

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAWNEE CHRISTIAN NURSING CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 13TH STREET</b> <b>HERRIN, IL 62948</b>		
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F 327	Continued From page 33 plans of residents deemed at risk for dehydration will be reviewed and updated as based on resident assessment. Physicians will be notified if the resident does not meet the dietician recommended fluid intake in a 24 hour period. Completion date: Feb. 22, 2013. C. Licensed staff will be re-educated on signs and symptoms of dehydration, indicators that place residents at risk for dehydration, and facility protocol for residents with GI symptoms and residents on antibiotics for treatment of infection. Licensed staff and CNA's will be re-educated on monitoring residents' fluid intake and proper recording methods. Re-education will be completed by February 22, 2013. Staff not currently working will not be permitted to work until after receiving re-education. Completion Date: Feb. 22, 2013 D. Residents with GI symptoms and residents on antibiotics for treatment of infection will be discussed by the IDT at weekly At Risk Meetings. Residents currently being treated for nausea, vomiting or diarrhea will be discussed at the facility's morning meeting to ensure their hydration needs are being met. Completion Date: Feb. 22, 2013	F 327			
F9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS:  300.610a) 300.690a)b)c) 300.695b)3) 300.695c)1)5) 300.695d)	F9999			

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F9999	Continued From page 34 300.695e) 300.3240a)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.  Section 300.690 Incidents and Accidents  a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.  b) The facility shall notify the Department of	F9999			

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F9999	<p>Continued From page 35</p> <p>any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.</p> <p>Section 300.695 Contacting Local Law Enforcement</p> <p>b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 5) Facility investigation of the situation. d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c). e) The facility shall also comply with other reporting requirements of this Part. (Source: Added at 26 Ill. Reg. 4846, effective April 1, 2002)</p>	F9999			

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F9999	Continued From page 36  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 Regulations are not met as evidenced by:  Based on interview and record review, the facility failed to develop and implement an abuse prohibition policy that complied with federal regulations by requiring the immediate reporting to the state agency of all allegations of abuse, neglect, mistreatment, or misappropriation of resident property and failed to implement its abuse prohibition policy to ensure that all allegations of abuse were reported immediately to the Administrator and investigated. In addition, the facility failed to ensure that all staff, including supervisory staff and Administration were effectively trained in abuse investigation and reporting requirements. On 1/14/2013, facility staff had knowledge of a situation which would have required a reasonable suspicion to immediately report and initiate an investigation of an alleged sexual assault, as a result of a statement made to staff by 1 resident (R2). In addition, the facility failed to notify local law enforcement and the state agency of an allegation of sexual abuse in the required time frame for 1 resident (R1). These failures resulted in 127 in-house residents being put at risk of potential abuse as a result of	F9999			

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F9999	<p>Continued From page 37</p> <p>the failure to investigate and report a suspicion of sexual abuse immediately to the Administrator, local law enforcement and the state agency as required.</p> <p>Based on interview, observation, and record review, the facility failed to investigate one allegation of sexual abuse, after becoming aware of such allegation for 1 resident (R2), and failed to ensure that all allegations of sexual abuse are immediately reported to the Administrator, local law enforcement and/or the state agency for 2 residents, (R1, R2) reviewed for reporting and investigations of alleged sexual abuse.</p> <p>Findings include:</p> <p>1. E1, Administrator stated on 2/21/2013 at 9:45am that she was told by E21, Evening Supervisor-Registered Nurse, on the morning of 1/22/13 (exact time unknown) of R2 having said something during incontinence care to E18, Certified Nurse Aide (CNA) about "a man being down there". E1 stated that when she was first told, on 1/22/13, it was unknown exactly when R2 had made the statement to E18. E1 stated that E21 was made aware of R2's statement on the evening of 1/21/2013 when E18 had reported it to E21.</p> <p>E1 stated on 2/21/2013 at 9:45am that she did not do an investigation of R2's statement nor report it as an allegation of abuse to the state agency or police. E1 stated " It just didn't occur to me that it was needed, R2 just does stuff". E1</p>	F9999			

