

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1220b)2) 300.3240a)</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 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>	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</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>2) All treatments and procedures shall be administered as ordered by the physician.</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>2) Overseeing the comprehensive assessment of the residents' needs, which 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>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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 WERE NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review, the facility failed to conduct a comprehensive assessment and follow physician orders to consistently monitor a resident who had a significant change in medical condition.</p> <p>This failure resulted to R2's delayed medical evaluation and treatment for five days. R2 was hospitalized with an admitting diagnoses of new stroke, encephalopathy and subarachnoid hemorrhage.</p> <p>This applies to one (R2) resident reviewed for declined in ADL (Activities of Daily Living).</p> <p>The finding includes:</p> <p>The POS (Physician Order Sheet) dated 12/2013 showed R2 was admitted to the facility on 8/7/2012 with diagnoses of cerebral vascular disease with left hemiparesis, cardiomyopathy, coronary artery disease, coronary artery bypass graft(2007), hypertension and diabetes.</p> <p>The two most current MDS (Minimum Data Set) dated 7/9/2013 and 9/25/2013 showed the following R2's assessments:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014	
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN		STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>-scored 15 for BIMS (Brief Interview For Mental Status) = cognitively intact - 3/3 = extensive assistance with two person physical assist 0/1= independent with eating with set up help only</p> <p>The nurse's notes dated 1/30/2013, 6/17/2013, 7/15/2013 and 10/13/2013 showed R2 was alert and oriented times three (person, place and time). R2 was also able to verbalized needs.</p> <p>The Nurse's Notes documentation also showed the following:</p> <p>-12/8/2013 at 1:15 P.M.; R2, after lunch was sleeping at the table. R2 did not open her eyes when staff tried to wake her up. The Director of Nursing (E1) was notified and attending physician (Z1) was paged. -12/8/2013 at 1:50 P.M.; Z1 replied and stated "Just keep (R2) monitor her closely." -12/8/2013 at 10:00 P.M.; R2 was awake and alert. -12/9/2013 at 5:00 A.M.; R2 with no complaint. -12/10/2013 for A.M. to 2 P.M. shift charting: R2 was alert and oriented x2. R2 was evaluated by Speech therapist. The diet was changed from regular consistency to pureed diet with thick liquids and Z1 was notified. R2 was also noted to be tired after breakfast. - 12/12/2013 at 8:15 A.M.; "(R2) was not alert, lethargic very sluggish, difficulty swallowing. Spoke to (Z1) related to change in LOC/mental status. Labs ordered, urinalysis, and chest xray ordered. Per (Z1), want to see results. " -12/13/2013 at 2:40 P.M., (R2) was sent to hospital due to change in LOC (level of consciousness). (R2) was alert and oriented at time of discharge to hospital at 10:00 A.M.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>The above documentation contained no evidence R2 was closely monitored as ordered by the physician. There was a lack of monitoring on 12/9/2013 for all day (6 A.M.- 2:00 P.M. shift; 2 P.M.- 10 P.M. and 10 P.M.- 6 A.M.) There was also a lack of monitoring and follow up on 12/12/2013 for 2 P.M.-10 P.M. and 10 P.M. to 6 A.M., even after R2 was noted with continued lethargy, decreased alertness, sluggishness and swallowing difficulty at 8:45 A.M. on same day. The next documentation was on 12/13/2013 at 2:40 P.M. when R2 was sent out to the hospital.</p> <p>Review of the Speech Therapist Notes dated 12/10/2013 showed the speech evaluation was not done "due to (R2's) extremely poor level of arousal after three attempts of evaluation."</p> <p>On 12/30/2013 at 11:55 A.M., E2 (Speech Language/Pathologist) stated R2 had a definite significant change in medical condition when seen on 12/10/2013 during an attempt for swallowing evaluation. E2 further stated that R2 remained unresponsive for three attempts of evaluation. E2 described R2 as follows and added the following steps were tried to wake or arouse R2:</p> <ul style="list-style-type: none"> -eyes not fully open, was not able to eat due to being unresponsive - Mouth was open, hanging down, no movement of the lips and no reflexes when a glass was pushed to R2's lips - R2 did not response to tactile stimuli when a cold spoon was placed touching the lips and mouth - No verbal response, only moans for occasionally - R2 had remained unresponsive despite of 	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>repositioning R2 in bed to sit up for eating at a 90 degree angle.