STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145581	A. BUILDING _____ B. WING _____	C 05/06/2015

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CAHOKIA NURSING & REHAB CENTER	**2 ANNABLE COURT CAHOKIA, IL 62206**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1541972 / IL 76454 - F221, F312, F309, F314, F322, Complaint Investigation 1542029 / IL 76531 - F221, F225, F226, F312, F314, F514 Complaint Investigation 1542332 / IL 76897 - F312, F314 Complaint Investigation 1542371 / IL 76947 - F157, F309, F322	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Facility failed to notify the physician promptly of a change in condition for 1 of 5 residents (R10), reviewed for recent hospitalizations in the sample of 28. Findings include: 1. The Facility's Pain Management Monthly Flow Record documents on 4/13/2015, on Day shift Pain Intensity = 8, Very Severe. Non -Verbal signs are #2, Tightly Closed, wide open, blinking eyes, #3, crying, moaning, and #6, guarding an area of the body. On 4/14/2015 the Facility's Pain Management Monthly Flow Record documents Score = 6, Severe Pain. Non verbal signs of pain are #9, Irritability and #1, facial wrinkling, grimacing. On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10's gown. The green vomitus was on her bed linens, extending from R10's shoulder to her hip. R10	F 157		

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smelled of feces.

On 4/16/15 the Pain Management record and Nurse's notes failed to document any information on R10's on going pain, moaning, or vomiting or that Z3, Physician of R10, had been notified of R10's symptoms.

In a telephone interview on 4/28/15 at 3:50 PM, E32, Licensed Practical Nurse,(LPN) stated " I worked on day shift (6:30 AM to 2:30 PM) on 4/16/15, R10 did have 2 emesis. R10 has a history of vomiting (previously when she ate), and now at times vomits with her G-Tube. E32 stated, "I did not tell anyone that R10 had vomited that day, as it was not uncommon for her to sometimes vomit. I did not notify Z3, R10's doctor."

On 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated R10's typical demeanor is she usually chats a sort of singing sound but no moaning nor groaning. E3 stated that on 4/16/15, she had not been told by E32 that R10 had vomited earlier on the day shift. Also, she (E3) had not assessed R10 when she wrote her Nurses Note that R10 had not vomited that day. E3, did not know if E18, (LPN/evening shift), had assessed R10 prior to E3's calling Z3 on 4/16/15 at telling him E3 was "stable with no nausea/vomiting." E3 stated she would have expected the staff nurse to complete a physical assessment of the resident before calling the doctor, especially if vomiting was reported, but no nausea and vomiting had been reported from either shift that day.

On 4/29/15 at 2:45 PM, Z3, (Physician on Call), stated during interview; on 4/16/15, that he had

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F 157	Continued From page 3	F 157		

been called for orders for R10's G-Tube feeding. At that time he had not been told R10 had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know. Z3, stated if he had known of the nausea and vomiting, he would have admitted R10 to the hospital for fluids and evaluation, earlier that day.

On 4/29/15 at 4:20 PM, Z5, (Primary Physician of R10), stated R10 did have a history of Nausea and Vomiting, but R10 also has a history of vomiting when she has a urinary tract infection that is becoming septic. Z5, stated, because R10 multiple medical issues, Staff should have called the physician and informed them of the nausea, vomiting, and pain, and let the physician determine if this was something that needed to be addressed or not. In this case R10 could have been sent to the hospital sooner, and treatments, surgical options or Hospice could have been discussed and offered to the family. If R10 was having nausea, vomiting, and pain it would indicated something was wrong and R10 probably needed to be seen by the physician.

The Facility policy Change in Condition; Notification dated 2/23/09, documented; It is the responsibility of licensed staff to contact the physician and resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definition: 1. A change in condition is any assessment finding, observance, or event that deviates or has the potential to cause a deviation in the resident's usual or expected physical, mental or psychosocial status. Policy: Upon identification of a change in condition licensed

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F 157	Continued From page 4 nursing personnel will contact the resident's physician to notify him / her of the change. All notifications should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a physician order, assess and document the risks versus benefits justifying the use of a restraint for 1 of 3 residents (R20) reviewed for restraints in the sample 28. Findings include: 1. R20's Minimum Data Set (MDS) dated 3/9/15, documents the Brief Interview of Mental Status (BIMS)as not addressed. The previous MDS dated 2/14/15 documents R20's cognition as severely impaired. R20's MDS further documents R20 is totally dependent on 1-2 staff members for assistance with Activities of Daily Living (ADL's) and requires extensive assistance of one staff member for eating. R20's Physician Order Sheet (POS) Dated 3/1/15 thru 3/31/15 does not document a	F 221		

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F 221	Continued From page 5 physician orders for any type of restraint or device. R20's Care Plan does not document the use of any type of restraint or device. R20's Incident Form dated 3/29/15, E32, (Licensed Practical Nurse, LPN), documents: "while eating in ADR (assistive dining room), CNA (Certified Nurse Assistant) stated "I (E9) think he's (R20's) choking." I (E32) turned around saw his (R20's) mouth wide open and tears began to roll down his face. I (E32) immediately pulled resident away from table to lower his chair and turn him on his side. Attempted to do so x2-3. Examined R20 to see what was stopping me (E32) from turning R20 on his side. Pulled his shirt up and noted R20 had a gait belt strapping him to his chair with opening behind R20's chair. Proceeded to remove belt at this time. Assistance arrived. Got R20 out of chair and performed the Heimlich Maneuver. Was able to clear R20 of the obstruction which was oatmeal." The Incident Form further documents by E9, (Certified Nurse Assistant, CNA), : "I took R20 in room put bib on him. Proceeded to pass trays in activity room.-Gave R20 his tray. I (E9) fed him and R20 took 2 bits of oatmeal. On 2nd bite R20 started to cough-covered his mouth-R20 then his eyes watered- no coughing-E32, LPN, was in room. I (E9) called her (E32) over. E32 noted R20 was choking-call the code (blue). Nurse worked on R20-tried to remove what was in his (R20's) throat but tried to remove from chair. She released gait belt from R20 and R20 was still holding onto chair. Second nurse to get hands free of chair-finally removed hands from chair-nurses performed Hemlock Maneuver. The Incident Form also document "Disciplinary Action	F 221		

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Form" and documents: Date of Incident: 3/29/15, Time: 8:03AM, Describe the violation: CNA placed gait belt around R20 while in w/c (wheelchair). The is an unauthorized use of restraint. What behavior is expected? Re-educate CNA on unauthorized use of restraints. Actions for employee improvement: do not use unauthorized restraint."

On 4/22/15 at 10:09 AM, E9, Certified Nurse Assistant (CNA) stated she had been caring for R20 and had been one to one with R20. E9 stated R20 had been one to one with staff for a month or longer, and she (E9) had worked with R20 the day before 3/29/15. E9 stated R20 was antsy and would try and get up to walk even though he couldn't walk alone. E9 stated R20 needed staff assistance and that is why he was on one to one because he had fallen in the past and would try to keep getting up. E9 stated she put R20 in his wheelchair and went to breakfast room. E9 stated she put the gait belt around R20 tying it to the back of R20's wheelchair to keep him safe while she (E9) passed breakfast trays. E9 stated she passed trays to everyone in the room and sat down to feed R20. E9 stated she fed R20 2 bites of oatmeal, and on the 2nd bite, R20 started to cough and wasn't able to cough the food up so she (E9) notified E32, (LPN). E9 stated she went to get additional help and when she (E9) returned to the dining room, R20 had coughed up the oatmeal he was choking on. E9 stated she was sent home by E1, (Administrator), because they (the facility) would have to do investigation on using the restraint. E9 further stated no one was aware that she had used the gait belt on R20 as a restraint.

