PRINTED: 10/09/2014 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C IL6001226 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2508 ST. JAMES ROAD **BROTHER JAMES COURT** SPRINGFIELD, IL 62707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Z9999 FINDINGS Z9999 Statement of Licensure Violations: 350.620a) 350.1210 350.1220j) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The facility shall notify the resident's physician of any accident, injury, or 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.

TITLE

(X6) DATE

09/04/14

PRINTED: 10/09/2014

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WING IL6001226 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2508 ST. JAMES ROAD **BROTHER JAMES COURT** SPRINGFIELD, IL 62707 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Z9999 Continued From page 1 Z9999 Section 350.3240 Abuse and Neglect An owner, licensee, administrator, a) employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced Based on record review and interview the facility failed to provide preventive services, general medical care and appropriate nursing services for 1 individual, (R1), whose abnormal laboratory test results were not addressed when they failed to: 1. Provide a policy and procedure, or written instructions regarding actions to be taken when laboratory test is outside normal ranges or otherwise abnormal. 2. Ensure nursing staff review all laboratory results 3. Ensure medical staff follow up on all abnormal laboratory results. 4. Inform the personal care physician of all abnormal laboratory testing results. 5. Inform guardian of individuals change in health status regarding abnormal laboratory results. 6. Complete thorough nursing assessments for individual with abnormal laboratory results These failures resulted in R1's subsequent hospitalization on 07/19/14. R1 died on 07/30/14. Findings Include:

On 08/14/14 at 5:30 PM, E1, Administrator, was notified that the facility failed to: Review and to address abnormal lab results for R1; inform the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001226	B. WING		C 08/21/2014	
NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE			
BROTHE	R JAMES COURT		JAMES ROA IELD, IL 627			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	of health status chathorough medical a obtained for this induction to the local hospital respiratory failure a Based on record refailed to provide premedical needs for 1 sample, R1, when t 1. Complete thoroug 2. Inform physician	n orders; inform the guardian ange; and to ensure timely and ssessment/treatment was lividual. R1 was later admitted on 07/19/14 and expired from and sepsis shock on 07/30/14. View and interview, the facility eventive care to address the of 1 individual, inside the he facility failed to: gh nursing assessments	Z9999			
	06/26/14, identifies functions at a Profo Disabilities. A completed laborar 14:17 (2:17 PM) doc Count at the level of 4.5 - 10.8. This doct this information was 07/11/14 at 2:37 PM services. During record review reveals: 07/11/14 - "no malace."	der Sheet (POS), dated R1 as an individual who und range of Intellectual tory test dated 07/11/14 at cuments R1's White Blood f 14.4. The normal range is ument also demonstrated that a faxed to the facility on 1 by outside laboratory w of nursing notes for R1 daptive behaviors"				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
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		IL6001226	B. WING		08/2	21/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BROTHE	R JAMES COURT		JAMES ROA				
DI(C	TOAINEO COCK	SPRINGFI	IELD, IL 627			7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ige 3	Z9999			3000	
Zəbəb	12:30 AM 07/14/14 at 12:30 A AM) describing mal to left distal area on 07/17/14 - "1340 (1 07/19/14 - "3 PM behaviors towards p (no time recorded) (medications) (no ti (vital signs) except time recorded)." "To 9:30 AM) staff retur but accepted a w/c back about 25 min ("seems shakey" (sp uncomfortable" (no "Facial wincing is of"hoarse cough no informed (no time re orders) rec'd (receiv (urinalysis) when po doesn't seem to fee specific time record informed (no time re 07/19/14 - "2250 (10 entry)On days/eves intake" multiple (il incidents of grabbin shaky. Refused vita cont (continue) to w agitation) Refused t T.O. from physician (Emergency Room) positive for pneumo 07/30/14 - 12:00 (no 0537 (5:37 AM) this	AM thru 07/17/14 0600 (6:00 ladaptive behavior and bruise ally. :40 PM) T (temperature) 98.1" R1 had two aggressive peers for no apparent reasonrefused AM meds are recorded). refused V/S temp (temperature) 97.0 (no N notified of his refusal (no faken outside for a walk (about rade saying R1 refused to walk (wheelchair)" (illegible) R1 (minutes) later saying R1 o) and "acts like he's specific time recorded) bserved" (no time recorded). Drecorded). T.O (telephone ved) (no time recorded) U/A ossible, CXR (chest x-ray) if el better by later today (no led). E2, DON and family ecorded)." 0:50 PM) (appears late (evening) poor fluid and food legible)"agitation and two ag peers-appeared pale and al signs""Sy's (symptoms) vorsen (hoarse cough and to allow vital signs to be taken. In, Z3, to send to ER of after local radiology results onia. E2, DON aware."	29999				
-	The nursing notes n	iad no evidence that:	į				