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F9999	Continued From page 38 stated that she was now doing an investigation.  E18, Certified Nurse Aide, (CNA) stated when interviewed by phone on 2/21/2013 at 8:00am that on or about 1/14/2013 during the midnight shift, she did a bed check on R2 and found her to be incontinent of urine. E18 stated that as she was cleaning R2, R2 said "Ow or Ouch" and when E18 asked her what was wrong, R2 said that she was "sore down there". E18 stated that she asked R2 why she was sore and that R2 stated "oh from those men poking around down there". E18 stated that she reported it to the nurse on the wing when she had finished with R2's care but could not recall who she had reported it to, but thought that it was either E20 or E21, both of whom are a Licensed Practical Nurse (LPN). E18 stated that she then documented what R2 stated in the behavior book on the comment papers. E18 was asked what the nurse's response was and E18 stated that she did not recall them saying anything but that they did not rush "in there" (To R2's room). E18 stated that she could not recall exactly but that a week or maybe two weeks later, another nurse was telling her and other staff to only go into another resident's room (R1) with two staff present because of an allegation of sexual abuse when "it triggered my memory". E18 stated that she grabbed the behavior book and showed E21 and E22, LPN, what she had documented. E18 stated that E22 told her to report it to E23, RN, Assistant Director of Nurses (ADON), which she stated she did the next morning. E18 said that E23 took the paper out of the book and put it on the desk. E18 stated that E23 seemed concerned by the look on his face.	F9999			

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F9999	Continued From page 39  E21, RN stated on 2/19/2013 at 4:10pm that E18 made her aware of the statements made by R2 "roughly a month ago". (Unsure of date and time). E21 stated that E18 had told her that "the other night" (unknown date) R2 had complained of hurting while being given incontinence care and when questioned further by E18, R2 had said "that man been messing with me down there". E21 stated that E18 told her that she had reported it that night to the charge nurse, E19, LPN. E21 verified that she saw the documentation of the incident written by E18 in the behavior book. E21 stated that she did a physical assessment of R2 with E22 present but noted nothing more than R2's normal redness. E21 stated that she did not document any of this but reported it to E2, DON the next morning .and was told that she would investigate it.  E19, LPN stated on 2/21/13 at 2:55pm that she did not recall being told anything in relation to R2 making a statement referencing having been inappropriately touched.  E23, ADON stated on 2/21/2013 at 9:55am that he had "no clue as to the date" but that it was early am that he was told by E18 about R2's statement and was showed the documentation in the behavior book. E23 stated he pulled the documentation that E18 had written from the behavior book and copied and laid it on the desk. E23 stated that when he reported the incident to E2, DON that morning, he was unable to find the documentation and did not know what happened to it.  E2 stated on 2/20/2013 at 4:40pm that the first	F9999			

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F9999	<p>Continued From page 40</p> <p>time she became aware of the statements made by R2 was during the R1 investigation (which occurred the week of 1/21/2013), and was told by either E18 or E21 but could not remember.</p> <p>Review of R2's Nurses Notes from 1/1/2013 thru 2/15/2013 found no documentation mentioning any statement being made by R2 in reference to being touched or "messed with" inappropriately by a man. The facility did not have an abuse investigation involving R2 available for review when asked on 2/15/2013 for all abuse allegations and investigations for the past 6 months.</p> <p>R2 has a diagnosis of Alzheimer's Dementia as noted on the Care Area Assessment (CAA) Review Report for Behavioral Symptoms dated 7/10/2012. The Facility Admission Sheet of 4/20/2010 documents a diagnosis of Dementia. R2 returned from a 5 day hospital stay on 2/17/2013 and was admitted to hospice care. R2 was observed in bed at 10:00am on 2/19/2013 sleeping. At 1:30pm on 2/19/2013 R2 was observed in bed, calling out "help" frequently. When asked what she needed, R2 did not reply. R2 did not respond when asked if she had ever been touched inappropriately or hurt by staff. R2's cognitive level is assessed as severely impaired on the 12/31/12 Resident Assessment Instrument.</p> <p>2. An "Initial Report To Public Health of Alleged Abuse" for R1 was received by the state agency's regional office, by fax, from the facility on January 22, 2013 at 5:38 pm, as noted by the time and date stamp on the report. On 2/15/2013, the facility was asked to provide all allegations of</p>	F9999			