On 4/23/15 at 12:05 PM, E32, (Licensed Practical

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Nurse) stated she was notified by E9, (CNA) that R20 was choking. E32 stated she went and assessed R20 and tried to reposition R20 but was unable to. E32 stated she attempted 2-3 times to move R20 but R20 was unable to be repositioned in his wheelchair. E32 stated she reassessed R20 and found a gait belt strapping R20 to his wheelchair. E32 stated the gait belt was under R20's clothing and tied around the back of the wheelchair. E32 stated she had never seen a gait belt used as a restraint on R20 and didn't know why it would be on sine R20 was on one to one with staff members.

On 4/23/15, E2, Director of Nursing (DON), stated she (E2) received a call from the facility on 3/29/15 that stated R20 had choked on oatmeal during breakfast and staff attempted to perform the Heimlich Maneuver on R20 but found a gait belt under R20's shirt that tied around to the back of R20's wheelchair. E2 stated E9, (CNA), put gait belt around so R20 could not get up while E9 passed breakfast trays out. E2 stated E1, (Administrator) sent E9 home for unauthorized use of a restraint. E2 further stated E9 did not have an order for any type of restraint or device and staff should not be using gait belts to restrain any resident. E2 stated she felt E9 used the gait belt to restrain R20 to keep R20 from falling and E9 made a dumb decision when she (E9) made the decision to use gait belt on R20.

On 4/21/15 at 11:19 AM, E1, (Administrator) stated she was notified on 3/29/15 that E9, CNA had used a gait belt to restrain R20 in his wheelchair to keep him safe during breakfast. E1 stated during breakfast R20 choked on oatmeal and E32, (LPN), had to perform the Heimlich Maneuver to assist in clearing R20's airway. E1

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F 221	Continued From page 8 stated E9 was assigned to R20 specifically because R20 was a fall risk and had falls in the past. E1 stated that E32 had felt resistance when trying to reposition R20 during R20's choking incident and that is when the gait belt around R20's waist was discovered. E1 further stated E9 was sent home because she did not have authorization to use a restraint. The Facility's Policy "Restrain Device Screening' dated 5/27/08 documents: "This facility will evaluate the use of any device alarm or other medical equipment adjacent, proximate or attached to a resident for potential restraining effects. Policy Guidelines: 1. This facility will evaluate devices and or proximate type safety alarms for potential restraining characteristics before they are fully implemented. 2. If the screening indicates that the device may have characteristics of a restrains then the device will be fully evaluated under the facility's restraint policy. 3. Regardless of the impact the device has on the resident, the use of the device will be incorporated in the resident's plan of care.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		

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F 225	Continued From page 9 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely investigate a report of potential abuse and failed to timely report to the State Agency an allegation of potential abuse for 1 of 11 residents (R20) reviewed for Abuse in the sample of 28. Findings include: 1. R20's Minimum Data Set (MDS) dated 3/9/15, documents the Brief Interview of Mental Status	F 225		

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(BIMS)as not addressed. The previous MDS dated 2/14/15 documents R20's cognition as severely impaired. R20's MDS further documents R20 is totally dependent on 1-2 staff members for assistance with Activities of Daily Living (ADLS)

R20's Incident Form dated 3/29/15, E32, (Licensed Practical Nurse) documents: "while eating in ADR (assistive dining room), CNA (Certified Nurse Assistant) stated "I (E9) think he's choking." I (E32) turned around saw R20's mouth wide open and tears began to roll down his face. I (E32) immediately pulled resident away from table to lower his chair and turn him on his side. Attempted to do so x2-3. Examined R20 to see what was stopping me from turning him on his side. Pulled his shirt up and noted he had a gait belt strapping him to his chair with opening behind R20's char. Proceeded to remove belt at this time. Assistance arrived. Got R20 out of chair and performed the Heimlich Maneuver. Was able to clear R20 of the obstruction which was oatmeal." The Incident Form further documents by E9, (Certified Nurse Assistant), CNA: "I took R20 in room put bib on him. Proceeded to pass trays in activity room.-Gave R20 his tray. I (E9) fed him and R20 took 2 bites of oatmeal. On 2nd bite R20 started to cough-covered his mouth-R20 then his eyes watered- no coughing-E32, (LPN), was in room. I (E9) called her (E32) over. E32 noted R20 was choking-call the code (blue). Nurse worked on R20-tried to remove what was in his (R20's) throat but tried to remove from chair. Release gait belt from R20 and R20 was still holding onto chair. Second nurse to get hands free of chair-finally removed hands from chair- nurses performed Heimlich Maneuver. The Incident Form also document "Disciplinary Action Form"

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F 225	Continued From page 11	F 225		

and documents: Date of Incident: 3/29/15, Time: 8:03AM, Describe the violation: CNA placed gait belt around R20 while in w/c (wheelchair). The is an unauthorized use of restraint. What behavior is expected? Re-educate CNA on unauthorized use of restraints. Actions for employee improvement: do not use unauthorized restraint.

On 4/22/15 at 10:09 AM, E9, Certified Nurse Assistant (CNA) stated she had been caring for R20 and had been one to one with R20. E9 stated R20 had been one to one with staff for a month or longer, and she (E9) had worked with R20 the day before 3/29/15. E9 stated R20 was antsy and would try and get up to walk even though he couldn't walk alone. E9 stated R20 needed staff assistance and that is why he was on one to one because he had fallen in the past and would try to keep getting up. E9 stated she put R20 in his wheelchair and went to breakfast room. E9 stated she put the gait belt around R20 tying it to the back of R20's wheelchair to keep him safe while she (E9) passed trays. E9 stated she she passed trays to everyone in the room and sat down to feed R20. E9 stated she fed R20 2 bites of oatmeal, and on the 2nd bite, R20 started to cough and wasn't able to cough the food up so she (E9) notified E32. E9 stated she was sent home by E1 because they would have to do investigation on using the restraint. E9 further stated no one was aware that she had used the gait belt on R20 as a restraint.

On 4/23/15 at 12:05 PM, E32, (Licensed Practical Nurse) stated she was notified by E9, (CNA) that R20 was choking. E32 stated she went and assessed R20 and tried to reposition R20 but was unable to. E32 stated she attempted 2-3 times to move R20 but R20 was unable to be repositioned

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in his wheelchair. E32 stated she reassessed R20 and found a gait belt strapping R20 to his wheelchair. E32 stated the gait belt was under R20's clothing and tied around the back of the wheelchair. E32 stated she had never seen a gait belt used as a restraint on R20 and didn't know why it would be on sine R20 was on one to one with staff members. E32 also stated she immediately notified E1, (Administrator) because she (E32) "thought it was a form of abuse and we report to E1 immediately. "

On 4/23/15, E2, Director of Nursing (DON), stated she (E2) received a call from the facility on 3/29/15 that stated R20 had choked on oatmeal during breakfast and staff attempted to perform the Heimlich Maneuver on R20 but found a gait belt under R20's shirt that tied around to the back of R20's wheelchair. E2 stated E9, (CNA) put gait belt around R20 so R20 could not get up while E9 passed breakfast trays out. E2 stated E1, (Administrator) sent E9 home for unauthorized use of a restraint. E2 further stated E9 did not have an order for any type of restraint or device and staff should not be using gait belts to restrain any resident. E2 stated she felt E9 used the gait belt to restrain R20 to keep R20 from falling and E9 made a dumb decision when E9 made the decision to use gait belt on R20. E2 further stated that she (E2) did not feel it was any form of abuse and no abuse investigation was conducted.

On 4/21/15 at 11:19 AM, E1, (Administrator) stated she was notified on 3/29/15 that E9, (CNA) had used a gait belt to restrain R20 in his wheelchair during breakfast. E1 stated during breakfast R20 choked on oatmeal and E32, (LPN), had to perform the Heimlich Maneuver to

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assist in clearing R20's airway. E1 stated E9 was assigned to R20 specifically because R20 was a fall risk and had falls in the past. E1 stated that E32 had felt resistance when trying to reposition R20 during R20's choking incident and that is when the gait belt around R20's waist was discovered. E1 further stated E9 was sent home because she did not have authorization to use a restraint. E1 further stated she did not think E9's use of a gait belt as a restraint on R20 was abuse and did not was to come in and investigate it right away. E1 stated she was irritated and that is why she sent R9 home and stated she would deal with it on Monday when she came in. E1 stated she wasn't going to come in since incident wasn't reportable to the State.

