STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

SHERIDAN HEALTH CARE CENTER 145665

Facility Name I.D. Number

2534 ELIM AVENUE, ZION, ILLINOIS 60099
Address

Date of Survey : 02/26/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.610(a) The facility shall have written policies and procedures, governing all services provided by the facility
300.1010(e) which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator,
300.1010(h) the advisory physician or the medical advisory committee and representatives of nursing and other
300.1210(a) services in the facility. These policies shall be in compliance with the Act and all rules promulgated
300.1210(b)(3) thereunder. These written policies shall be followed in operating the facility and shall be reviewed at
300.1220(b)(3) least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.
300.2040(d)
300.3240(a) The DON shall oversee the nursing services of the facility including:

Planning an up-to-date resident care plan for each resident based on the resident=s individual needs and goals to be accomplished, physician=s orders, and personal care and nursing needs. Personnel representing other services such as nursing, 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. The plan shall be reviewed at least every three months.

All residents shall be seen by their physicians as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)

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.

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(Cont.)

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident=s comprehensive assessment and plan of care. 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.

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 residents=s medical record.

Personal care shall be provided on a 24-hour, seven-day-a-week basis.

The resident shall be observed to determine acceptance of the diet and these observations shall be recorded in his record.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (A, B) (Section 2-107 of the Act)

These REQUIREMENTS are not met as evidenced by:

Based on record review and interviews with staff, the facility failed to:

1) assess and monitor a change in R2's medical/psychiatric condition;
2) immediately notify the physician of a change in R2's behavior and an increase in R2's frequency of refusing meals; and significant weight loss
3) accurately document R2's food intake;

These failures resulted in R2=s needing to be transferred to the hospital on Tuesday, 2/3/04, and admitted with a primary diagnosis of gastrointestinal bleed and secondary diagnoses including dehydration and cachexia.

R2 died 12 hours later of respiratory failure secondary to cachexia and malnutrition.

The findings include:

1. R2 was a 52-year-old male who was admitted to the facility on 8/31/98 with diagnoses of Blindness in both eyes and Schizophrenia per admission face sheet. Assessments dated 12/2/03 and 9/2/03 document that R2 was moderately impaired in cognitive skills for decision-making. These assessments also document that R2 was independent with eating. The most recent Resident Assessment Summary dated 9/2/03 documents that R2 "displays moderately impaired decision-making skills due to delusions and paranoid deations...requires supervision and cues to ensure safety" and "he has been without psychotropic medications since 10/00 because of refusal to take them."

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2. The most recent Psychiatric Assessment dated 10/1/03 document that R2 "is obsessed with his religious views. Has delusions - talking to God." This assessment also documents that R2 has hallucinations and that his perception, judgment and insight are impaired. Social Service Assessment dated 9/2/03 documents "Resident may not make correct decisions for self at times by refusing treatment/meds, stating God will heal him. Res displays delusional behavior mentioning he's Son of God..."

Specialized Services Progress Notes dated 12/2/03 documents "Resident exhibits delusional/hallucinotic behavior (stares in altered state/talking to self or non-existing being) and will relate he had communication with God...will frequently refuse care or act against healthful recommendations..refuses showers/shaves/meds/meals..." Social Service Quarterly Progress Note dated 12/2/03 documents "Res displays poor choices by refusing meds/treatments stating 'God will heal me'".

3. Nursing notes dated 1/24/04 at 6:45 AM document that R2 told the nurse that he was not feeling well and needed to see a doctor. The note also documents that R2 was "noted to be cold and clammy but not in respiratory distress." The next nursing note entry is dated 2/3/04 and documents, "found res in bed weak appearance emaciated unable to obtain vital signs page MD stat." E3 (Assistant Director of Nursing) was interviewed by phone on 2/24/04 and confirmed that there were no entries in the nursing 24-hour log regarding R2 from 1/19/04 to 2/2/04.