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F9999	<p>Continued From page 41</p> <p>abuse and investigations for the past 6 months. An investigation was reviewed with a date of 1/21/2013 that indicated that during a Care Plan meeting on 1/21/2013 (no time given), Z5 alleged that R1 had stated on January 14, 2013 that R1 had been raped. E24, Social Service Designee, stated on 2/15/2013 at 4:05 pm that the Care Plan meeting occurred in the afternoon, sometime between 1-2 pm on 1/21/2013. E1, Administrator stated on 2/15/2013 at 4:00 pm that she was present during the Care Plan meeting for R1 on 1/21/2013 when Z5 made the allegation of R1 stating she had been raped. E1 stated that an investigation was initiated immediately but that she did not notify the local police until 9 am on 1/22/2013. E1 stated that she did not notify the state agency until 1//22/2013 at 5:30pm, at which time she faxed the initial report of the investigation to the state agency's regional office.</p> <p>Review of the facility policy titled "Resident Abuse Investigation" with a "revision" date of 2/11/2010 revealed "that all allegations of resident abuse, regardless of the source of abuse, will be fully investigated to prevent further incidents...The Abuse Prevention Coordinator or his/her designee will initiate the investigation of the allegation...ALL allegations of abuse will be reported to the state authorities as soon as practical, local law enforcement...in accordance with current state and/or federal regulations...The Abuse Prevention Coordinator or his/her designee will notify the State regulatory agency...of the alleged abuse within 24 hours of the receipt of the allegation.</p>	F9999			

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F9999	Continued From page 42  (A)  300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3) 300.1220b)2)3) 300.3240a)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999			

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F9999	Continued From page 43  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 needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)	F9999			

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F9999	Continued From page 44  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. Restorative measures shall include, at a minimum, the following procedures:  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:  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.  Section 300.1220 Supervision of Nursing Services  b) The DON shall supervise and oversee the nursing services of the facility, including:  2) Overseeing the comprehensive assessment of the residents' needs, which	F9999			

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F9999	<p>Continued From page 45</p> <p>include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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, 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.</p> <p>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)</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to develop individualized hydration plans based on assessed</p>	F9999			

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F9999	<p>Continued From page 46</p> <p>needs, assess for signs/symptoms of dehydration, ensure the estimated 24 hour fluid requirements were met, and monitor intake and output for residents at risk of dehydration for 8 residents (R3, R4, R6, R8, R9, R11, R12 and R13) reviewed for hydration needs due to Clostridium Difficile (C-Diff), loose stools, infections and/or abnormal lab values possibly indicative of Dehydration.</p> <p>This failure resulted in R8 developing an elevated Potassium, Blood Urea Nitrogen (BUN), Creatinine, and White Blood Count on 2-5-13 (lab report of 2-5-13). Interviews indicate R8 was experiencing episodes of dizziness, abdominal pain, nausea, and an increase in loose stools the first week in February 2013. R8 was diagnosed with Clostridium Difficile on 2-7-13 (lab report). R8's Medical Certificate of Death dated 2-9-13 lists immediate cause of death as Respiratory Failure due to or as a consequence of Septic Shock, due to or as a consequence of Acute Renal Failure, which the physician indicated all began with Dehydration.</p> <p>On 2-26-13, the facility identified on a document titled "Shawnee Christian Nursing Center", that 40 of the 127 residents in the facility currently have either a diagnoses of Clostridium Difficile (Active Infection) (1 resident), symptoms of loose stools without diagnosis of C-Diff (4 residents), and/or abnormal lab values (BUN &gt;25 and/or Creatinine &gt; 1.3) indicative of possible Dehydration (35 residents).</p> <p>Findings include:</p> <p>1. R8 was admitted to this facility on 1-14-13,</p>	F9999			