On 4/30/15 at 11:05 AM, E1 stated to date, the State Agency still has not been notified of R20's incident on 3/29/15. E1 further stated she did not know she was supposed to notify Illinois Department of Public Health. At 11:15 AM, E1 further stated "we (facility) are not planning to file a report. We will get the Statement of Deficiency and then see if we need to file a report."

The Facility's Abuse Policy dated 1/12 documents: This policy affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility therefore prohibits acts of mistreatment, neglect, abuse and or crimes from being committed against its residents. This facility desires to established a resident sensitive and resident secure environment. The purpose of this policy is to develop a mechanism to reduce the risk of abuse, neglect, misappropriation of resident property and or crimes from being

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F 225	Continued From page 14 omitted against the residents of this facility. This will be done by implementing the following systems and/or practices: Identifying occurrences and patterns of potential mistreatments; implementing systems to investigate all repots and allegations of mistreatment promptly an aggressively, and making the necessary changes to prevent future occurrences and filing accurate and timely investigative reports. The Facility's Abuse & Training Policy date 1/12 documents: "Handout B (Page 4 of 4) Identification of Abuse." "Don't try and figure out if it's abuse. Just report it! Bulleted item #5 Improper use of restraints." The Facility's Policy "External Reporting of Abuse, Neglect, Theft and Crimes" dated 1/12 documents: "Upon receipt of an allegation of abuse, neglect, theft or that crime has occurred against a resident the facility Administrator or his/his designee will initiate external reports to the following; A. The Department: i. The Administrator or his/her designee will contact the Department immediately but no later than 24 hours following an observed even, allegation or formulation of a reasonable suspicion that a crime occurred against a resident that did not result in serious bodily injury. ii. In cases of serious bodily injury the Administrator will contact the department immediately but no later than two (2) hours from the time the allegation or formation of the reasonable suspicion that a crime was committed against a resident."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 15 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize its Abuse policy by not reporting an allegation of abuse to the State Agency in a timely manner and by delaying the initial investigation of potential abuse for 1 of 11 residents (R20) reviewed for Abuse in the sample of 28. Findings include: R20's Incident Form dated 3/29/15, E32, Licensed Practical Nurse documents: "while eating in ADR (assistive dining room), CNA stated "I (E9) think he's choking." I (E32) turned around saw his moth wide open and tears began to roll down his face. I (E32) immediately pulled resident away from table to lower his chair and turn him on his side. Attempted to do so x2-3. Examined R20 to see what was stopping me from turning him on his side. Pulled his shirt up and noted he had a gait belt strapping him to his chair with opening behind R20's char. Proceeded to remove belt at this time. Assistance arrived. Got R20 out of chair and performed the Heimlich Maneuver. Was able to clear R20 of the obstruction which was oatmeal." The Incident Form further documents by E9: "I took R20 in room put bib on him. Proceeded to pass trays in activity room.-Gave R20 his tray. I (E9) fed him and R20 took 2 bites of oatmeal. On 2nd bite	F 226		

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F 226	Continued From page 16 R20 started to cough-covered his mouth-R20 then his eyes watered- no coughing-E32 was in room. I (E9) called her (E32) over. E32 noted R20 was choking-call the code (blue). Nurse worked on R20-tried to remove what was in his (R20's) throat but tried to remove from chair. Release gait belt from R20 and R20 was still holding onto chair. Second nurse to get hands free of chair-finally removed hands from chair-nurses performed Heimlich Maneuver. On 4/22/15 at 10:09 AM, E9, Certified Nurse Assistant (CNA) stated she had been caring for R20 and had been one to one with R20. E9 stated R20 had been one to one with staff for a month or longer, and she (E9) had worked with R20 the day before 3/29/15. E9 stated R20 was antsy and would try and get up to walk even though he couldn't walk alone. E9 stated R20 needed staff assistance and that is why he was on one to one because he had fallen in the past and would try to keep him from getting up. E9 stated she put R20 in his wheelchair and went to breakfast room. E9 stated she put the gait belt around R20 tying it to the back of R20's wheelchair to keep him safe while she (E9) passed trays. E9 stated she she passed trays to everyone in the room and sat down to feed R20. E9 stated she fed R20 2 bites of oatmeal, and on the 2nd bite, R20 started to cough and wasn't able to cough the food up so she (E9) notified E32. E9 stated she went to get additional help and when she (E9) returned to the dining room, R20 had coughed up the oatmeal he was choking on. E9 stated she was sent home by E1 because they would have to do investigation on using the restraint. E9 further stated no one was aware that she had used the gait belt on R20 as a restraint.	F 226		

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F 226	Continued From page 17 On 4/23/15 at 12:05 PM, E32, (Licensed Practical Nurse) stated during interview that she was notified by E9, CNA that R20 was choking. E32 stated she went and assessed R20 tried to reposition R20 but was unable to. E32 stated she attempted 2-3 times to move R20 but R20 was unable to be reposition in his wheelchair. E32 stated she reassessed R20 and found a gait belt strapping R20 to his wheelchair. E32 stated the gait belt was under R20's clothing and tied around the back of the wheelchair. E32 stated she had never seen a gait belt used as a restraint on R20 and didn't know why it would be on sine R20 was on one to one with staff members. E32 also said she immediately notified E1, (Administrator) because she (E32) "thought it was a form of abuse and we report to E1 immediately. " On 4/23/15, E2, Director of Nursing (DON), stated she (E2) received a call from the facility on 3/29/15 that stated E9, (CNA) used a gait belt as a restraint around R20 so R20 could not get up while E9 passed breakfast trays out. E2 stated E1, (Administrator) sent E9 home for unauthorized use of a restraint. E2 further stated R29 did not have an order for any type of restraint or device and staff should not be using gait belts to restrain any resident. E2 stated she felt E9 used the gait belt to restrain R20 to keep R20 from falling and E9 made a dumb decision when E9 made the decision to use gait belt on R20. E2 further stated that she (E2) did not feel it was any form of abuse and no abuse investigation was conducted. On 4/21/15 at 11:19 AM, E1, (Administrator) stated she was notified on 3/29/15 that E9, (CNA)	F 226		

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had used a gait belt to restrain R20 in his wheelchair to keep him safe during breakfast. E1 stated E9 was sent home because she did not have authorization to use a restraint. E1 further stated she did not think E9's use of a gait belt as a restraint on R20 was abuse and did not want to come in and investigate it (the incident) right away. E1 stated she was irritated and that is why she sent R9 home and stated she would deal with it on Monday when she came in. E1 stated she wasn't going to come in since incident wasn't reportable to the State.

On 4/30/15 at 11:05 AM, E1 stated to date, the State Agency still has not been notified of R20's incident 3/29/15. E1 further stated she did not know she was supposed to notify Illinois Department of Public Health. At 11:15 AM, E1 further stated "we (facility) are not planning to file a report. We will get the Statement of Deficiency and then see if we need to file a report."