Several "Late Entry" notes followed the 2/3/04 nursing note entry. Per interview with E4 (Administrator) these notes were written on 2/4/04.

E5 (Social Service Assistant Director) wrote a late entry which documented an incident that occurred on 1/27/04 at 10:00 AM in which R2 was observed to come in the building from outside and enter the elevator. The note documents that it was very cold outside and that R2 did not have a coat on. E5 documents that she touched R2's arm and that it was "very clammy." E5 also documents that she asked E23 (RN/assessment coordinator) to go to R2's room with her because he "was clammy and not looking very well."

E23 (RN/M) documents a late entry for the 1/27/04 incident in which she states that R2 "appears to have a change in LOC (level of consciousness), more delusional." E23 also documents that R2 refused to let her examine him, stating, "'Get away! I don't need you to touch me. I'm fine! God takes care of me.'"

E22 (LPN) documents a late entry for 1/27/04 in which she states, "was made aware of resident having SOB [shortness of breath]" and "did go check on resident and he informed me he was fine and God took care of him..." E22 further documents that "resident appeared pale." In another late entry for 1/27/04 at 12:00 PM E22 documents "resident refused to eat anything today - said he was fasting unable to get him to eat. Will continue to monitor."

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E1 (Assistant Administrator) documents a late entry for 1/30/04 in which he states that E4 (Administrator) informed him that the resident "looked too thin" and "had been fasting.@ E1 further documents that "resident indicated that he was fasting per religious beliefs" and that R2 stated that God told him to fast. E1 documents another late entry for 1/27/04 in which he writes, "Resident indicated that he was fine but that someone was trying to kill him."

4. The most recent full Nutrition Assessment dated 8/15/03 documents that R2 was 71 inches tall and weighed 123 pounds. This assessment also documents R2's Ideal Body Weight (IBW) range to be 155 - 189 pounds and that R2 had a Body Mass Index (BMI) score of less than 19. The note further documents that R2 was in the "high risk" category for overall nutrition risk. Care Plan dated 1/28/04 documents "Resident has experienced a recent weight loss of 13 pounds. Resident frequently refuses meals - States he is 'fasting' due to religious beliefs - displays delusional behavior about religion." Monthly Weight and Vital Sheet records document that R2 weighed 128 pounds in January 2004 and 115 pounds in February 2004. Resident transfer form dated 2/3/04 documents that R2 weighed 110 pounds on 2/3/04. This represents a significant weight loss of 14% in 30 days.

E8, E10, E12, E14 and E24 (CNAs) were all interviewed between 2/10/04 and 2/17/04, either in the conference room or on the 3rd floor, and reported that it would be difficult to get an accurate assessment of what R2 was actually eating or drinking because he would often take food and drinks back to his room. Interviewees stated that food and drink that R2 took back to his room were not recorded in the food logs. It was also reported that an "R" or a "0" in the food log indicates that R2 refused his meal tray altogether.

Food logs document that R2 refused all of his meals on 2/2/03 and refused 23 meals in January 2004.

Refusal of Treatment (Resident) Policy dated 01/04 state that when a resident refuses care/treatment the physician will be notified, the responsible party/family will be notified and nurses will document thoroughly in nurses notes. Based on record review and interviews presented in this deficiency this was not done.

Meal Monitoring Policy dated 7/11/03 states, "all aspects of the meal are to be monitored, including food items taken to the Resident's room." Based on CNA interviews this was not done.

Weight Loss Assessment and Care Planning Policy dated 01/04 documents that a Registered Dietitian will review all residents who are or at risk to become below IBW. R2 was not assessed by a Registered Dietitian after his significant weight loss was identified on 1/28/04 and was last seen by a Registered Dietitian on 12/9/02 per review of all nutrition notes.

Record review indicates that there was no care plan in place to address R2's fasting behavior even though Nutrition Notes document knowledge of this behavior as far back as 8/28/99. There was also no plan in place to address how to accurately assess R2's food and liquid intake when he took these items to his room.