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F9999	<p>Continued From page 47</p> <p>according to the Admission Record face sheet. R8's diagnoses includes Colon Cancer (Physician's Office visit Note of 12-31-12), Low Anterior Resection with Coloproctostomy and Diverting Ileostomy, according to the Operative Report dated 1-7-13. R8's January 2013 Physician's Orders include Physical Therapy, Occupational Therapy, Speech Therapy evaluate and treat.</p> <p>E7 (Certified Occupational Therapist Assistant) stated on 2-20-13 at 2:00 p.m. that "I cared for R8 from admission until she went into the hospital. R8 had been admitted to the facility for rehabilitation with the intention of returning home. R8 had made great progress. R8 had dizziness during her first week at the facility but it had dissipated. R8 was doing well with self care and learning to care for her colostomy. During the first week of February 2013, R8's dizziness came back and R8 was complaining of nausea and not feeling well. R8 said she was having a lot of stool coming into the colostomy bag, so she was checked for C-Diff. We were trying to do her home assessment, on 3 different occasions, on Monday and Wednesday, that last week she was here, but she was not feeling well enough to do it. R8 was getting weaker toward the end of that week."</p> <p>E6 (Certified Nurse Aide) stated on 2-20-13 at 1:10 p.m. "I had R8 in my group quite a bit while she was here. R8 was always asking for ice water. R8 started complaining of nausea and belly pain on 2-3-13, a couple of days later she was diagnosed with C-Diff. R8 would say I am so sick and nauseated. One of the evenings R8 had bloody stool in the colostomy bag and 2-3 days</p>	F9999			

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F9999	<p>Continued From page 48</p> <p>later she passed away. The last evening I had her she was very pale in the face, rubbing her stomach, saying I am so sick and don't feel good. R8 was having more stools in the colostomy bag, where we would empty it every time she went to the bathroom. Previously we would only empty it once a shift."</p> <p>E5 (Registered Nurse) stated on 2-20-13 at 10:41 a.m. "R8 was doing pretty good for the first couple of days in February. we were teaching on colostomy care because R8 planned to go home. On 2-5-13 R8 complained of a little dizziness overnight. I checked her orthostatic blood pressure and glucose and called the doctor. Orders for labs and a Urinalysis were obtained, which were all completed. On 2-6-13 R8 said she was having more output in her colostomy bag than usual. I got a stool sample for C-Diff since R8's previous roommate had tested positive for C-Diff. I looked at lab results on 2-6-13. Routine lab results we fax to the doctor. With critical lab results we call the doctor. With R8's labs I would have expected the doctor to be called since they weren't considered routine. We didn't put anything different in place for R8 based on the lab results. In report on 2-6-13, they had said the doctor had been contacted and Zofran was ordered. R8 drank quite a bit, but I don't know if it was a sufficient quantity.</p> <p>A document titled "SBAR Communication Form" dated 2-5-13 indicates at 1 p.m. that Z1 (Physician) was notified regarding R8's emesis and dizziness. Orders were obtained for Complete Blood Count (CBC), Basic Metabolic Profile (BMP) and Urinalysis. At 6 p.m. an order for Zofran was also obtained.</p>	F9999			