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F 226	Continued From page 19 mistreatments; implementing systems to investigate all repots and allegations of mistreatment promptly an aggressively, and making the necessary changes to prevent future occurrences and filing accurate and timely investigative reports. The Facility's Abuse & Training Policy date 1/12 documents: "Handout B (Page 4 of 4) Identification of Abuse." "Don't try and figure out if it's abuse. Just report it! Bulleted item #5 Improper use of restraints." The Facility's Policy "External Reporting of Abuse, Neglect, Theft and Crimes" dated 1/12 documents: "Upon receipt of an allegation of abuse, neglect, theft or that crime has occurred against a resident the facility Administrator or his/his designee will initiate external reports to the following; A. The Department: i. The Administrator or his/her designee will contact the Department immediately but no later than 24 hours following an observed even, allegation or formulation of a reasonable suspicion that a crime occurred against a resident that did not result in serious bodily injury. ii. In cases of serious bodily injury the Administrator will contact the department immediately but no later than two (2) hours from the time the allegation or formation of the reasonable suspicion that a crime was committed against a resident."	F 226		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 20 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the Facility failed to provide timely assessessment and monitor for changes in condition for one of 4 residents (R10) reviewed for possible aspiration and pain in the sample of 28. This failure resulted (R10) having a delay in hospitalization and treatment. R10 was admitted to a local emergency and subsequently to the Intensive Care Unit, with diagnoses of Hypotension, Sepsis, Hyperkalemia, Illeus, Vomiting, and Dehydration. Findings include: R10's Admission Sheet documents diagnoses in part of : History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder. R10's Care Plan, dated 2/9/15, documents a Problem of "at risk or altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches / Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met." The Care Plan - Pain, dated 2/9/15, documents;	F 309		

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R10 is at risk for pain... Signs/ Symptoms of pain will be identified and pain interventions will be implemented immediately.

The Facility's Pain Management Monthly Flow Record documents on 4/13/2015 Day shift Pain Intensity = 8, Very Severe. Non - Verbal signs are #2, Tightly Closed, wide open, blinking eyes, #3, crying moaning, and #6, guarding an area of the body. Interventions included giving Vicodin 5/325, at 1:44 AM for "complaints of pain". Other interventions of turning and repositioning were documented as ineffective. For the day shift when pain was documented to be Very Severe, no other interventions drug or non-drug were documented. There is no documentation the Z3, (Physician) was notified of R10's pain.

On 4/14/2015 the Facility's Pain Management Monthly Flow Record documents Score = 6, Severe Pain. Non verbal signs of pain are #9, Irritability and #1, facial wrinkling, grimacing. Interventions included Ativan 0.5mg (milligrams) given for "constant yelling out / increased agitation." Non-drug interventions included turning and repositioning. There is no documentation of interventions on the day shift where it is documented R10 is in pain. There is no documentation Z3, (Physician), was notified of R10's pain.

On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10's gown. The green vomitus was on her bed linens,

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extending from R10's shoulder to her hip. During this time R10 smelled of feces. At 12:15pm, R10 remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown and she continued to smell of urine and stool. At 1:30pm, E6 (Certified Nurses Aide) was in her room and had just rolled her over and placed a mechanical lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement.

On 4/16/15 the The Medication Administration record documents that R10 received Hydrocod/Acetaminophen 5/325 mg tablet at 1:10 PM for "complaints / hollering - "hurts". The pain management record does not document R10's having pain or the interventions.
Pain Management record and Nurse's notes for the day shift failed to document any information on R10's moaning / pain, or vomiting. The 4/16/15 Medication Administration Record has no documentation of medication given for R10's nausea and vomiting on this day.

On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10's feeding tube. The bottle was labeled "4/16/15, 2:30 AM, amount 5." R10's tube feeding pump was turned off until 5:05 PM with 850 cc remained in the bottle. Physicians orders dated 3/27/15 documented rate of 50 cc's per hour for 23 hours. Calculation of the flow rate from time of hanging at 2:30 AM, indicates there should have only been 300 cc's remaining in the bottle at 5:05 PM . At 5:05 PM, E18 turned on R10's tube feeding pump at a rate of 75 cc's per hour.

On 4/16/15 at 18:25 (6:25 PM), E3 (Assistant

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Director of Nursing) documented the discrepancy in the G-tube rates in her Nurses Notes. At this time she called Z3, to clarify orders, and documented "informed Z3, resident weight stable, no Nausea and Vomiting", orders received to resume tube feeding at rate prior to hospitalization, "that there is no harm done," will continue to monitor resident."

In a telephone interview on 4/28/15 at 3:22 PM, E36, Certified Nurses Assistant (CNA) stated "I did work with R10 on 4/16/15. R10 did have several, 2 -3 emesis of large amounts. I told E32, (Licensed Practical Nurse, LPN), about R10's emesis. I was told to keep the head of her bed elevated. At 1:30 I took R10 to the shower and cleaned her up.

In a telephone interview on 4/28/15 at 3:50 PM, E32, (LPN0, stated " I worked on day shift (6:30 Am to 2:30 PM) on 4/16/15, R10 did have 2 emesis. R10 has a history of vomiting (previously when she ate), and sometimes now with her G-Tube. I gave her the PRN (as needed) medication as ordered on her Medication Administration Record. No, I did not chart on this, as it was a busy day and I did not do it." A review of R10's PRN-Medication sign off record found no documentation that E32 on 4/16/15, had given any medication to R10 for her 2 episodes of vomiting. E32 also stated, "I did not tell anyone that R10 had vomited that day."

In a previous interview on 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated R10's typical demeanor is she usually chats a sort of singing sound but no moaning nor groaning. E3 stated that on 4/16/15, she had not been told by E32 that R10 had vomited earlier on

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the day shift. Also, she (E3) had not assessed R10 when she wrote her Nurses Note that R10 "had not" vomited that day. E3, did not know if E18, (LPN/evening shift), had assessed R10, prior to her (E3's) calling Z3 on 4/16/15 and telling him E3 was "stable with no nausea/vomiting." E3, stated she would have expected the staff nurse to complete a physical assessment of the resident before calling the doctor, especially if vomiting was reported, but no nausea and vomiting had been reported from either day or evening shift.

On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 the night of 4/16/2015 - 4/17/15. E34 stated it had been reported to her at 5:00-5:15 AM, by E35, (CNA) that R10 had two emesis. I documented it at "06:25 AM, two emesis". E34, (RN), said she noticed the vomitus was brown and had assessed R10's bowel sounds and skin. E34, (RN) stated R10 didn't respond or make eye contact, which R10 usually did respond to others and did make eye contact. E34, RN then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

On 4/29/15 at 2:45 PM, Z3, (Physician on Call), stated; on 416/15, stated that he had been called for orders for R10's G-Tube feeding. At that time he had not been told R10 had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know. Z3, stated if he does not know if sending R10 to the hospital sooner would have changed her outcome, due to her multiple medical problems,

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but had he known of the nausea and vomiting, he would have admitted R10 to the hospital for fluids and evaluation, earlier that day. As it was, Z3 stated he was not called until 4/17/14 and told R10 had vomited.

On 4/29/15 at 3:35 PM, a telephone interview was conducted with E1- (Administrator), E2 - (Director of Nursing), and E30, (Regional Nurse). E30 stated, "it was normal for R10 to have emesis, and staff would not have called the physician as it was not seen as a change in R10's condition. E1 stated, Z5 (Primary Physician), "would not" have wanted to be called for vomiting as it was normal for her to vomit at times. When informed of R10's observed condition on 4/16/15 of moaning, and laying in vomit, E1, E2 and E30 stated they were not aware of this, and would check with their staff. E1, E2, and E30 stated they were not aware of R10 having documented pain for 2 days prior to 4/16/15. E1, E2, E30 stated they were not aware E32 had not documented R10's episodes of vomiting or that she had given R10 PRN medications for vomiting. They stated that they were also not aware that on 4/16/15, E32 had not told any staff either verbally or in writing of R10's vomiting and moaning multiple times that day. E2 stated "we will have to address that internally." E1, E2, and E3 stated "they would review R10's record and talk to staff to find out why, (if R10 routinely vomited), there was no record of nursing staff giving PRN-anti-nausea medications documented in the Medication Administration Record of R10 for the months of March 2015 and April 2015."