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5. E7 (Care Plan Coordinator) was interviewed on 2/10/04 in the conference room. E7 stated that residents are usually weighed between the 1st and the 5th of each month but that R2 was weighed on 1/27 or 1/28/04 because "we heard he was fasting." E7 stated that on Tuesday 1/27/04 in the morning meeting she "overheard that [R2] was on a fast." E7 stated that for this reason she requested that E13 (CNA/occupational rehab) weigh R2 early. R2 was weighed at 115 pounds. E7 stated that she usually only saw R2 as she came and left work because he would be outside smoking. E7 stated that when she learned about his weight loss she put a care plan in his chart. E7 stated that she did not notify R2's physician about his fasting behavior and significant weight loss.

E6 (Assistant Social Service Director) was interviewed on 2/11/04 in the conference room and confirmed what she wrote in her late entry note for 1/27/04. E6 added that besides feeling clammy on 01/27/04 R2 "looked pasty and all sweaty...really wasn't himself" and "looked more thin than usual." E6 further stated, "he looked like the man on Thinner. His eyes were bulging and I could see he cheek bones." E6 stated that she told E2 (Assistant Director of Nursing) "I think [R2] needs to be sent out." E6 stated that E2 responded that R2 was fasting and that E1 had talked with R2.

E15 (Certified Dietary Manager) was interviewed on 2/11/04 in the conference room and stated that she would see R2 almost everyday, sometimes 2-3 times a day because R2 would come to the kitchen if he had a complaint or if he wanted something different for meals. E15 stated that the last couple of weeks prior to R2 going out to the hospital "he wasn't coming down asking me for things like he usually does." E15 stated, "...before he went into the hospital - probably a Thursday (1/29/04) - I got a shock." E15 described R2 to look "like a skeleton with the skin hanging over his bones." E15 stated that the next day she looked for R2's return tray in the dishwasher room and noticed that he only ate 1/2 sandwich and that everything else on the tray was not touched. E15 stated that she alerted R2's CNA and requested that the CNA tell the nurse that R2's tray was almost all there.

E23 (RN/M) and E22 (LPN) were interviewed on 2/11/04 in the conference room. Both confirmed what they wrote in their late entry note of 1/27/04 and both added that they noted that R2 also appeared pale on 1/27/04. E22 stated that on the morning of 1/27/04 R2 told her "'you know I'm fasting.'" E23 stated, "I don't know if he (R2) would admit that he was having a medical problem because of his psyche diagnosis. It would be up to nursing to assess whether or not he needed an intervention."

E11 (CNA) was interviewed by telephone on 2/18/04 and stated that she last saw R2 at breakfast on Monday morning, 1/26/04. E11 stated that R2 told her he wasn't eating because he was fasting. E11 stated that R2 agreed to take his milk off the tray.

E13 (CNA/Occupational Rehab) was interviewed on 2/10/04 in the conference room and stated of R2, "He would fast several times a year for 2 or 3 days at a time for religious reasons." E13 stated that on Friday, 1/30/04, she overheard R2 telling a staff member, "'I'm not eating, I'm fasting.'"

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E10 (CNA) was interviewed on 2/10/04 in the conference room and stated that she wrote a note for R2 which stated that he could fast for a couple of days a week for religious reasons. R2 requested this note of permission so he could show it to other staff members so that they would not bother him about fasting.

E14 (Nursing Assistant) was interviewed on 2/10/04 in the conference room and stated that the last 3 days that she worked before R2 went out to the hospital he wouldn't come to the dining room for dinner because he said "he was fasting."

E16 (LPN) was interviewed on 2/17/04 at the 3rd floor nursing station and stated that she was the one who found R2 on 2/3/04. E16 stated that he looked very weak and short of breath and that his bed and clothes were soiled.

