight trends. Negative trends will be evaluated by the treatment team to determine whether or not significant weight change has occurred. 6. The threshold for significant unplanned and undesired weight loss shall be based on the following criteria: (percentage of body weight loss= (usual weight-actual weight) divided by (usual weight) x 100): 1 month 5% (significant loss) greater than 5% (severe weight loss) 3 months 7.5% (significant loss) greater than 7.5% (severe weight loss) 6 months 10% (significant loss) greater than 10% (severe weight loss)</p> <p>Analysis: 2. The physician along with the interdisciplinary team will identify conditions and medications that may be causing anorexia, weight loss, or an increased risk of weight loss. This includes but is not limited to: Cognitive or functional decline; Chewing or swallowing abnormalities, pain, Medication-related adverse consequences, Environmental factors (for example, noise distractions in dining room), Increased nutritional needs, Poor digestion or absorption, fluid and/or nutrient loss, Inadequate availability of food or fluids. Care Planning: Care planning for undesirable weight loss or impaired nutrition shall be a multidisciplinary effort and will include the physician, nursing staff, Registered Dietician, a member of for the Food and Nutrition Department, consultant pharmacist, and the resident or the resident's legal surrogate. Care plans will consider the wishes of the resident and the right to choose their own treatment plan. 2. Individualized care plans shall address the</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>following to whatever extent possible: Identified of the problem that is causing the weight loss. Goals with measurable time frame for improvement. Interventions and approaches.</p> <p>The facility's policy, "Behavioral Health Services (Previously Behavior Management Program) revised 1/2023, documents, "Purpose: To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. Initial measures: 10. Notify the physician of the resident's signs/symptoms and lack of response to medications and other interventions as indicated. 12. If the behavior symptoms do not subside or resolve, or if resident continues to exhibit behaviors that pose a threat to themselves or others, notify the physician for further orders or call 911 as deemed appropriate." (B)</p>	S9999		