</p> <p>E2 further added this was not R2's baseline and this was definitely a significant change. E2 said a CNA (Certified Nurse Assistant) in which E2 cannot remember the name had told her R2 had been noted to for the past few days with a significant change in medical status. E2 also stated she had informed E1(Director of Nursing) regarding her observation of R2.</p> <p>On 12/31/2013 at 10:36 A.M., E3 (CNA) stated she saw E2 on 12/10/2013 during an attempt for swallow evaluation. E3 also stated R2 had a definite significant change in status and was not the same R2 anymore. E3 also added R2's significant change had been ongoing for few days already before 12/10/2013 until the day R2 was sent sent out to the hospital(12/13/2014). E3 described R2's significant changes as follows:</p> <ul style="list-style-type: none"> - "(R2) had stopped talking and if she does, it does not make sense and was not coherent" - "(R2) was like in deep sleep and remained with no response even you scream her name or touch her with use of some force" - "(R2) was not eating lunch when saw on 12/10/2013 due to unresponsiveness" - "(R2) was not able to bear weight during transfer and had to totally lift her with 2 person assist" <p>On 12/31/2013 at 10:19 A.M., E4(CNA; Rehab Aide; Activity Aide) stated during interview on (12/10/2013), R2 was "sleeping a lot, not responding, nods but will not talk back, tried to wake her up but would not response, eyes closed and slumped sideways while seated on her wheelchair." E4 also stated R2 was observed with the significant change few days before the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>hospitalization of 12/13/2013.</p> <p>On 12/31/2013 at 9:40 A.M., E5 (Licensed Practical Nurse) stated R2 was noted to be "more tired than usual. On 12/10/2013, (E2) informed me to update Z1 for diet change and (R2) looked very sleepy." E5 further stated he was more concern with R2 on 12/12/2013 because (R2) remained weak, lethargic and she did not come out of it. (R2) used to come out of it when she get sleepy or tired but not this time."</p> <p>On 12/31/2013 at 11:00 A.M., E6 (LPN, Licensed Practical Nurse) stated she had informed Z1 regarding R2's significant change on 12/12/2013. E6 also added that "whatever I charted on 12/12/2013 was what I told (Z1)." E6 also stated there R2 was not checked for neurological assessment and functional assessment.</p> <p>The nurses' notes dated 12/8/2013 to 12/13/2013 showed no evidence there was a thorough assessment that would have included a comprehensive neurological and functional status. The nurses' notes also did not reflect the observations made by E2, E3, E4 and E5.</p> <p>On 12/30/2013 at 11:05 A.M., Z1 stated she was notified regarding R2's lethargy. Z1 also added that she was she was not given a complete details of assessment that would have included a thorough neurological and functional status and therefore was not able to get the whole picture of what was going on with R2. Z1 further added she was not notified R2 had not improved and showed persistent decreased alertness. Z1 also added her treatment orders were based on the assessment and information that was relayed to her and if the assessments lack information, the order might not have been appropriate. Z1 also</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 7</p> <p>stated her expectation was to monitor R2 closely and consistently and if there was no improvement, she should have been notified with detailed and thorough assessment in order to be able to provide prompt appropriate treatment. Z1 said "it was the lack of complete assessment and information that was relayed to me that made me gave an order for urinalysis and chest x-ray. I would have sent her out to the hospital sooner if I would have known that she was not eating and having swallowing difficulty with continued lethargy and decreased alertness."</p> <p>The Emergency Department record dated 12/13/2013 at 2:22 P.M. showed R2 response only to painful stimuli.</p> <p>The History and Physical Hospital record dated 12/14/2013 entered by Z1 showed "(R2) has been having increasing lethargy with decreased responsiveness over the past few days. MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) of the brain result showed a new stroke as well as subarachnoid hemorrhage."</p> <p>The Hospital Flow Sheet showed R2 was in the critical care unit from 12/13/2013 to 12/16/2013. R2 was assessed as "lethargic" on 12/13/2014; stuporous on 12/14/2013 and 12/15/2013 and comatose on 12/16/2013.</p> <p>The Hospital record dated 12/29/2013 showed R2 was sent out to a hospice center with medical diagnoses of "comatose, CVA, HTN and Diabetes."</p> <p>(B)</p>	S9999		
-------	---	-------	--	--