		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		145160	B. WIN	IG			C 4/2012
NAME OF P	ROVIDER OR SUPPLIER	·			EET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	CARE CENTER				55 WEST CARPENTER PRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 505	Continued From pa Hospital ER re time of death 12-13	cords showed asystole and	F٤	505			
F9999	FINAL OBSERVAT	IONS	F99	999			
	LICENSURE VIOL	ATIONS					
	300.610a) 300.610c)2) 300.1210a) 300.1210d)3) 300.3240a)						
	Section 300.610 Re	esident Care Policies					
	procedures, govern the facility which sh Resident Care Polie least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facilit least annually by th	have written policies and hing all services provided by hall be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and hursing and other services in policies shall be in compliance rules promulgated thereunder. tes shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a					
	minimum the follow 2) Resident care se services, emergend nursing services, re	licies shall include, at a ving provisions: ervices including physician cy services, personal care and estorative services, activity eutical services, dietary					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	05/04/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
	145160	B. WI	NG _			C 4/ <b>2012</b>
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL CARE CENTER				SPRINGFIELD, IL 62702		
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
<ul> <li>services, and diagnos laboratory and x-ray).</li> <li>Section 300.1210 Ger Nursing and Personal</li> <li>a) Comprehensive Re with the participation of resident's guardian or applicable, must deve comprehensive care p includes measurable of meet the resident's m and psychosocial nee- resident's comprehen- allow the resident to a practicable level of inco- provide for discharge restrictive setting base needs. The assessme the active participation resident's guardian or applicable. (Section 3- d) Pursuant to subsect care shall include, at a and shall be practiced seven-day-a-week base 3) Objective observati resident's condition, in emotional changes, as determining care required</li> </ul>	ces, clinical records, dental stic service (including neral Requirements for I Care esident Care Plan. A facility, of the resident and the representative, as elop and implement a plan for each resident that objectives and timetables to redical, nursing, and mental eds that are identified in the usive assessment, which attain or maintain the highest dependent functioning, and planning to the least ed on the resident's care ent shall be developed with n of the resident and the representative, as i-202.2a of the Act) ction (a), general nursing a minimum, the following d on a 24-hour, sis: ions of changes in a ncluding mental and is a means for analyzing and uired and the need for ation and treatment shall be f and recorded in the	F9	999			

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		145160	B. WI	NG			C 4/ <b>2012</b>
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	CARE CENTER				55 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa Section 300.3240 A	-	F9	999			
		ee, administrator, employee or nall not abuse or neglect a					
	These requirement by:	s were not met as evidenced					
	failed to respond to critically low blood s (R4) reviewed for a sample of 6. This f getting immediate of	view and interview, the facility changes in condition and to a sugar level, for 1 of 3 residents change in condition, on the ailure resulted in R4 not care for a blood glucose level diac arrest and expiring.					
	Findings include:						
	in part; acute renal Infection, Hypoosm Protein - Calorie Ma Obstruction and Dia Circulatory Disorde The Physician C December 2011 do The POS shows of continuous due to c Humalog 100 Units 8:00AM, 12:00 noo 100U/ML at 10 unit (blood glucose mor bedtime and call M Review of the Fa	t of 11-4-11 shows a diagnosis failure, history of Urinary Tract olality and Hyponatremia, alnutrition, Chronic Airway abetes with Peripheral r. Order Sheet (POS) of cuments R4 is a full code. rders for Oxygen 2-3 liters diagnosis of Hypoxia; to be given sliding scale at n and 6:00PM and Lantus s to be given at 9:00PM; hitoring) before meals and at D (physician) if less than 70. acility Skilled Nursing Flow 11 documents R4's blood					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTI		(X3) DATE SU COMPLE	IRVEY
		IDENTIFICATION NOMBER.	A. BU	ILDIN	NG	(	
		145160	B. WI	NG _			4/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	CARE CENTER			-	555 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F9999	pressure (BP) at 14 3 liters of O2; Skin alert and oriented; a (1:30PM) document oriented. Able to m finish Physical Ther well. Vital signs tak 152/68, Blood oxyg cannula (n/c). O2 th Blood oxygen now a symptoms of pain of Nurses Notes were entries noted: 12-12-11 at 4:15 Practical Nurse/Nur documents Z6, R4's thought R4 had cont to the ER (Emerger documents that E5 that R4's BP was a Sats was 88% at 2 3 liters with a pulse breath. Lungs dimint therapy. On 12-27- didn't seem any diff reason to go to the 12-12-11 at 4:15 Nursing, DON,docu called and stated sh ER. E2 asked reas ER. Z7 stated that "mom was out of it, documents E2 called medical status. 12-12-11 at 7:40	8/56; Oxygen (O2) at 94% on warm and dry; Cooperative, and appetite fair. Note at 1330 ts, in part, R4 is alert and ake needs known. unable to apy (PT) due to not feeling ten at that time and BP en at 88% at 2 liter per nasal urned up to 3 liters per n/c and at 94%. No signs or or discomfort or distress noted. reviewed with the following 5PM written by E5, Licensed reviewed with the following 5PM written by E5, Licensed se Manager (LPN) for R4's s daughter, was visiting and fusion and needed to be sent ncy Room). The Note tried to explain to daughter little high today 148/56, O2 liters and O2 was increased to ox of 94%. No shortness of nished. Laid down after 11 at 1:20PM, E5 stated R4 erent and didn't have any	F9	999			