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F9999	<p>Continued From page 49</p> <p>The document titled "Patient Report" dated 2-5-13 and reported 2-5-13 at 19:24 documents in part Potassium 5.5 H (3.5-5.1), BUN 27 H (7-22), Creatinine 1.23 H (0.67-1.17), Blood Calcium 10.8 H (8.5-10.1), Sodium 128 L (136-145), Chloride 88 L (98-107), Glomerular Filtration Rate 56 L (60), White Blood Count 16.3 H (4.8-10.8). The document titled "MEDLAB" and dated 1-22-13 indicates these same values were all normal at that time with the exception of the White Blood Count which was only slightly elevated at 11.2. The document titled "MEDLAB" and dated 2-6-13 (specimen collected) and 2-7-13 (reported) Positive for the C. difficile Antigen and the C. difficile Toxin A and B.</p> <p>According to the February 2013 ADL Flow Record , which has inconsistent documentation, on the days it is documented (2-1 through 2-4-13) they have zeros for the number of bowel movements in the colostomy bag. There is no documentation regarding bowel movements from 2-5 through 2-8-13 .The Skilled Daily Nurses Notes regarding bowel movements for 2-2 through 2-8-13 ( the day R8 was admitted to the hospital, SBAR Communication form dated 2-8-13) only indicates under the section titled Bowel and Bladder, by the word diarrhea, there is one checkmark for evenings on 2-6-13,one checkmark for days and one for evenings on 2-7-13. On these same Skilled Daily Nurses Notes under the section titled Skin it is always marked normal.</p> <p>The SBAR Communication Form dated 2-8-13 at 8:00 a.m. indicates that R8's physician (Z1) was notified of pain, increased lethargy, bloody drainage liquid form in ileostomy bag. Z1 ordered</p>	F9999			

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F9999	<p>Continued From page 50 to send to ER. R8 admitted with C-Diff and Dehydration.</p> <p>R8's Initial Plan of Care ( no date) with goal date of 5-2-13 lists under the heading of Problem "Potential for weight loss and dehydration related to colon cancer with recent surgery, possible med effects, etc...", under the heading Goal "Will have no weight loss or signs/symptoms of dehydration during the next 90 days", Under the heading Approach in part "Monitor and record intake; Enc adequate intake of food/fluids at meals, snacks, med pass, food related activities and social events, etc...; monitor labs as ordered." Also under the heading Problem, with no start date "Diagnosis C-Diff with potential for secondary complications", under the heading Goal "Will have signs/symptoms C-Diff resolved and will have no secondary complications through next review with goal date of 5-2-13", under the heading Approach, in part "Observe for watery diarrhea, fever, loss of appetite, nausea, cramps, etc...; any increase/decrease in watery stools or other signs/symptoms/complications and report for follow up." There is no specific plan in place to ensure R8's assessed fluid needs are met.</p> <p>The Registered Dietitian Assessment dated 1-22-13 and marked as admission has R8's fluid needs calculated as 1710 total cc in a 24 hour period.</p> <p>The only documentation of R8's fluid consumption during her stay at this facility from 1-14-13 through 2-8-13 (Admission Record) was on the January and February 2013 Food Intake Records. There is a section on these records for mL's of fluid consumed at each meal. The only</p>	F9999			

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F9999	<p>Continued From page 51</p> <p>day there is any documentation for fluid consumption at breakfast and lunch is on 1-19-13, all other dates for these 2 meals are blank. The fluid consumption at supper meals is documented and ranges from 240 - 300 mL's at each of those meals.</p> <p>E2 (Director of Nurses) stated on 2-20-13 at 4:30 p.m. "We do not have a specific plan in place to meet the 24 hour fluid requirements for resident's assessed needs. We do encourage fluids. R8 was not on intake and output."</p> <p>R8's History and Physical with admission date of 2-8-13 to the local hospital states in part under the heading Chief Complaint/History of Present Illness "This is an 81 year old white female who has not been feeling well for the past week. She stated she lost her appetite, has not really eaten anything. She had a lot of liquid stool coming out of the ileostomy. Patient's lab tests show findings suggesting she is hypovolemic....The workup showed the hemoglobin was 17.6; this is probably due to dehydration and hypovolemia. BUN is 80, creatinine 3.7. Patient's potassium was 6.3, sodium 124... Amylase was noted to be elevated at 388...Patient is admitted for further evaluation and treatment." Under the heading "Physical Examination: General: She is weak, pale, looks dry/dehydrated, but alert. Head and Neck: Mouth dry...Abdomen:... Bright red blood noted in the ostomy bag...Skin: Very dry. Neurological: She is alert and oriented...Impression: 1. Hypovolemia 2. Gastrointestinal Bleeding 3. Acute Renal Failure 4. History of COPD 5. Recent Clostridium difficile was positive."The Emergency Room Report of 2-8-13 lists Dehydration as a diagnosis</p>	F9999			

