DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, vs. STERLING PAVILION, LTD D/B/A STERLING PAVILION Respondent,	)))))))))	Docket No. NH 14-C0155

NOTICE OF TYPE "B" VIOLATION(S);
NOTICE OF FINE ASSESSMENT;
NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois (the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation for IL68566, 65872 that was conducted by the Department on March 21, 2014 at Sterling Pavilion, 105 East 23rd Street, Sterling, Illinois 61081. The Facility's current license number is 0040436. On April 18, 2014, the Department found one or more Type B violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 IL. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary Statement of Licensure Violations which is attached and incorporated hereto as Attachment A and made a part hereof.

Pursuant to Section 3-303(b) of the Act, the licensee shall, **within (10) days of the delivery to the licensee of this Notice of Violation, prepare and submit to the Department a plan of correction for all Type "B" violations** for which a plan of correction is required. **The plan of correction shall be sent to the attention of: Leona Juhl at the Illinois Department of Public Health, Division of Long-Term Care Quality Assurance, 525 West Jefferson, Springfield, Illinois 62761.** The plan should include a correction date not to exceed thirty (30) days for Type "B" violations, a description of how the violation was or is to be corrected, and a statement describing what measures will be taken to avoid reoccurrence of the violation. If the Department for any reason rejects the submitted plan of correction, a notice of the rejection and the reason for the rejection will be forwarded to the facility representative. A modified plan shall be filed within ten (10) days of receipt of the notice of rejection. If the modified plan is not timely submitted, or if the modified plan is rejected, the Department will impose a plan of correction.

The Plan of Correction (POC) cannot be submitted on the Summary Statement of Licensure Violations. Only the first page of the Statement of Deficiencies must be submitted with the signature of the facility's representative and the date. The POC itself should be on separate sheets of paper which

are attached to the first page of the Summary Statement of Licensure Violations. Please do not use proper names such as resident, staff, or any other individual's names or trademarks in the POC.

Each POC shall be based on an assessment by the facility of the conditions or occurrences that form the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences.
Evidence of such assessment and evaluation shall be maintained by the facility. Each POC shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

Submission of a POC shall not be considered an admission by the facility that the violation has occurred.

Pursuant to Section 3-303(c) of the Act, **you may submit a report of correction in place of a POC for any of the violations which have already been corrected**. The report of correction shall contain the correction date, a description of how the violation was corrected and statement describing what measures will be taken to avoid reoccurrence of the violation.

A "Type B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Nursing Home Care Act.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of $2,200.00, as follows:

-Type B violation for violating one or more of sections 300.610a), 300.1210b), 300.1210d)3), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation 300.1210b) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within thirty (30) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "B" Violation(s), and Notice of Fine Assessment. In order to obtain a hearing the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices. **The request for hearing must be sent to the attention of Leona Juhl at the Illinois Department of Public Health, Division of Long-Term Care, Quality Assurance, 525 West Jefferson Street, Fifth Floor, Springfield, Illinois 62761.**

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING. A REQUEST FOR HEARING DOES NOT RELIEVE YOU OF THE RESPONSIBILITY TO SUBMIT A PLAN OF CORRECTION OR REPORT OF CORRECTION.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-305(10), 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. **The written waiver must be sent to the attention of Leona Juhl at the Illinois Department of Public Health, Long Term Care Quality Assurance Division, 525 West Jefferson 5th Fl, Springfield, IL 62761.**

Toni Colón

Toni Colón
Designee of the Director
Illinois Department of Public Health

Dated this 21st day of April, 2014.

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PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	MS Registered Agent Services
Licensee Info:	Sterling Pavilion, LTD.
Address:	191 North Wacker Dr., Ste 1800 Chicago, IL 60606

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 21st day of April 2014.

Leona Juhl
Long Term Care
Illinois Department of Public Health

14-C0155/Sterling Pavilion/3-21-14/llj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009179	A. BUILDING: _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.1220b)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. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

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S9999	Continued From page 1	S9999		

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:

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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S9999	Continued From page 2 resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility neglected to follow their policy and procedure for Neglect, Lab, Xray and Diagnostic test result, change in resident condition/status and policy on pain by not assessing a resident with signs of pain, not obtainting Xray results within the same day, neglected to include report of a residents pain and pending Xray to the next shift for a resident with a complaints of pain and not bearing weight on her leg. This resulted in a resident not receiving any assessment for pain or pain management for 36 hours for a resident with a fractured hip and femur. This applies to 1 of 1 residents (R1) reviewed for pain and assessment in the sample of 3. The findings include: The 2/25/14 MDS(Minimum Data Set) shows R1 was admitted to the facility of 11/1/10 with multiple diagnoses to include Alzheimer's Disease, Parkinson's Disease and Osteoarthritis. On 9/3/13, R1 was assessed to require the use of a stand lift for transfer. On 3/18/14 at 10:45 AM, E7 CNA (Certified Nursing Assistant) stated she worked 3/3/14 from 2:00 AM until 2:00 PM. E7 stated about 4:30 AM-5:00 AM on 3/3/14, R1 was trying to climb out of her bed. E7 stated she decided to get R1 up for the morning and began to dress her. E7 stated while she was dressing R1, R1 was moaning and	S9999		

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S9999	Continued From page 3	S9999		

groaning while being moved from the bed to the recliner. E7 stated R1 would not put any weight on her right leg and she was leaning in the chair recliner. E7 stated "I reported this to the nurse at 6:00 AM, the day shift nurse who had just started her shift." E7 stated that throughout the day R1 was transferred with the stand lift at least 5 times during the day shift. Not including the next 2 shifts. E7 stated "I see these people everyday and I know when something is not right. She (R1) seemed to be in a lot of pain."

On 3/18/14 at 9:50 AM, E8 LPN (Licensed Practical Nurse), stated she was on duty 3/3/14 when the initial report of pain was identified. E8 stated the CNA had reported R1 appeared in pain while transferring with the stand lift and was not bearing weight on her right leg. E8 stated she had noticed R1 in a recliner favoring her left hip and was lying in fetal position on her right side. E8 said R1 did appear to have some pain but she had just received her pain medication at 5:00 AM. E8 stated she did not chart her assessment of pain or her positioning in the chair. E8 stated she only gave the scheduled pain medication. E8 stated because she did not see the incident of alleged pain, she did not believe it and did not want to chart anything that was not witnessed. E8 stated she made no attempts to observe any stand lift transfers during her shift.

The nursing notes for 3/3/14 do not document a pain assessment or physical assessment. A late entry note on 3/6/14 at 9:00 AM (9 hours after R1 was sent to the local hospital) documents an assessment for 3/3/14 at 10:00 AM. The late entry note reads "Resident appeared to be guarding left hip when placed in recliner in front of nurses station. Resident rolled self in a side-lying position on the right hip while in the recliner. This

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S9999	Continued From page 4	S9999		

nurse (E8) assessed the left hip for any sign of injury. Resident expressed no signs of pain." When asked about the late entry documentation, E8 stated "I just forgot to chart her pain, but I reported it to the next shift." On 3/18/14 at 10:00 AM, E8 stated R1 should have been documented on at least every two hours and the assessment of her hip and pain should have been reported to the next shift.

On 3/18/14 at 11:15 AM, E3 LPN stated she had worked on 3/3/14 and received report from E8 for her shift. E3 stated she did not receive any report of R1 having pain or difficulty standing with the stand lift.

On 3/18/14 at 10:45 AM, E7 reported for work on 3/4/14 at 4:00 AM. E7 stated she again reported to E9 LPN, R1's signs and symptoms of pain and not bearing weight with transferring. E7 stated when she reported the symptoms to the nurse, she did not seem to know R1 began having pain on 3/3/14.

On 3/18/14 at 10:30 AM, E9 LPN, stated she reported for work on 3/3/14 at 10:00 PM and did not receive report on R1's leg pain. E9 stated that when E7 reported for work at 4:00 AM on 3/4/14 she informed her about R1's leg pain and lying on her side. E9 stated she immediately assessed R1 at that time. E9 stated R1 was sleeping at 4:30 AM and did not seem to be in any pain or discomfort at that time. E9 stated R1 was re-assessed at about 5:00 AM on 3/4/14, after she was transferred out of bed into the recliner.

On 3/4/14 at 6:13 AM, E9 LPN (Licensed Practical Nurse), documented R1 was leaning to the right and stating her left leg/hip hurts. R1's

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S9999	Continued From page 5	S9999		

ROM (Range of Motion) as usual to lower extremities. Stiffness noted. CNA's (Certified Nursing Assistant) report that she will not bear weight on the right leg. No bruising/swelling noted. Doctor paged. At 11:11 AM, E2 DON (Director of Nurses), documents " X-ray here."

