STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B:	COMP	PLETED
			D WILLS			3
	IL6009179 B. WING		01/3	30/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STERLIN	NG PAVILION		23RD STR			
			G, IL 61081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:	THE STATE OF THE S			
	a) The facility shall I procedures governing facility. The written pure formulated by a land Committee consisting administrator, the admedical advisory conformed facility and other policies shall comply. The written policies the facility and shall by this committee, of and dated minutes of Section 300.1010 Mm. The facility shall resident's condition safety or welfare of a limited to, the present decubitus ulcers or a percent or more with facility shall obtain a of care for the care of the care	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting.		Attachment Statement of Licensure		S

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/17/15

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
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					С	
		IL6009179	B. WING		•	
		12000170			01/30/2015	
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CTEDI IN	NG PAVILION	105 EAST	23RD STR	EET		
SIEKLII	NG PAVILION	STERLING	G, IL 61081			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (VE)	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE DATE	
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S9999	Continued From pa	ge 1	S9999			
	•		MARKET TO STATE OF THE STATE OF			
	Castian 200 4040 C	Daniel Daniel Communication	THE PART OF THE PA			
		General Requirements for	design of the second of the se			
	Nursing and Persor	iai Care	-			
	h) The facility shall a	provide the necessary care	NATIONAL PROPERTY OF THE PROPE			
		in or maintain the highest	HPD (CARDonner			
		, mental, and psychological				
		sident, in accordance with				
		prehensive resident care				
		properly supervised nursing				
	care and personal care shall be provided to each					
		total nursing and personal				
	care needs of the re					
		ection (a), general nursing				
		t a minimum, the following				
	and shall be practice					
	seven-day-a-week b	oasis:				
	0) 01: "					
		ations of changes in a				
		including mental and				
		as a means for analyzing and				
		quired and the need for				
		uation and treatment shall be iff and recorded in the				
	resident's medical re					
	rodiacinto iniculcal fe	JOJI G.				
	Section 300.3240 At	ouse and Neglect				
		e, administrator, employee or				
70 av		all not abuse or neglect a				
		tion 2-107 of the Act)				
***************************************		s are not met as evidenced				
	by:					
	Based on observation	n, interview, and record				
	review the facility fail	led to notify a physician when				
	two residents exhibit	ed significant declines in				
	their physical conditi	on. This failure resulted in a				
		nd hospitalization for R1 and				
	R2.					

Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION ::	(X3) DATE SURVEY COMPLETED	
		IL6009179	B. WING			C 80/2015
NAME OF	DEOVIDED OD SUDDUED		DDEGG OFFI	OTATE TRANSF	1 01/3	012015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, " <b>23RD STRI</b>	STATE, ZIP CODE		
STERLIN	ig Pavilion		3, IL 61081			
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	reviewed for a chan of 9.	3 residents (R1 & R2) ge in condition in the sample				
	The findings include	<b>)</b> :				AND THE PROPERTY OF THE PROPER
	showed a written or physician, "If the par shortness of breath facility's document t Readmission Asses	charge notes dated 12/27/14 der to specifically notify the tient has any sudden or sudden weight gain." The itled, Residents at Risk for sment, dated 12/29/14 ving a history of Pneumonia.				
	stated on 1/24/15, (scall light on and wer told her he "didn't fe felt prickly." E9 said said she reported R (Registered Nurse -	AM, E9 (Restorative CNA) Saturday), she observed R1's at to assist him. E9 said R1 el right and that his left arm he "just didn't look right." E9 1's expressed concerns to E6 RN).				
	worked with R1 on S Sunday (1/25/15) on complained of "feelii was "running a low g about 99 degrees Fa temperature not doo	PM, E6 (RN) stated she Saturday (1/24/15) and the day shift. E6 stated R1 ng weaker" on Saturday and grade temp (temperature) of ahrenheit." (Elevated sumented.) E6 stated she Therapist) to check his				
	received report for the E6 (RN). E4 said E6 feeling well and was (temperature) so he the day." E4 said be Z10 called and told he	AM, E4 (LPN) stated he ne PM shift on 1/25/15 from 5 reported R1 "was not running a low grade temp stayed in his room most of etween 6:30 PM and 7:00 PM, him R1 was "short of breath d she (Z10) wanted him to			:	