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	1ULT	IPLE CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	NG	COMPLE	
		145160	B. WI	NG _			C 4/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	L CARE CENTER				555 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	speech No comp any distress. "Write replied with "I'm tire long day with therap pain of 6 on 1-10 sc medicated with PRI results obtained pa R4 in room for supp poor. R4 encourag et to have energy fo symptoms of hypo// 12-13-11 at 5:5 glucose check at 34 respiration even an touch. Z1 paged av 12-13-11 6:05 A called and told this the Nurse needed of 12-13-11 6:10 A went into R4's room in full cardiac arress had a large amount coming from her m Medical Service (EI 12-13-11 6:35 A returned call and or 12-13-11 6:35 A returned call and or 12-13-11 6:50AN R4 to the hospital. 12-13-11 7:45 de	blaints and does not appear in er asked R4 how she felt. R4 ed" R4 also stated she had " a py." R4 complained of BLE cale @ 1800 (6PM) . R4 N (as needed) Norco. + in down to 2 at 1900 (7PM). Der per her request. Appetite je to eat by writer d/t diabetes or ADL's therapyNo signs or hyperglycemia. 50AM, documents blood 4. R4 unresponsive, d unlabored pale and cold to waiting return call. paged a second time. Still AM, note documents Telanurse was an emergency and that orders. AM the Nurse documents she h to check on her and R4 was t. CPR was initiated and R4 t of dark brown discharge outh and nose. Emergency MS) called. M, EMS arrived and took over M documents Z13, Physician, rdered Glucagon. ocumentation states the Nurse the Glucagon and EMS did not	F9	999			

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145160	(X2) N A. BU B. WI	ILDI		FORM OMB NO. (X3) DATE SL COMPLE	ted C
	ROVIDER OR SUPPLIER	143100				01/04	4/2012
	CARE CENTER				TREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	of 12-12-11 show th being ill. The Note unable to perform in feeling weak & part (nursing) notified vit with E 9, Physical 12-27-11 at 1:50 PM was the first time R Record review of for December 2011 100% at meals from December 11. The 25% for breakfast a evening meal was r on 12/12/11. There is nothing show R4 was asses refusing therapy, in requiring O2 to be i liters and assessme Sugar of 50 mm/dl On 12-29-11 at 3 stated by the time th to give the Glucago stated they were go would work faster th E 1, Administrate AM, the facility does Procedure for respon E5 stated on 12- have called the Medica orders for Glucagor R4's Care Plan	hat R4 refused Therapy due to documents, "R4 feeling in therapy today. R4 stated icipation unwilling. Ng tals taken:" During interview Therapy Assistant, on <i>A</i> , E 4 stated that 12-12-11 4 had refused therapy. f R4's Food Intake Records show she ate between 50 to in December 1, 2011 through e Record shows R4 ate only and 20% at lunch and the not documented as to intake in R4's Nurses Notes that seed for decreased appetite, creased blood pressure, increased from 2 liters to 3 ent of R4's low Fasting Blood on 12-6-11. 8:30PM, Z10, Paramedic, he Nurse came into the room in. R4 was in asystole. Z10 ing to give glucose which han the Glucagon. or, stated on 12-27-11 at 1:10 is not have a Policy and onse to low blood sugar. -27-11, that the Nurse should dical Director when she did not in Z1. E5 stated E 1 was going al Director to get standing	F9	999	9		