On 3/18/14 at 11:15 AM, E3 said on 3/4/14 at 6:30 AM, she was given report on R1's hip pain and was told the doctor had been paged. E3 stated about 6:30 AM, Z3 (Physician) called an order to have an X-ray taken of R1's right hip due to pain and weakness. E3 stated she immediately called the X-ray company and requested the X-ray. E3 said she assessed R1 when she gave her medications at 11:00 AM on 3/4/14. E3 stated she had asked R1 if she had any pain and R1 just stared at her. E3 said sometimes R1 will shake her head yes or no to answer a question or she just has no expression at all. E3 stated R1 is non-verbal and she would not be able to say she is in pain. E3 stated through out the day on 3/4/14 she was leaning in the recliner and sleeping.

The nursing notes for R1 on 3/4/14 do not show any assessment performed by any nurse after E9's documentation. The nursing notes do not address a pain assessment or a physical assessment of R1's right hip.

On 3/13/14 at 3:40 PM, E3 stated she did check on R1 through the day on 3/4/14, but did not document her assessment. E3 stated she should have documented her assessment.

E11 LPN, worked on 3/4/14 from 2:00 PM to 10:00 PM. On 3/18/14 at 4:45 PM, E11 stated she did receive report from E3 that R1 had been complaining of pain and were waiting for results

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S9999	Continued From page 6	S9999		

of a hip X-ray. E11 stated "I did check in on her when I gave her medications, about 9:00 PM. I asked her if she had any pain. No I did not do any sort of physical assessment, she was already getting pain medicine 4 times a day." E11 stated she should have documented any signs of pain she had to make sure she was stable while waiting for her X-ray results. E11 stated "I did not think she was in any pain, she is very hard to assess. She had not had any falls and honestly I did not think it (her hip) was broken."

E13 RN (Registered Nurse) worked 3/4/14 from 10:00 PM until 3/5/14 at 2:00 AM. On 3/18/14 at 5:30 PM, E13 stated she had relieved E11 on 3/4/14 and E11 did not report R1's complaints of pain or that X-ray results were still pending from 12:00 PM. E13 stated had she been given report of the pain, she would have assessed R1 and called the X-ray company for the results of the X-ray. E13 stated because she did not receive report R1's hip pain and X-ray, she did not pass in report to the next shift the information.

The March 2014 Medication Administration Record (MAR) for R1 shows she receives Tramadol 50 mg four times a day for pain. The MAR also shows each shift a pain assessment is to be performed. From 3/4/14 until 3/5/14, R1's MAR documents no pain.

R1's Nursing Notes for 3/5/14 do not document any assessment of pain or physical assessment.

On 3/13/14 at 8:30 AM, Z2 (Xray company representative) stated she had received an order for X-ray on 3/4/14 and the X-ray was taken the same day at 11:20 AM. Z2 stated the physician

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S9999	Continued From page 7	S9999		

had signed off the results at 11:59 AM on 3/4/14, and the facility was called at 12:07 PM to notify the nurse the results were being faxed. Z2 stated it is not standard practice to give the results of the X-ray over the phone, but if the nurse asks, we will read the results to the nurse. Z2 stated "On this case, it looks like (Xray company) only called and told the nurse the result was being faxed at that time, the nurse did not ask for a reading of the results and therefore she was just told the result was being faxed to the facility."

On 3/18/14 at 11:15 AM, E3 LPN (Licensed Practical Nurse), stated she was called by the Xray company and told the results from the X-ray were being faxed to the facility. E3 stated she checked the fax at 12:30 PM, 2:00 PM, and then called them again at 3:30 PM to tell them she had not received any fax and to re-fax the results . E3 stated she had come to the end of her shift at 3:30 PM and reported to E11 LPN, to follow up on getting R1's Xray results.

The nursing schedule shows E11 worked on 3/4/14 from 2:00 PM to 10:00 PM. On 3/18/14 at 4:45 PM, E11 stated she did receive report on 3/4/14 from E3 that R1 had been complaining of pain and the facility was still waiting for the results of the hip Xray. E11 stated "I did check in on R1 when I gave her medications, about 9:00 PM. I was really busy during my shift and that was the first chance I had to see her. I asked her if she had any pain. She had no complaints of pain. She was already getting pain medicine 4 times a day." E11 stated she should have documented any signs of pain she had to make sure she was stable while waiting for her Xray results. E11 stated she had not performed any physical assessment of R1's hip or leg during her 8 hour shift. E11 stated "I did not think she was in any

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S9999	Continued From page 8	S9999		

pain, she is very hard to assess. She had not had any falls and honestly I did not think it (her hip) was broken."