Illinois Department of Public Health

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		II 6000470	B. WING			C	
		IL6009179	L		01/	30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
STERLIN	NG PAVILION		' 23RD STRI G, IL  61081				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	go to the hospital. It to check his vital sig (blood oxygen satur (Normal values 95-was applied at 2 Litter no change in satura "bumped it up to 3L reading of 80%. E4 EMT's (Emergency arrived." E4 said "Tme (Z10) called 911 any physical signs of increased respirator R1's vital signs. E4 then he would call 9 the resident's physical A nursing note dated R1 was exhibiting so the day. A nursing r7:00 PM documents "This nurse received (R1) informing me (IA ssured (Z10) that I him (R1). Obtained Nurse (E12 LPN) ob 75% on room air. A standing order. Lun and breathing at a raminute). O2 sats upentry made by E12 oshowed, "received pemergency room to (R1) admitted to hos Pneumonia."	E4 said he went to R1's room and obtained an SPO2 ration reading) of 75%. 100%). E4 said the Oxygen ers (L) via nasal cannula with ation. E4 said he then and obtained an SPO2 said, "at about that time the Medical Technician's) he ambulance personnel told." E4 said he did not observe of distress other than "an ry rate." E4 did not document stated if a resident is "critical" and the stated is a resident is "critical" and the stated is "criti	S9999				
		of not him not feeling well					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009179	A. BUILDING:		C 01/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 0170	70/2013
SIERLING PAVILION		23RD STR				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	returned to the hosp to his "Kidney Grow have expected R1 to and added that he had passed. Z7 sai change in conditions particularly those involved and added that he had passed. Z7 sai change in conditions particularly those involved with R2 was admitted to aftercare following a surgery.  On 1/28/15 at 9:07 A worked with R2 on Stime R2 "told me her and I saw bruising a said "I don't recall if R2 did tell me she her and I saw bruising a said "I don't recall if R2 did tell me she her 1/23/14 (10:00 PM) said he responded to the bathroom. E1 legs to help her up, slooked at her right lo happened. E14 said Therapy had been pit." E14 described R discolored, dark bruidown to her ankle the said there was a "spemedial ankle. E14 sbeen telling everyone her since Monday, (1 burning concerns with the said there was a strong the since Monday, (1 burning concerns with the said there was a strong the since Monday, (1 burning concerns with the said there was a strong the since Monday, (1 burning concerns with the said there was a strong the since Monday, (1 burning concerns with the said there was a strong the since Monday, (1 burning concerns with the said there was a strong the said the said there was a strong the said the said there was a strong the said the said the said there was a strong the said th	7 stated he was aware R1 bital but thought it was related th." Z1 stated he would not to pass away "at this time," and not been made aware R1 d it is his expectation that any is be reported to him, volving a decline.  Sheet dated 1/17/15 showed the facility on 1/17/15 for a scheduled knee replacement  AM, E14 (CNA) stated he had Sunday (1/18/15) at which ar leg was sore. I looked at it and some discoloration." E14 I reported it to the nurse, but ad already told the nurses." work with R2 again until to 1/24/14 (6:00 AM). E14 to R2's call light to assist her 4 said as he touched her she "yelped." E14 said he wer leg and asked her what I R2 told him "Physical utting green (cold/hot) gel on to 1/2's right lower leg as se at the calf with redness at was "hot to touch." E14 lit" in her skin near the right aid, "(R2) told me she had the who has been caring for 1/19/15) about the pain and the her right lower leg."	S9999			
1	nurse for R2 on the r	M, E13 stated she was the hight shift 10:00 PM(1/23/15) . E13 stated she gave R2				