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1. Laboratory tests were assessed.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6001226		B. WING		C 08/21/2014		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	1/2014
	R JAMES COURT		IAMES ROA			
BROTHE			ELD, IL 627			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ge 4	Z9999			
29999	2. Thorough nursing that: a. included comb. included pull and/or after cough was recorded to c. addressed reacting uncomfortabed. addressed RO7/19/14, untimed ee. addressed Rand multiple reports f. addressed Rand multiple reports f. addressed Rand pearance on 07/3. DON providing fudocuments stating I status change During an interview 08/14/14 at 10:17 Aor having knowledg results of 07/11/14. had no records related by facility laboratory results, of given as a result of results of 07/11/14. During an interview (DON), on 08/13/14 anyone at the facility the family about the 07/11/14.	g assessments had been done applete vital signs monary assessments before was recorded or when cough be worse eports of R1 being shaky and le on 07/19/14, untimed entry 1's refusal to walking on entry 1's poor fluid and food intake of agitation on 07/19/14, 1's shaky and pale 19/14, untimed entry urther instructions after DON was informed of health with Z3 (physician) on M, Z3 denied being contacted e concerning R1's laboratory Z3 confirmed that their office ted to R1's laboratory test. with R1's guardians on M, the guardians denied being regarding R1's abnormal or medical treatment being the abnormal laboratory with E2, Director of Nursing, at 2:09 PM, E2 denied y informed the physician or abnormal lab for R1 on	25555			
	reveals: 07/11/14 - "no mala	w of nursing notes for R1 daptive behaviors"				

Illinois Department of Public Health

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PRINTED: 10/09/2014

Illinois F	Department of Public	Health			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION		SURVEY PLETED
		IL6001226	B. WING	B. WING		C 08/21/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BROTHE	ER JAMES COURT		. JAMES ROAI FIELD, IL 627			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		HOULD BE	(X5) COMPLETE DATE		
Z9999	12:30 AM 07/14/14 at 12:30 A AM) describing mal to left distal area or 07/17/14 - "1340 (1 07/19/14 - "3 PM behaviors towards reasonrefused A refused V/S (vital si (temperature) 97.0, "Taken outside for a returned saying R1 a w/c (wheelchair)" min (minutes) later (sp) and "acts like h wincing is observed informed. T.O (tele (received) U/A (urin	ng notes until 07/14/14 at AM thru 07/17/14 0600 (6:00 ladaptive behavior and bruise nly. :40 PM) T (temperature) 98.1' .R1 had two aggressive peers for no apparent M meds (medications). igns) except temp DON notified of his refusal." a walk (about 9:30 AM) staff refused to walk but accepted (illegible) R1 back about 25 saying R1 "seems shakey" ne's uncomfortable" "Facial d" "hoarse cough noted. Drephone orders) rec'd lalysis) when possible, CXR sn't seem to feel better by late."				

DON aware."

07/19/14 - "2250 (10:50 PM) On days/eves (evening) poor fluid and food intake"... multiple (illegible)..."agitation and two incidents of grabbing peers-appeared pale and shaky. Refused vital signs"..."Sy's (symptoms) cont (continue) to worsen (hoarse cough and agitation) Refused to allow vital signs to be taken. T.O. from physician, Z3, to send to ER (Emergency Room) and arriving at 1845 (6:45 PM), after local radiology results positive for pneumonia. E2,

07/30/14 - 12:00 (noon) ...".R1 passed away at

2. Thorough nursing assessments had been done

The nursing notes had no evidence that:

1. Laboratory tests were assessed.

0537 (5:37 AM) this morning"...