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F9999	<p>Continued From page 52</p> <p>The hematology reports in comparison from the 2-5-13 report to the 2-8-13 report are as follows: BUN on 2-5-13 was 27 and on 2-8-13 had increased to 80; Potassium on 2-5-13 was 5.5 and had increased to 6.3 on 2-8-13; Creatinine on 2-5-13 was 1.23 and on 2-8-13 it was 3.7; Chloride on 2-5-13 was 88 and on 2-8-13 it was 91; White Blood Count on 2-5-13 was 16.3 and on 2-8-13 it was 17.4.</p> <p>R8's Medical Certificate of Death dated 2-9-13 lists Immediate cause of death as Respiratory Failure, due to or as a consequence of Septic Shock, due to or as a consequence of Acute Renal Failure.</p> <p>Z1 (Physician) stated on 2-19-13 at 10:40 a.m. that the Acute Renal Failure started with the Dehydration. Z1 also stated that he was not notified of the abnormal lab values from the 2-5-13 results until 2-7-13, when the facility called on the C-Diff results. Z1 also stated that the facility should have picked up on R8's condition at least 12 hours sooner than they did.</p> <p>2. R13 was admitted to the facility on 1-31-13, according to the Admission Record face sheet. The February 2013 Medication Administration Record (MAR) indicates that R13 was on Ceftin 500 mg twice daily for 7 days beginning on 2-1-13. The February 2013 CNA Care Record indicates that R13 began experiencing loose stools as follows: 2-6-13, 3 loose stools on day shift; 2-7-13, large loose on nights and 2 loose on days. A lab report dated 2-7-13 indicates a specimen was obtained to be tested for C-Diff and the results were positive and reported on 2-9-13. The February 2013 MAR indicates that</p>	F9999			

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F9999	<p>Continued From page 53</p> <p>Flagyl 500 mg three times daily was ordered and started on 2-9-13 and completed on 2-15-13. The February 2013 CNA Care Record continues to include loose stools on 2-9 through 2-12-13 and 2-16 through 2-20-13.</p> <p>R13 stated on 2-20-13 at 2:15 p.m. that he didn't feel well enough to talk. A strong fecal odor was noted. R13 was holding head in both hands. R13 requested that surveyor get help to change his diaper, at which time surveyor summoned help for R13. E25 (Licensed Practical Nurse) on 2-20-13 at 3:20 p.m. stated " R13 had vomited this morning and had 4 loose stools today. R13 just got off antibiotic for C-Diff. R13 may have what is going around" On 2-20-13 at 3:45 p.m. E25 showed the surveyor on R13's MAR where the last dose of Flagyl had been taken on 2-15-13. Surveyor then asked E25 what the plan for R13 was, since the Flagyl had been completed 5 days ago and R13 was continuing to have multiple loose stools daily. E25's response was well I could call the doctor. E25 contacted Z6 (Physician) at that time and according to E25, orders were obtained for Complete Blood Count, Basic Metabolic Profile, Kidney Ureters and Bladder Xray for the morning, Vancomycin 250 mg three times daily for 7 days and consult with the Gastroenterologist.</p> <p>R13 stated on 2-21-13 at 11:25 a.m. "I am weak and not feeling well. I have had 3 loose stools this morning."</p> <p>R13's laboratory report dated 2-20-13 indicates the following: White Blood Count 12.1 H (4.8 - 10.8); Blood Urea Nitrogen 27 H (7-22); Creatinine 1.31 H (0.67-1.17); Hemoglobin 12.8 L</p>	F9999			