On 3/18/14 at 5:30 PM, E13 RN (Registered Nurse) said she relived E11 at 10:00 PM on 3/4/14. E13 stated she did not receive report regarding R1's Xray report. E13 stated she would have called the Xray company and had them fax the results if she had been given any information about not having the results. E13 stated she stayed on shift until 2:00 AM on 3/5/14 and since she did not know of the X-ray she did not pass on report to the next shift to follow up on obtaining the results.

The facility policy for Lab, X-Ray and Diagnostic Test Results dated 11/2013, documents 1. a. If the staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow.

On 3/18/14 at 10:30 AM, E9 LPN, stated she first was aware of R1's pain and weakness of her leg on 3/4/14 when she paged the physician to get an order for an X-ray. E9 stated " It was at the end of my shift so all I did was page the doctor and I would assume the doctor would order an X-ray, but I had to go home. (E3) took the call from the doctor." E9 stated she was off the next night on 3/4/14 and returned to the facility on 3/5/14 at 10:00 PM. E9 said " There was another resident being sent out to the local hospital for a fracture, and then I wondered about (R1) and how her X-ray results were. I looked in her chart and could not find the X-ray result so I called the Xray

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	IL6009179	A. BUILDING: _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PAVILION	105 EAST 23RD STREET STERLING, IL 61081

(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	Continued From page 9	S9999		

company to have them fax the final report." The fax date and time of the result was 3/5/14 at 23:34 (11:34 PM).

The 3/4/14 Patient Report of X-ray documents R1 had right side weakness and pain. The procedure performed was an X-ray with 2 views of the right hip. The findings show an acute femoral neck fracture.

The nursing notes for R1 document E9 called the results to Z3 (Physician) at 11:39 PM, and new orders received to send to the Emergency Room if ok with family. E9 contacted the Power of Attorney and R1 was sent to the hospital on 3/6/14 at 12:09 AM.

The facility's 11/2013 Change in a Resident's Condition or Status policy states Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and /or status. 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

On 3/6/14 at 12:44 AM, R1 was seen by Z4 (Emergency Room Physician) 36 hours after the original Xray was taken at the facility. Z4 documents R1 presents with lower extremity pain, lower extremity swelling and knee pain. The onset was 2 days ago. The course/duration of symptoms is constant and worsening. The symptoms are pain, swelling, tingling and numbness. The degree of pain is moderate, exacerbated by weight bearing. The relieving factor is none.

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S9999	Continued From page 10	S9999		

On 3/10/14, R1 was discharged from the hospital. On 3/14/14 at 2:10 PM, Z3 (Primary Physician) stated she initially was going to discharge R1 on a pain medication "as needed", but due to family concerns regarding her lack of pain medications prior to her hospitalization, Z3 stated she scheduled the pain medication. Z3 stated R1 should have been assessed through the day and night while waiting for the Xray results. Z3 said the nurses should have assessed her leg and her pain level and documented their findings.

On 3/13/14 at 11:40 AM, E2 DON said she was aware R1 had no documented assessment from 3/3/14 to 3/5/14. E2 stated E11 had documented a late entry on 3/6/14 because E11 said she forgot, and I asked her to enter the late entry. E2 stated there is a 36 hour time gap for any documentation of R1's pain and assessment while waiting for the Xray results. E2 stated "I am looking into that issue."

On 3/14/14 at 2:10 PM, Z3 stated it usually takes a fall to get the fractures R1 had. She would have been in moderate distress, enough pain that she required intravenous narcotics to get her comfortable. Z3 stated the CT (computed tomography) scan showed the hip fracture to be 2-10 weeks old and there was probably an impaction injury or event to worsen her pain. Z3 stated using the stand lift would cause an impaction of a fracture. Z3 stated her concern was with the facility not acquiring the Xray results for 36 hours and during that time R1 would have been in pain and without enough pain medications to keep her comfortable.

The facility's 11/2013 Pain Protocol policy states 1. The staff will identify individual who have pain

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S9999	Continued From page 11	S9999		

or who are at risk for having pain. 2. The nursing staff will screen each individual for pain whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain. 3. The staff will identify the nature and severity of pain. 3b. The staff will observe the resident for evidence of pain: for example, while being repositioned.

The 3/2013 facility policy for Abuse Prevention defines Neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness or in the deterioration of a resident's physical or mental condition. The Orientation and Training of Employees shall include appropriate care delivery and treatment interventions for resident's with limited vision, hearing, communication, cognition, and mobility. 5. Protection of Residents and Staff - the nursing staff is additionally responsible for reporting on a facility unusual occurrence report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee.

(B)