STATE FORM 6899 JL1811 If continuation sheet 6 of 7

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IIIIIIOIS L	Department of Public	Health				
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6001226		B. WING		C 08/21/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
			JAMES ROA			
BROTHI	ER JAMES COURT	SPRINGF	IELD, IL 62	707		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Z9999	b. included pul and/or after cough was recorded to c. addressed re acting uncomfortab d. addressed R e. addressed R and multiple reports	monary assessments before was recorded or when cough to be worse eports of R1 being shaky and le 1's refusal to walking 1's poor fluid and food intake	Z9999			

Illinois Department of Public Health STATE FORM

Imposed Plas of Correction

ID Prefix Tag No.

Combined Plan of Correction and Credible Allegations of Compliance

W318 483.460 The facility will ensure that specific health care services requirements are met.

The facility maintains comprehensive nursing policies and procedures, including policies related to laboratory services.

The Medical Director, Administrator, and DON reviewed and revised the policy on Laboratory Services (see attached).

The Laboratory Services policy addresses the receipt of laboratory results and describes the necessary follow-up, such as informing the physician and guardian, and monitoring the client for significant changes.

Licensed nursing staff was trained on the policy on August 14, 2014 (see attached).

Abnormal laboratory results will be noted on the shift change report. All licensed personnel will review the shift change report prior to the start of each shift to ensure that the necessary follow-up is conducted.

The DON and/or her designated licensed staff shall routinely monitor labs to ensure that the policy is followed and the necessary follow-up is initiated.

Licensed personnel audited all laboratory reports received in the last three months to ensure that the necessary follow-up was initiated.

Any licensed staff found not to be following facility policy will be disciplined up to and including termination.

The DON and Administrator shall monitor for continued compliance.

completion date: 20 days from Receipt of Notice

Imposed Planz Corrector

ID Prefix Tag No.

Combined Plan of Correction and Credible Allegations of Compliance

W322 483.460(a)(3) The facility will provide or obtain preventive and general medical care.

The facility maintains comprehensive nursing policies and procedures, including policies related to laboratory services.

The Medical Director, Administrator, and DON reviewed and revised the policy on Laboratory Services (see attached).

The Laboratory Services policy addresses the receipt of lab results and describes the necessary follow-up, such as informing the physician and guardian, and monitoring the client for significant changes.

Licensed nursing staff was trained on the policy on August 14, 2014 (see attached).

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Any licensed staff found not to be following facility policy will be disciplined up to and including termination.

The DON and Administrator shall monitor for continued compliance.

Completion Date: 20 days from Notice

Imposed Plan & Correctu'

ID Prefix Tag No.

Combined Plan of Correction and Credible Allegations of Compliance

W331 483.460(c)

The facility will provide clients with nursing services in accordance with their needs.

The Medical Director, Administrator, and DON reviewed and revised the policy on Laboratory Services (see attached).

The Laboratory Services policy addresses the receipt of laboratory results and describes the necessary follow-up, such as informing the physician and guardian, and monitoring the client for significant changes.

Licensed nursing staff was trained on the policy on August 14, 2014 (see attached).

Abnormal laboratory results will be noted on the shift change report. All licensed personnel will review the shift change report prior to the start of each shift to ensure that the necessary follow-up is conducted.

The DON and/or her designated licensed staff shall routinely monitor labs to ensure that facility policy is followed and the necessary follow-up is initiated.

Licensed personnel audited all laboratory reports received in the last three months to ensure that the necessary follow-up was initiated.

Any licensed staff found not to be following facility policy will be disciplined up to and including termination.

The DON and Administrator shall monitor for continued compliance.

Brother James maintains comprehensive nursing policies and procedures, including monitoring and reporting a significant change in a client's condition. Significant health changes such as hospice care will be reported to the DON. The DON will notify the appropriate staff of

Completin Date: -12-20 days from Receipt & Dorce