On 4/29/15 at 4:20 PM, Z5, (Primary Physician of R10), stated "R10 did have a history of Nausea and Vomiting, but R10 also has a history of

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vomiting when she has a UTI (urinary tract infection) that is becoming septic. Z5, stated, the facility should have been aware of the history of R10's UTI's and vomiting. As R10 does have PRN (as needed) medications for vomiting, but it would only be normal if it was a one time spontaneous event. However, if she had vomited two or three times already I (Z5) would want to know she had vomitied to rule out possible issues of being septic or other problems due to her history of gastroparesis." Z5, stated, "because R10 had multiple medical issues, it is better if staff called the physician and informed them of the nausea, vomiting, and pain, and let the physician determine if this was something that needed to be addressed or not. If R10 was having nausea, vomiting, and pain, it would indicated something was wrong and probably needed to be seen by the physician. In the case of R10 on 4/16/15, she could have been sent to the hospital sooner, and treatments, surgical options or Hospice could have been discussed and offered to the family."

The Facility policy Change in Condition / Notification dated 2/23/09, documented; It is the responsibility of licensed staff to contact the physician and resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definition: 1. A change in condition is any assessment finding, observance, or event that deviates or has the potential to cause a deviation in the resident's usual or expected physical, mental or psychosocial status. Policy: Upon identification of a change in condition licensed nursing personnel will contact the resident's physician to notify him / her of the change. All notifications should be preceded by an

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F 309	Continued From page 27 appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. Examples of Changes in Condition: (include but not limited to) Emesis or Diarrhea, Symptoms of an Infectious Process with or without fever, Abnormal reports of Pain, Subjective reports made by the resident "I don't feel good, something is wrong", contact physician after thorough physical and mental assessment.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide assistance for timely toileting and hygiene for 8 of 14 residents (R3, R6, R9, R10, R14, R15, R16 and R18) reviewed for incontinent needs and hygiene in the sample of 28. Findings include: 1. The Minimum Data Set (MDS) dated 2/19/15 identifies R3 as being a 75 year old male admitted to the facility on 1/31/15 with diagnoses of Pagets Disease and Reflux among others. The MDS documents R3 to have severe cognitive impairment and require extensive assist of one staff for hygiene/toileting and is occasionally	F 312		

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incontinent of bowel and bladder. The Care plan dated 2/13/15 includes interventions for staff to assist with transfers and toileting.

On 4/16/15 at 10:10 AM, R3 was in his wheelchair in his room with his wife (Z1) at his side. Z1 was dressing him and stated she had to shave him and trim his nails when she came in that morning because staff doesn't pay attention to that. Z1 also stated his face was dirty which she also had to clean. R3 remained in his wheelchair throughout the rest of the morning with his wife in attendance. R3 was observed being pushed about the facility by his wife and at 3:25pm, he was still in his wheelchair. Z1 was asked if staff had toileted him or laid him down since she got him up earlier that morning and stated "no." Z1, left and R3 was left sitting alone in his wheelchair at the front of the 300 hall. R3 was observed to still be sitting there at 3:45pm, 4pm, 4:12pm, 4:20pm, 4:30pm, 4:40pm, 4:45pm, 5:08pm, and at 5:20pm when the observation ended. No staff were seen to toilet and/or take him to check/change if necessary or change his position.

On 5/17/15 at the daily meeting at 3pm, E2 (Director of Nursing) confirmed that residents should be checked, changed and/or toileted at least every two hours.

2. The MDS dated 2/4/15 identifies R14 to have no cognitive impairment and requires extensive assist of one staff for transfer and toileting. The MDS also documents R14 to be occasionally incontinent of bowel and bladder.

On 4/16/15 at 2:55pm, R14 was sitting in her wheelchair at the front of hall 300. R14 was

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observed continuously from 2:55 PM until 5:00 PM, and sit without any staff approaching her until 5:00 PM, when E14 Certified nurses Aide (CNA) came up to her and without asking if she needed to use the toilet, propelled her directly into the dining room for supper. At 5:20pm, she was still sitting in the dining room awaiting her meal.

3. R15's MDS dated 2/28/15 identifies her to have severe cognitive impairment, and requires extensive assist of two staff for tranfers, extensive assist of one staff for toileting and is frequently incontinent of bowel and bladder.

On 4/16/15 at 2:55pm, R15 was sitting in her wheelchair in the doorway of 300 hall. R15 was observed continously from 2:55pm to 5:10pm when E3 Assistant Director of Nurses (ADON) came and without asking if she needed to use the toilet and/or check/change if needed, propelled her directly into the dining room for supper. At 5:20pm, R15 was sitting in her wheelchair at the table awaiting her supper meal.

4. Additional examples of sitting for long periods of time without toileting/checking and/or changing on 4/16/15 includes R6 (2:55pm - 5:20pm), R16 (2:55pm - 5:20pm), R18 (2:55pm - 5:20pm), and R9 on 4/17 from 7:30am - 10:30am. All these residents require extensive assist of staff to transfer/toilet and are incontinent of bowel and bladder according to their MDS. All listed sat from 2:55 PM until 5:20 PM without staff offering to repostition, or check for incontinence.

During the Daily meeting on 4/17/15 and on 4/24/15, E2 Director of Nurses (DON) agreed that all residents should be either checked/changed if needed and/or offered the toilet or toileted at least

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F 312	Continued From page 30 every two hours. 5. The MDS dated 2/9/15 identifies R10 to be dependent on staff for all actities of daily living including bathing/hygiene and toileting. On 4/16/15 at 11:04am, R10 was in bed with the head of her bed elevated. She had green-brown dried vomitus on her face/neck and on the front of her hospital gown. At 12:15pm, she remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown and she smelled of urine and stool. At 1:30pm, E6 (Certified Nurses Aide) was in her room and have just rolled her over and placed a mechanical lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement. No information was given by staff as to why R10 was allowed to lay in vomit, and not given timely needed care for nearly 2.5 hours.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record	F 314		

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review, the facility failed to follow it's policy for timely repositioning of residents for Pressure Ulcer Prevention for 7 of 10 residents (R3, R6, R9, R14, R15, R16, and R18) in the sample of 28.

Findings include:

1. The Minimum Data Set (MDS) dated 2/19/15 identifies R3 as being a 75 year old male admitted to the facility on 1/31/15 with diagnoses of Pagets Disease and Reflux among others. The MDS documents R3 to have severe cognitive impairment and require extensive assist of one staff for bed mobility and transfer and is occasionally incontinent of bowel and bladder. The Care plan dated 2/13/15 identifies R3 to be at risk for pressure ulcers and includes interventions for staff to assist with transfers and toileting.

On 4/16/15 at 10:10 AM, R3 was in his wheelchair in his room with his wife (Z1) at his side. Z1 was dressing him and stated she had to shave him and trim his nails when she came in that morning because staff doesn't pay attention to that. Z1 also stated his face was dirty which she also had to clean. R3 remained in his wheelchair throughout the rest of the morning with his wife in attendance. R3 was observed being pushed about the facility by his wife and at 3:25 PM, he was still in his wheelchair. Z1 was asked if staff had toileted him or changed his position, got him out of the chair for any reason and stated "No." Z1 left and R3 was still sitting in his wheelchair at the front of the 300 hall at 3:40 PM. He was observed to still be sitting there at 3:45 PM, 4:00 PM, 4:12 PM, 4:20 PM, 4:30 PM, 4:40 PM, 4:45 PM, 5:08 PM, and at 5:20 PM

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when the observation ended. No staff were noted to transfer or change R3's position, or toilet or check him for incontinence.

2. The MDS dated 2/4/15 identifies R14 to have no cognitive impairment and requires extensive assist of one staff for transfer and toileting. The MDS also documents R14 to be occasionally incontinent of bowel and bladder and to be at risk for pressure ulcers.

On 4/16/15 at 2:55 PM, R14 was sitting in her wheelchair at the front of hall 300. R14 was observed continuously from 2:55 PM until 5:00 PM, to sit without any staff approaching to change his position and/or check for incontinence or transfer her. At 5:00 PM, E14 Certified nurses Aide (CNA) came up to her and failed to ask if R14 needed to use the toilet, but propelled her directly into the dining room for supper where she remained in her wheelchair for supper. At 5:20 PM, she was still sitting in the dining room awaiting her meal.