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F9999	<p>Continued From page 54 (14 - 18) and Hematocrit 39.4 L (42 - 52).</p> <p>The Registered Dietitian (RD) Assessment dated 2-19-13 calculates a 24 hour fluid need of 2289 cc's, for R13.</p> <p>R13's Initial Plan of Care with a date of 2-7-13 by the problem of Dehydration potential related to fever/antibiotic therapy, there is no individualized plan to meet the assessed fluid requirements as calculated by the RD. The Care Plan also includes a problem/need of Foley catheter with an intervention of Intake and Output. E2 (Director of Nurses) verified on 2-28-13 at 4:14 p.m. that R13's intake and output was not started until 2-21-13.</p> <p>E2 (Director of Nurses) stated on 2-20-13 at 4:30 p.m. "We do not have a specific plan in place to meet the 24 hour fluid requirements for resident's assessed needs. We do encourage fluids."</p> <p>3. R6 was admitted to the facility on 12-30-12, according to the Admission Record face sheet. According to the CNA Care Record for February 2013, R6 began experiencing loose stools on 2-5-13. A lab report indicates a specimen for C-Diff was obtained on 2-5-13 with the results being positive and reported on 2-6-13. R6's Nurses Notes indicate that on 2-5-13 R6 was admitted to the hospital for Dehydration, Altered Mental Status and Acute Diverticulitis. The Nurses Notes indicate that R6 was returned to the facility on 2-8-13. The February 2013 Medication Administration Record indicates that R6 began Levaquin 500 mg daily, Flagyl 500 mg every 8 hours and Vancomycin 12 mg/ 5 ml by mouth every 6 hours on 2-9-13.</p>	F9999			

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F9999	<p>Continued From page 55</p> <p>The Registered Dietitian (RD) Assessment dated 1-22-13 calculates a 24 hour fluid need of 2580cc's, for R6.</p> <p>R6's Resident Care Plan with a date of 1-10-13 by the problem of Dehydration potential related to fever/antibiotic therapy, with dates updated of 1-21-13 and 2-8-13, there is no individualized plan to meet the assessed fluid requirements as calculated by the RD.</p> <p>4. R9 was admitted to the facility on 1-21-13. R9's January 2013 Physician's Orders indicate that R9 was started on Levaquin 500 mg daily for 5 days on 1-21-13. R9's Bowel Movement Record for January 2013 indicates that R9 had 2 loose stools on 1-27-13, 6 loose stools on 1-28-13, 4 loose stools on 1-29-13, 5 loose stools on 1-30-13 and one loose stool on 1-31-13. A lab report for C-Diff indicates that a specimen was collected on 1-29-13 and reported on 1-30-13 as positive for C-Diff. R9's January 2013 MAR indicates that Flagyl was started on 1-30-13. This same MAR also indicates that R9 was being given the ordered Docusate Sodium Softgel on 1-27 through 1-31-13, during the time that R9 was experiencing loose stools.</p> <p>R9's Nutritional Assessment dated 1-22-13 calculates her 24 hour fluid requirements at 1470 cc's.</p> <p>R9's Initial Plan of Care (no date) does not identify dehydration as a potential problem. C-Diff is identified as a problem with a date of 1-30-13. There is no individualized plan in place to meet R9's fluid needs.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHAWNEE CHRISTIAN NURSING CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 13TH STREET</b> <b>HERRIN, IL 62948</b>		
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F9999	Continued From page 56  R9's Food Intake Records for January and February 2013 have a line for fluid in mL's for each meal. The only meal/fluid recorded on these forms from the date of admission on 1-21-13 until the date of discharge on 2-14-13 was for the supper meal. The amount of fluids consumed at the supper meals ranged from 120-480 cc's.  E2 (Director of Nurses) stated on 2-20-13 at 4:30 p.m. "We do not have a specific plan in place to meet the 24 hour fluid requirements for resident's assessed needs. We do encourage fluids."  5. R12 was admitted to the facility on 12-12-12, according to the Admission Face sheet. R12 stated on 2-15-13 at 3:45 p.m. "I had a colostomy reversal about 2 weeks ago. I have a lot of loose stools. My surgeon said that is quite normal until my body gets readjusted and caught up." R12's Bowel Movement Records for January and February 2013 indicate that R12 has multiple loose stools on most days.  R12's RD Assessment dated 1-22-13 calculates the 24 hour fluid requirements at 1950 cc's.  R12's Resident Care Plan dated 12-26-12 does not identify dehydration as a potential problem. The care plan does identify VRE in the urine (no date) and history of UTI's (no date) as problems. There is no individualized fluid plan in place to ensure that R12 meets the 24 hour fluid requirements.  E2 (Director of Nurses) stated on 2-20-13 at 4:30 p.m. "We do not have a specific plan in place to meet the 24 hour fluid requirements for resident's	F9999			