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Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
AIND FLAIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		LOW	IPLETED
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		IL6009179	B. WING		1	30/2015
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			**************************************	DEFICIENCY)		
S9999	Continued From pa	ge 5	S9999			
	pain medication (de	ocumented in the notes as	man-poppings			
		on 1/23/15), and "about 1 to	2001			
		came to me" expressing	VALUATION			
		d a bruise behind her right	deliconate			
		it was blackened from the				
		s heel was red and warm."				
		ed area was dark purple,	Oli de la constante de la cons			
		E13 said she assessed the				
	right lower leg "betw	veen 12:30 and 1:30 AM."				
	E13 stated, "Because	se the Specialists (Orthopedic	Ten and the second seco			
		k Nursing Homes at night, I	A POPULATION AND A POPU			
		ntil 5:30 AM when I knew they	NO.			
		unds at the hospital." The				
		1/15 at 6:12 AM, showed a				
	return call was rece		TO VICTORIA DE LA COLONIA DE L			
		n and an order was given to	- Control Statement			
	call 911 and send R	2 to the local hospital.	TO CONTRACT OF THE PARTY OF THE			
entered to project our	The nursing note of	1/24/15 at 3:51 AM reads,	NAVA ANTONIO POR A			
		ow leg pain." The only right	THE COLUMN TO TH			The state of the s
		cumentation was written on	A CONTRACTOR OF THE CONTRACTOR			
		The 1/24/15 note reads as	and it is a second			
		om with C/O (complaints of)	- Childelphama			
		pain. Right leg assessed.	PARTITION			
		approximated. There is no	III DOMESTIC			10000000
	sign of infection. Rig	ght calf bruise has darkened				
		kle and appears black.				
		cattered fluid filled blisters.	Tananaga a			
	•	e has a reddened area that is	· · · · · · · · · · · · · · · · · · ·			
		painful. It measures 8.5 (cm)				
		n has pitted in several areas				
		areas. MD (Z6 - Orthopedic				
		his time. (Z6) is currently at				
	(local nospital). Awa	aiting return call at this time."				
	The progress potes	identified R2 had a change in				
		y of pain status on 1/19/15				
		completed until 1/24/15				

between 12:30 AM and 1:30 AM. (More than 4 days later). The physician was not notified until

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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S9999	Continued From page	ge 6	S9999			
	change in pain was	(more than 4 days after a reported and more than 4 ages in R2's leg condition was				
	admitted to the hosp cellulitis. Z6 stated complaints, he could sooner. The earlier prevented some of t stated it is his under topical analgesic wh pain. Z6 said earlier shortened R2's hosp have expected the fathe complaints being physicians should be later," as complaints  On 1/27/15 at 3:30 F R2's right lower extre pillow with some drie pillowcase. R2 explaines and calf extending downedial ankle area was extending between the tothe plantar area. To outlined in purple mathe infected tissue.  The facility policy title Condition or Status, I our facility shall prosess.	PM, (at the local hospital), emity was propped on a ed yellow drainage on the ained the drainage was a popping." R2's right lower and dark in color from the top on to to her ankle. The right				
(   r	(sponsor) of changes	in a resident's ition and/or status" Some			THE RESIDENCE OF THE PARTY OF T	

Illinois Department of Public Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		E SURVEY PLETED
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STERLING PAVILION 105 EAS			23RD STRE	STATE, ZIP CODE EET		
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S9999	Continued From pa	ge 7	S9999			
	Pressure, venous o incision, DVT (deep vascular disease" a states the staff are reported level of pair report to the physici changes in the level policy defines a "sig or improvement to to not normally resolved The policy also has emergencies, notificativenty-four (24) hou the resident's medic statusNurse will rerecord information residents condition.  The facility policy title	disease, Rheumatoid arthritis, r arterial ulcers, surgical vein thrombosis), Peripheral nd "Pneumonia." The policy to document the resident's in with adequate detail," and an or practitioner, "significant of the resident's pain." The inificant change" as, "a decline he residents status thatwill existent without intervention." written, "Except in medical cations will be made within urs of a change occurring in cal/mental condition or ecord the resident's medical elative to changes" in the				
	<ul> <li>Clinical Protocol, F "someone with an a nursing staff will ma</li> </ul>	Revised 11/2013 shows, cute change of condition, the ke detailed observations and rmation to report to the				
	Management, Revis management" is def alleviating the reside acceptable to the re recognize the prese characteristics of pacauses of painand and consequences acute pain or signific chronic pain." Staff situations that may pain including," Deg	ed Pain Screening and ed 11/2013, states, "Pain ined as the process of ent's pain to a level that is sident. Staff is to "effectively note of pain; identify the in; addressing the underlying monitor the resident's pain of pain at least each shift for eant changes in levels of are to "identify conditions or predispose the resident to enerative Joint Disease, pressure, Venous or Arterial				

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY	
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	ulcers, surgical incis Disease and Pneun	sions, Peripheral Vascular nonia.				
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			Action to minimal to the Control of		HEREOTOPICA BANKA	
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Illinois Department of Public Health STATE FORM