3. R15's MDS dated 2/28/15 identifies her to have severe cognitive impairment, requires extensive assist of two staff for tranfers, extensive assist of one staff for toileting and is frequently incontinent of bowel and bladder.

On 4/16/15 at 2:55 PM, R15 was sitting in her wheelchair in the doorway of 300 hall. R15 was observed continously from 2:55 PM through 5:10 PM when E3 Assistant Director of Nurses (ADON) came and failed to ask if R15 needed to use the toilet and/or check/change if incontinent care was needed, but propelled her directly into the dining room for supper. At 5:20pm, R15 was sitting in her wheelchair at the table awaiting her

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F 314	Continued From page 33 supper meal without any repositioning being done. 4. Additional examples of sitting for long periods of time without repositioning being done timely on 4/16/15 includes R6 (2:55 PM - 5:20 PM), R16 (2:55 PM - 5:20 PM), R18 (2:55 PM - 5:20 PM), and R9 on 4/17 from 7:30 AM - 10:30 AM. All these residents require extensive assist of staff to transfer/toilet and are incontinent of bowel and bladder according to their MDS. During the Daily meeting on 4/17/15 and on 4/24/15, E2 Director of Nurses (DON) agreed that all residents should be either checked/changed if needed and/or offered the toilet or toileted at least every two hours. 5. On 4/17/15, E5, (CNA), stated that he got R9 up at 7:30 AM. Additionally, R9 was observed to be up in her wheelchair from 9:15AM. to 10:10 A.M. R9's Minimum Data Set (MDS), dated 2/20/15, documents that R9 requires total dependance and two plus physical assistance for transfers. The facility Policy for Pressure Ulcer #331.041 documents staff are to "encourage and/or assist resident with frequent weight shifts in chairs (every 15 minutes) when they are unable to perform this task on their own. Position changes are recommended at least every one hour when residents are confirmed to the chair and are dependent on staff for the performance of this task.	F 314		
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		

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F 322	Continued From page 34 Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the Facility failed to provide timely monitoring and ensure food intake met the required amount as ordered by the physician for 4 of 4 residents (R3, R10, R12, & R19) with Gastrostomy Tubes (G-Tubes) observed for adequate hydration, nutrition and weight loss in the sample of 28. This failure resulted in significant weight losses for R3, R19, and R10 and R19 being admitted to the hospital with a diagnoses in part of dehydration. Findings include: 1. The MDS dated 3/19/15 documents R19 was	F 322		

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readmitted to the facility on 3/25/15 following a hospitalization for Dehydration, Dysphasia, Constipation and Urinary Tract infection in part. The MDS documents R19 to have moderate cognitive impairment and requires total assistance of staff for all activities of daily living.

The care plan dated 3/3/15 identifies the tube feeding and includes interventions that all R19's calories and fluid needs will be met by 6/3/15 and staff are to monitor for signs/symptoms of dehydration, report problems to nurse.

The monthly weight record, documents R19's January 2015 weight was 157.6 pounds. Registered Dietician (RD) notes dated 2/24/15 document that R19 went from an oral feed and tube feeding to NPO (nothing by mouth.) R19 was totally dependent on his tube feeding to supply all his fluid and nutritional needs prior to his hospitalization in March.

An RD note dated 3/24/15 document for the month 3/2015 R19's weight was 148.2 pounds. This is 5% decrease in 1 month, 7% decrease in 3 months, 9% in 6 months. An order was given for Glucerna 1.2 to be given at 70cc/hour for 21 hours per day, at total of 1470cc/day.

The Nurses Notes of 4/09/15 at 2:15pm, document R19 weighed 142.4 pounds. This is a 5.2% weight loss despite the fact that he receives all his nutritional needs from his tube feeding. The Nurses Notes dated 4/9/15 document that the RD was called due to weight loss and the tube feeding was increased to Glucerna 1.5 70cc/hour with 200cc every 4 hours water flush.

The April Physician's Order Sheet (POS) includes

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a Gastrostomy Tube (G-tube) feeding dated 4/9/15 to be Glucerna 1.5 cal at 70cc (centimeter) an hour for 21 hours (1470cc total), and water flushes of 200cc every 4 hours. The POS also documents R19 takes Dilantin and has the tube feeding turned off one hour before and after the doses of Dilantin are given at 6:00 AM and 6:00 PM.

The Nurses Notes on 4/17/15 at 9:18 AM documents; R19 is up in the reclining chair with tube feeding infusing well. On 4/18/15 at 2:15PM, the nurse documents R19 to have an elevated temperature of 100.5 axillary with clear urine draining from his urinary catheter. At 3:55PM, the physician's office calls and a U/A (urinalysis) was ordered with a culture and sensitivity. At 5:50pm, the nurses notes document R19 having "no eye focusing, mouth breathing. Skin cool to touch. Facial perspirations noted. Moans out at intervals at this time" Blood pressure 102/58, Temperatures 101.4 axillary, pulse 116, and respirations 16. The physician was called again and R19 was sent to the emergency room. The Nurses Notes documents At 6:58PM, R19 was sent to the hospital. At 10:35PM, the hospital called and R19 was admitted to the Intensive Care Unit. Emergency Room hospital records dated 4/19/15 document R19 to have "pale and dry mucosa" with current problems listed as "Septic Shock, Acute Urinary Tract Infection, Dehydration, Acute/Chronic renal failure, Hyperkalemia, and Acute Hypernatremia."

The April 2015 Medication Administration Record (MAR) shows all flushes and feedings initialed by nursing staff for all three shifts. However, the Fluid Intake and Output Record which documents the G-tube feeding amounts actually administered

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are incomplete for the month of April, 2015. No 24 hour amount was calculated to ensure that R19 is receiving the ordered amount of feeding. Based on 70cc/hour for 21 hours, R19 should be receiving 490cc per shift or 1470cc per 21 hours. The Intake records document on 4/18/15 for day shift (6:30am-2:30pm) that R19 received 477 cc of tube feeding and on 2nd shift (2:30pm to 10:30pm), he was documented as receiving 376cc. Nothing is recorded for the night shift, for a total of 853cc/24 hours. On 4/17/15, day shift is blank, 2nd shift - 417, and 3rd shift, 329cc, totaling 746cc/24 hours. On 4/15, 1st shift is documented as 560cc, 2nd as 420, and 3rd 914cc for a total of 1894cc. The facility was unable to provide the week prior to 4/15/15 and only three weeks of intake records for March were provided and those were incomplete. There is no evidence that the facility assessed R19 to determine a causative factor as to why R19 would present to the hospital with dehydration on his readmission to the hospital in April. There is no documentation in regards to any assessments being done or evidence that nurses closely monitored R19's feeding to ensure his nutritional and hydration needs were met.

On 4/22/15 at 11am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. E2 stated she was unable to determine why R19 would have dehydration if he received all his feedings and flushes. E20 when asked if she expected the nurses to follow orders and

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administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them."

2. The MDS dated 2/9/15 identifies R3, as being admitted to the facility on 1/31/15 with diagnoses in part of; Pagets Disease and Reflux. The MDS documents R3 requires extensive assist of one staff for most activities of daily living and has severe cognitive impairment.

According to the February 2015 POS, R3's tube feeding was Jevity 1.5, given Bolus 300cc every 4 hours via enteral syringe, with a 120cc water flush every 6 hours. At that time, R3 was also receiving an oral diet of puree food. The 2015 March Medication Administration Record, MAR, show nursing staff initials documented the tube feeding being given every 4 hours around the clock with the water flushes every 6 hours.