E17 (LPN) was interviewed on 2/10/04 in the conference room and stated that on the evening before R2 was sent out to the hospital (2/2/04) he complained that he wasn't feeling well and requested Tylenol. E17 stated that he brought R2 the Tylenol in applesauce in hopes of getting him to eat something but that R2 refused the Tylenol because it was in applesauce. E17 stated that he was aware of R2's weight loss approximately 7 - 10 days prior to him being sent out. E17 also stated that he was aware that R2 had been fasting and that he talked with him about this on 2/2/04 and that R2 responded that he had only been fasting a day or two and that he'll be okay. E17 stated that R2 "rarely" had health complaints.

E9 (Social Service Director) was interviewed on 2/11/04 in the conference room and stated that she was aware that R2 had a history of fasting in the past. E9 stated that she received reports from her staff, in the 1st or 2nd week of January, that R2 was becoming "much more obstinate...more behavior issues." E9 stated that this was an escalation of negative behavior that had occurred before and that his behaviors were "cyclical." E9 said that R2 would deny that he had schizophrenia or that he was blind and that he would refuse to talk about his symptoms. E9 stated that it would be hard to find out what R2 ate because he would take things back to his room and wouldn't always tell you what he ate. E9 stated that she felt R2 was capable of making his own decisions about eating and drinking even though he stated that he was taking his direction from God about what to eat or when to eat.

E3 (Assistant Director of Nursing) was interviewed on 2/10/04 in the conference room and stated that she was asked to go to R2's room the morning of 2/3/04 by E5 (Director of Nursing) because R2 had not been eating. E3 stated that when she saw him she said, "Oh my God!" because "his cheeks looked hollow, his eyes were sunken and he looked like he was a little short of breath." E3 stated that R2's physician was notified for the first time on 2/3/04. This was approximately 7 days after the facility was aware of R2's significant weight loss and change in medical/psychiatric condition, including his refusal to eat.

6. Review of hospital records indicate that R2 was admitted to the emergency room on 2/3/04 and was given a primary diagnosis of Gastrointestinal Bleeding and secondary diagnoses of dehydration, cachexia, blindness and schizophrenic. The Daily Physical Assessment dated 2/3/04 documents that R2 was "very emaciated,

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cachectic....very thin, skin is dry and flaky...very weak, unable to ambulate steady." The emergency room discharge note documents "patient given greater than 1500 cc over 3 hours without urine output will give another 500cc and reassess labs..." Hospital labs for 2/3/04 indicate a BUN of 39, a Creatinine of 2.7 and an Albumin of 2.0. Normal values are usually 8 - 18, 0.6 - 1.5, and 3.5 - 5.0 respectively. Hospital nursing notes document "patient's lips are parched, cracked with brownish crustation, tongue is very dry. Patient very emaciated, dry skin, very poor turgor."

Z3 (Emergency Room Physician) was interviewed on 2/18/04 at 12:30 PM and confirmed that he was the ER physician who examined R2 on the morning of 2/3/04. Z3 stated that R2 was "severely emaciated, severely dehydrated and severely malnourished" based on his assessment. Z3 also stated that "he (R2) looked like he was starving, he looked cachetic."

Z1 (R2's Primary Physician) was interviewed on 2/11/04 at 3:00 PM and stated that R2's cause of death was "respiratory failure secondary to cachexia and malnutrition." Z1 stated that he was first notified of R2's significant weight loss and refusal to eat on the day R2 was transferred to the hospital (2/3/04). Z1 stated that a head nurse from the nursing facility told him that R2 had been fasting for 2 weeks and that they were investigating this. Z1 stated that he was later told that R2 was fasting 1-2 days a week. Z1 stated that R2's GI bleed was not the cause of death and that "the big problem was his poor nutrition." Z1 stated that he told the facility "you should have notified me that this patient was in this condition." Z1 stated that when he saw R2 on the evening of 2/3/04 he was "listless and very cachetic."

(A)