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F9999	<p>Continued From page 57</p> <p>assessed needs. We do encourage fluids."</p> <p>6. R11 was admitted to the facility on 11-20-09, according to the Admission Face sheet. Z6 (Physician) stated on 2-15-13 at 4:45 p.m. that R11 has Functional Bowel Disease and will sway from constipation to loose stools. The facility keeps me well informed of R11's condition."</p> <p>R11's Bowel Movement Record for January and February 2013 document multiple loose stools almost daily.</p> <p>R11's Nutritional Assessment completed by the RD and dated 2-29-12 calculates R11's fluid requirements at 2385 cc's in 24 hours.</p> <p>R11's Resident Care Plan dated 11-7-12 and 2-19-13 have a goal of will have no signs/symptoms of Malnutrition or Dehydration thru next review. There is no individualized plan in place to ensure that R11's 24 hour fluid requirements are met.</p> <p>E2 (Director of Nurses) stated on 2-20-13 at 4:30 p.m. "We do not have a specific plan in place to meet the 24 hour fluid requirements for resident's assessed needs. We do encourage fluids."</p> <p>7. R3 was admitted to the facility on 4/27/2012 according to the Admission Face Sheet. R3 has a history of Urinary Tract Infections (UTI) according to the diagnosis list on the current Care Plan with a review date of 1/22/2013. R3 was treated for a Urinary Tract Infection from 1/22/13 thru 1/29/13. A goal on the current Care Plan is for R3 to not have any signs or symptoms of malnutrition or dehydration. Approaches are for staff to monitor</p>	F9999			

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F9999	<p>Continued From page 58</p> <p>and record amount of intake. An approach listed for "potential for skin breakdown" related to "recent UTI" is to encourage fluid. There is not a specific plan in place to ensure that R3 is consuming a sufficient amount of fluids. The annual RD assessment dated 6/28/2012 indicated a fluid need of 2040 cc's per day. Review of the January and February 2013 Food Intake Records indicate daily fluid intake at meals ranging from 510 cc's to 880 cc's. No other fluid tracking was noted being used to monitor fluid intake.</p> <p>8. R4 was admitted to the facility on 12/7/12, with diagnoses that include Dysphagia and Anorexia according to the Admission Face Sheet. The History and Physical dated 10/12/2012 from the hospital indicates that R3 was admitted at that time with dehydration, Acute Renal Failure and a possible UTI.</p> <p>The current Care Plan dated 12/7/2012 indicates that R4 has a history of UTI's and to encourage fluids to 1500 cc's daily and to encourage juice at meals, "(preferably cranberry)". There is no specific plan in place to ensure that R4 is being offered and encouraged to drink the 1500 cc's. The only tracking of fluids was noted on the Food Intake Records. January and February 2013 Food intake Records indicate daily fluid intake at meals to range from 460 to 940 cc's. Treatment with an antibiotic, "Cipro" for a UTI was started on 12/14/2013 as noted on the December 2012 Physician Orders Sheet (POS). The January 2013 POS indicated that Macrobid was initiated on 1/2/2013 for a UTI</p> <p>(A)</p>	F9999			