Dietary History and Initial Screening dated 1/30/15 have R3's weight as 152.8 pounds. The RD documents R3 consumes approximately 25-50% of his meals and that the tube feeding provided 51% or more of Kcal and greater than 51% of fluid needs per day. Rd note dated 3/23/15, documents R3's March 2015, weight was 145 pounds, a 7.8 pound weight loss with the tube feeding every four hours and an oral tray. R3's weight on 4/2/15 was recorded as 136.6 pounds, an additional 9 pound weight loss. R3 has lost a total of 9.43% of her body weight in 63 days (from 1/30/15 to 4/2/15). There is no indication the facility staff assessed R3's weight loss to determine what could be contributing to R3's weight loss, although feedings were recorded as given.

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E33's, (Dietary Manager), note, dated 4/14/15 documents "resident is now NPO (nothing by mouth) status as of 4/13/15. Will update order when received. Weight for April is 136.6 and March 145, resident has had a 9 # (pound) weight loss in 30 days (5.8%). RD will assess upon next visit. E33's note did not document the total overall weight decline of 9.43% since 1/30/15.

On 4/20/15, R3's tube feeding was changed due to weight loss with an order for Jevity 1.5cc Bolus 300cc every 3 hours while awake and NPO. There is no corresponding RD note with this change. The MAR documents the every three hour feeding and shows that on average, R3 gets his feeding 7 times a day or approximately 2100cc of feeding with some days recorded as little as 4 times/day, and some as much as 8 times/day. The information on the MAR conflicts with the Intake and Output records. Examples include: On 4/20 and 4/21/15, the 3rd shift nurses initialed R3 getting 300cc at 12am, 3am and 6am (900cc) but on the intake record, wrote in only 600cc. On 4/19/15, day shift initialed R3 getting 300cc at 9:00AM, 12:00pm and 3:00pm but only documented 600cc on the intake record.

On 4/17/15 at 2:30pm, (R3's wife), Z1 stated she always questioned whether R3 was getting enough feeding when he was first admitted because she donated cases of Jevity and with the order being 300cc, nurses would have to use one whole can and about 60cc from a second can. Z1 stated she observed the nurses giving just one can and then in the most recent past, observed a nurse "shooting his feeding in using a syringe" because she said she was in a "hurry." Z1 stated she also felt staff didn't spend enough time feeding him when he could eat. Z1 stated she

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talked to facility staff about it but was unable to give names of who she spoke with. Z1 stated R3 has lost a great deal of weight since admission and she was concerned that he wasn't getting enough.

On 4/21/15 at 12:00 noon, E16 Licensed Practical Nurse (LPN) checked placement and flushed R3's g-tube before giving him 300 cc of Jevity per gravity with a syringe.

On 4/22/15 at 11:40am, E20 (RD) was asked about the discrepancies between the MAR and the intake record and R3's overall weight loss while getting a Jevity around the clock. E20 stated she did not routinely look at the intake records or the MAR and that she relies on the charge nurse to tell her about residents. E20 stated the order for 300cc when awake was not her order but agreed that it leaves some question as to whether or not he's getting what he needs daily in his tube feeding. E20 stated she also does not routinely observed residents eating or tube feedings but evaluates the resident monthly and is called all the time with questions.

3. The Admission Record identifies R12 as admitted to the facility on 9/30/13 with diagnoses of Pneumonia, Respiratory Failure, Pleural effusions, and Right sided Cerebral Vascular Accident in part. The MDS documents R12 to be dependent on staff for all activities of daily living and have cognitive impairment.

The April 2015, Physician's Order Sheet, POS, includes an order for a puree diet, honey thick fluids at noon meal only - NPO (nothing by mouth) otherwise and Jevity 1.2 @ (at) 60cc/hour for 23 hours continuous, flush with 150cc of water

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every 4 hours, 30cc with medications. The 23 hour total amount for Jevity should be 1380cc or approximately 460cc/shift.

R12's weight record documents her weights as 4/3/15 - 134 pounds and on 4/14/15 as - 131 pounds.

On 4/17/15 at 8:05am, R12 was in bed, slouched down with her tube feeding running at 60cc/hour per pump. The 1000cc bottle of Jevity 1.2 had 675cc left in it and was labeled as being hung on 4/16/15 at 2200 (10pm) which is approximately 10 hours. The bottle of 1000cc had 675cc left in it at 8:05am. Calculating the feeding at 60cc an hour for 10 hours results in 600cc should have infused. R12's feeding showed a deficit of 275cc, that R10 did not receive for the 10 hours .

On 4/21/15, at 4:00pm, R12's tube feeding was running at 60cc/hour per pump. The 1000cc bottle of Jevity 1.2 had 400cc left in it and was labeled as being hung at 1:30am on 4/21. Calculating 14.5 hours times 60cc equals 870cc. R12's feeding was again 270cc less than should have infused since the time the bottle was hung.

The Intake and Output Sheets from 4/16/15 have 3rd shift documenting 293cc, daily shift 582cc and no amount documented for 2nd shift (a total of 875cc for day). On 4/17/15, 3rd shift recorded 617cc/shift, day shift 330cc/shift and nothing recorded for 2nd shift (at total of 947cc for day). On 4/18/15, only day shift documented 854cc for 24 hours. On 4/19/15 only 3rd shift documented 483cc (no other for day). On 4/20/15, 3rd shift recorded 580cc and day shift - 321cc with nothing recorded on 2nd (a total of 901 for day). On 4/21/15, the nurses have documented an intake

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of 305cc/night shift and 405cc per day shift and again, none recorded for 2nd shift (a total of 710cc). All of the above days documentation indicated R12 failed to meet her required intake of 1480cc/day.

On 4/22/15 at 8:15am, E30, (Corporate Nurse) stated the facility had identified an issue with tube feedings and weight loss and had been working on it recently the past couple months. E30 agreed that nurses should be aware of what feeding amount is to be given during their shift and a 24 hour amount should be calculated especially if weight loss is occurring.

The Facility's Policies, Standards, Protocols, and Procedures Manual Enteral Feeding Delivery Policy dated 12/06/12, documents; "Adequate nutritional support through enteral feeding will be provided to residents that are unable to meet their dietary needs through the oral intake of food. Enteral feedings will be administered in a manner that promotes resident dignity, safety and function.."
Policy Guidelines and Interpretation #2, A physicians's order specifying type of solution, rate and frequency is required. #4, The nurse will confirm that there are appropriate, by mouth (PO) or nothing by mouth (NPO), orders for all residents with tube feedings. The decision to allow or disallow PO will be made in conjunction with the physician, Registered Dietitian and the Speech Therapist, as appropriate, given resident diagnosis and status. #8, The following procedure is contraindicated if the resident's tube is obstructed, improperly positioned, the resident is vomiting, bowel sound are absent, or if the resident appears to be in respiratory distress. Procedures / Pump #4, Monitor resident for signs

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and symptoms of aspiration and/or feeding intolerance." #5, On the formula label document resident's name, date and time formula was hung/administered, formula type, if using a feeding bag, and rate/amount to be infused and initials of person performing procedure. #6, Flush tube as ordered by physician.

4. R10's Admission Sheet documents diagnoses in part of : History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

R10's Care Plan, dated 2/9/15, documents a Problem of "at risk or altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches / Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met." Monitor for incontinence frequently. Monitor and document bowel movements (BM), report diarrhea, constipation or no BM in 3 days. G-Tube Flushes and care as ordered. Diet as ordered water flushes.

R10's Physician Order Sheet, dated 3/27/15, documents an order for "Glucerna 1.2 at 50 cubic centimeters (cc) per hour for 23 hours continuously, via infusion kit and pump with IV (intravenous) Pole. Flush PEG (Percutaneous Endoscopic Gastrostomy) tube with 150 cc's Q-4 hours (every) via enteral syringe. Flush 150 cc every 4 hours (with water)."

From 3/27/15 through 4/7/15 the Interdisciplinary

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Progress notes indicate R10 received Glucerna 1.2 at 50cc/hr X 23 hours. However, on 4/8/15 the nurses notes document G-tube patent infusing at 75 cc per hour flushed without difficulty.