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	-	AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	1ULT	IPLE CONSTRUCTION	(X3) DATE SL	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	NG	COMPLE	TED C
		145160	B. WI	NG _			4/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	CARE CENTER			-	555 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	.ge 27	F9	999			
		(A)					
	300.610a) 300.1010h) 300.3240a)						
	Section 300.610 Re	esident Care Policies					
	procedures, govern the facility which sh Resident Care Polic least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th	have written policies and ning all services provided by all be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. tes shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a					
	Section 300.1010 N	Nedical Care Policies					
	of any accident, injuresident's condition safety or welfare of	notify the resident's physician ury, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145160	B. WIN	G			C 4/ <b>2012</b>
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	CARE CENTER				55 WEST CARPENTER PRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	percent or more wit facility shall obtain a of care for the care injury or change in notification. Section 300.3240 A a) An owner, licens agent of a facility sh resident.	a weight loss or gain of five hin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of	F99	99	DEFICIENCY)		
	failed to follow their Physician of laborative residents, R4, revie laboratory results in resulted in R4 not go tests/treatment to do she expired. Findings include: The facility Polit that is undated, door be notified of any cl condition that deviat line and/or results of Z3's Progress	etermine internal bleeding and cy on "Physician Notification" cuments, "The Physician will nanges in the resident's te from the established base					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145160	B. WI	NG _			C <b>4/2012</b>
-	ROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER		
CAPITO					SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	results to Z3. BMP microalbumin, Vitar in 3 weeks. Laboratory tests laboratory values of of 58 (normal 7-27 (normal 0.5 - 1.5 m within normal level Hemoglobin 8.4 (not Hematocrit 24.7 (not A note was writte Any Orders? Our fa Z3." There is nothin addressing the abo Laboratory BUN elevated at 87 BUN/Creatine Ratic Hemoglobin 8.3; He There is no docu record that would in was notified of the a and these laborator medical record unti inquired about the r On 12-29-11 at Nursing, (DON) sta drawn on 12-6-11 b where they were an R4's medical record At 1:02PM, E2 s labs in the "to do file do file is, E2 stated reviewed. Doctor n At 1:20PM, E2 s information to prove 12-6-11 labs. On 1-3-11 at 11:	, CBC Phosphorus, nin D, Iron panel to be drawn of 11/29/11 show abnormal f Blood Urea Nitrogen (BUN) mg/dl); Creatinine 2.2 g/dl); BUN/Creatine Ratio at 26 (normal 6-34) and ormal 12.0 - 16 g/dl); ormal 36 -48 %). n "Z1 Any N.O. (new orders)? ax xxx-xxxx. 11/29 faxed to ng in R4's Nurses Notes ve labs. test for 12-6-11 document ; ?; Creatinine of 2.2; o was now elevated at 40; ematocrit 24.6. umentation in R4's medical ndicate Z3 or any Physician above lab results of 12-6-11 ry results were not in R4's I 12-29-11 when Surveyor results. 12:10PM, E2, Director of ted she thought labs were out stated she didn't know nd confirmed they were not in	F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145160	B. WI	NG _			C 4/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	CARE CENTER				555 WEST CARPENTER SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	documented on the were faxed to Z3. Z faxed to Z3 and the 11-29-11 were faxe shows they were no Z14 stated Z3 orde understand why the Z1 and not Z3 when stated Z3 was not in At 1:00PM, Z14 sta and stated he would and stool card due would not have left BUN/Creatinine Ra would be a concern Nurses Note of documents R4's blo unresponsive, resp pale and cold to tou documents she wer her and R4 was in f initiated and R4 had brown discharge co nose. Emergency I EMS report of 12 patient at 6:35AM w 1000-2000 ml. Airw blood; cyanosis; pu unresponsive. Note time, excessive am patient, EMS attem fieldIntubation una amount of blood in of dark blood was of mouth, Cyanosis ar notedEMS notified	5-11. Z14 was informed it was labs of 11-29-11 that they Z14 stated the labs were not computer shows labs of d to Z1 and fax transcript of faxed to Z1 until 12-6-11. red the labs and didn't e facility would fax the labs to n Z3 ordered the labs. Z14 nformed of the 12-6-11 at all. ted Z3 was shown the labs d have ordered an iron panel to concern of bleed out. He it alone. "With the tio and low Hemoglobin there	F9	999	Э		

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		AND HUMAN SERVICES				FORM	: 05/04/2012 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED C
		145160	B. WI	ING	à		4/2012
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER		
CAPITO	CARE CENTER				SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	Continued From pa to continue efforts a Hospital ER re- time of death 12-13	and transport." cords showed asystole and	F9	999			

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