Per Physician's order of 3/27/15, at a rate of 50cc / hour X 23 hours, R10 should receive 1150cc/day of feeding. Review of R10's Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 during this time. R10's intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15 - 1236cc, 4/3/15 -790cc, 4/4/15 - 1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 - 1511cc, 4/10/15 - 1632cc, 4/11/15 - 1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 - 1872cc.
On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 received 200cc to 400cc less feeding than required. And the rest of the days received between 100cc and 900cc more per day than ordered by the physician. No information was given for these discrepancies in R10's intake.

On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10's gown. The green vomitus was on her bed linens, extending from R10's shoulder to her hip. R10 smelled strongly of feces.

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F 322	Continued From page 45 On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10's feeding tube. The bottle was labeled "4/16/15, 2:30 AM, amount 5 (?)." R10's tube feeding pump was turned off from 1:30 PM until 5:05 PM with 850 cc remained in the bottle. Calculation of the flow rate from time of hanging at 2:30 AM to 5:05 PM, indicates there should have only been 275 cc's remaining in the bottle (not 850cc). On 4/16/15 at 5:05 PM, E18, Licensed Practical Nurse (LPN), stated "she checked for R10's tube feeding order on the current monthly Medication Administration Record (MAR) dated 4/2015 which documents "Glucerna 1.2 at 75 cc's per hour from 7:00 PM to 7:00 AM ." (order is inconsistent with current MD order of 50cc/hour for 23 hours.) E18 stated she then turned on R10's tube feeding pump at a rate of 75 cc's per hour. On 4/22/15 at 11am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. E2 stated she was unable to determine why R19 would have dehydration if he received all his feedings and flushes. E20 when asked if she expected the nurses to follow orders and administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them." E2 stated that she though R10 was doing fine, but was not aware R10 had been hospitalized.	F 322		

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On 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated "On 4/16/15 I spoke to Z3, (Physician on call). He told me to write for the Glucerna to be given per the previous admission order. I wrote the order on 4/16/15 for R10's Glucerna to run 75cc / hour for 23 hours. I was not aware the G-Tube feeding should be from 7:00 PM to 7:00 AM only. I did not verify the order against the original in the chart." Additionally, E3 stated she had not been told by E37 that R10 had vomited earlier on the day shift.

On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 the night of 4/16/2015". She stated she had documented at "06:25 two emesis". The emesis had been reported to her at 5:00-5:15 AM when the E35, (CNA) showed her the linens with emesis. E34, (RN) noticed the vomitus was brown and had assessed R10's bowel sounds and skin. E34, (RN) stated R10 didn't respond or make eye contact, which R10 usually did respond to others and make eye contact. E34, (RN) then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

R10 was transferred from the Facility to the local hospital Emergency Room (ER) on 04/17/15. The local hospital ER report documents R10 diagnoses Primary Impression: Hypotension, Additional Impressions: UTI (lower urinary tract infection), Sepsis, Illeus, Vomiting, Hyperkalemia, and Dehydration. R10 was treated with bolus fluids and admitted to the hospital.

On 4/29/15 at 2:45 PM, Z3, (Physician on Call), during interview stated; on 4/16/15, stated that he

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F 322	Continued From page 47 had been called for orders for R10's G-Tube feeding. At that time he had not been told R10 had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know and had he known of the nausea and vomiting, he would have admitted R10 to the hospital for fluids and evaluation, earlier that day.	F 322		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete and accurate Intake and Output Records for Gastrostomy Tube feedings, Abuse Investigations and Fall Reports for 5 of 5 residents (R10, R19, R12, R3 and R20) in a sample of 28. Findings include:	F 514		

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1. R19's, April 2015 Medication Administration Record (MAR) shows all flushes and feedings initialed for all three shifts. The Fluid Intake and Output Record that the facility uses to document the amount of tube feeding actually administered are incomplete with no 24 hour amount calculated to ensure that R19 is receiving the ordered amount. The Intake records that document the amount of tube feeding actually administered for 4/18/15 for day shift (630am-230pm) documents that R19 received 477 cc of tube feeding and on 2nd shift (230pm to 1030pm), he was documented as receiving 376cc. Nothing is recorded for the night shift. On 4/17/15, day shift is blank, 2nd shift - 417, and 3rd shift, 329cc totaling 746cc/24 hours. On 4/15, 1st shift is documented as 560cc, 2nd as 420cc, and 3rd 914cc for a total of 1894cc. The facility was unable to provide the week prior to 4/15/15 for the Intake records and only three weeks of intake records for March were provided with those also being incomplete.

2. R12's Intake and Output Sheets documenting her gastrostomy feedings on 4/16/15 have 3rd shift documenting 293cc, daily shift 582cc and no amount documented for 2nd shift. On 4/17/15, 3rd shift recorded 617cc/shift, day shift 330cc/shift and nothing recorded for 2nd shift. On 4/18/15, only day shift documented 854cc, on 4/19/15 only 3rd shift documented 483cc. On 4/20/15, 3rd shift recorded 580cc and day shift - 321cc with nothing recorded on 2nd. On 4/21/15, the nurses have documented an intake of 305cc/night shift and 405cc per day shift and again, none recorded for 2nd shift.

3. R3's MAR's document the every three hour

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	145581	A. BUILDING _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	**2 ANNABLE COURT CAHOKIA, IL 62206**

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feeding and shows that on average, R3 gets his feeding 7 times a day or approximately 2100cc of feeding with some days recorded as little as 4 times, and some as much as 8 times/day. The information on the MAR conflicts with the Intake and Output records. Examples include: On 4/20 and 4/21/15, the 3rd shift nurses initialed R3 getting 300cc at 12am, 3am and 6am (900cc) but on the intake record, wrote in only 600cc. On 4/19/15, day shift initialed R3 getting 300cc at 9:00AM, 12:00pm and 3:00pm but only documented 600cc on the intake record.

4 . Physician's order of 3/27/15, at a rate of 50cc / hour X 23 hours, R10 should receive 1150cc/day of feeding. Review of R10's Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 during this time. R10's intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15 - 1236cc, 4/3/15 -790cc, 4/4/15 - 1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 - 1511cc, 4/10/15 - 1632cc, 4/11/15 - 1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 - 1872cc.
On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 received 200cc to 400cc less feeding than required. And the rest of the days received between 100cc - 900cc more per day than ordered by the physician. No information was given for these discrepancies and missing information in R10's intake.

5. The Facility's Fall Incident Tracking Log dated January 2015-March 2015 document R20 had

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F 514	Continued From page 50 falls on 2/11/15, 2/12/15, and 2/20/15. R20's Nursing Notes dated 2/11/15 do not document any falls. R20's Nursing Notes dated 2/12/15 document: "R20 in room pulled pole with TF (tube feeding) down and landed on mattress on floor. Staff assisted R20 to geri-chair without difficulty. Staff check on R20 during rounds and observed R20 trying to stand without assistance and rolled out bed on mattress." R20's Nursing Notes further document on 2/20/2015. "At 2:55AM; R20 was found on floor heard a loud fall an we got to room R20 was on floor bleeding from right forehead copious amounts blood on floor. Z4, (Medical Doctor), was called now and ambulance was called. 3:15AM; Hospital was called and report was given. At 3:10 AM, Ambulance is here for R20 at this time." R20's Nursing Notes further document: "5:55AM; Hospital called R20 being sent out to another hospital with diagnosis of hematoma (Subdural). On 4/23/15 at 12:04 PM, E2, Director of Nursing stated she was unsure how many falls R20 has had, but fall investigations were completed on all of R20's falls for but are just missing. On 4/23/15 at 1:30PM, E1, (Administrator) stated she could not locate any of R20's fall investigations and they have no documentation to provide for any R20's falls. 6. On 4/22/15 at 8:15am, E33 (Corporate Nurse) agreed that the documentation in resident records is inconsistently completed and information at times conflicts. E33 stated the nurses should be documenting correct complete information on both the Nursing Notes and in any necessary	F 514		

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F 514	Continued From page 51 Logs or Records.	F 514		