STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145769	A. BUILDING _____ B. WING _____	C 10/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP SKILLED NSG & REHAB	**826 NORTH HIGH CARLINVILLE, IL 62626**

(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 #1444591/IL72593:F157 and F327 Complaint #1444697/IL72720: F157 and F327	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 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.	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician of a continued decline in condition for one of five residents (R5) reviewed for physician notification in the sample of 9. Findings include: R5's Nurse's Notes dated 10/11/14 at 8:30 AM, documented R5 had left the dining room due to complaints of not feeling well. The Nurse's Note documents R5 had one bout of diarrhea and one emesis. The Notes documented R5's BP (Blood Pressure) 100/52, P (Pulse) 56, R (Respirations) 16, T (Temperature) 97.2. R5's Nurse's Note, at 9:30 AM, documents a call was placed to Z2, Physicians Assistant (PA), on call for R5's Doctor, to inform him of R5's condition. The Nurse's Note documents the facility made Z2 aware R5 had received a flu shot on 10/10/14. The Nurse's Note documents Z2 advised E7, Licensed Practical Nurse (LPN), to monitor R5 at this time. R5's Intake Record for 10/11/14 documented R5 had no fluids for breakfast, 480 cubic centimeters (cc) fluids for lunch and no fluids for dinner. There was no other documentation in R5's medical record indicating R5 had consumed any other fluids on this day. On 10/12/14, R5's Fluid Intake Record documented R5 had 120 cc fluid for breakfast and 120 cc fluid intake for lunch. There was no other documentation in R5's medical record indicating R5 had consumed any other fluids on this day.	F 157		

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F 157	Continued From page 2	F 157		

R5's Nurse's Notes dated 10/12/2014 at 5:15 PM, documented the Power of Attorney (POA) wants resident to go to local hospital related to lethargic and cold symptoms. The Nurse's Note at 5:20 PM documents R5 went to hospital with family in a family car.

On 10/16/14 at 2:00 PM, E5 Certified Nurse Assistant (CNA) who was assigned to care for R5 on 10/11/14 and 10/12/14 on the 6-2 shift, was interviewed regarding how many times did R5 have an emesis on E5's shift. E5 said, "On Saturday, I would say she vomited three times and had diarrhea four times. E5 said R5's diarrhea was very watery. E5 said on Sunday R5 had vomited two times and had diarrhea three times.

On 10/16/14 at 2:10 PM, E6 CNA, who was assigned to care for R5 on the 2-10 PM shift, was interviewed regarding how many times R5 had emesis and diarrhea on E6's shift. E6 said R5 had no vomiting and one bout of diarrhea on 10/11/14. On 10/12/14, E6 said R5 complained of nausea a couple of times before she went to the hospital. E6 said on Saturday R5 was very alert and talking but on Sunday she just wanted to sleep.

On 10/15/14 at 2:30 PM, E4 LPN, was interviewed and asked if he was the nurse caring for R5 on 10/11/14 and 10/12/14, E4 said yes. E4 was asked to describe R5's symptoms. E4 said R5 had "cold symptoms, when asked to describe the cold symptoms E4 said, "generalized weakness, emesis and diarrhea." E4 said, R5 "received the flu shot on Friday (10/10/14) and thought (R5's) symptoms were related to that." E4 was asked if he had notified Z2 on 10/11/14 or

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F 157	Continued From page 3 10/12/14 that R5's symptoms were ongoing, E4 said "No". E4 was asked if he had notified Z2 that R5's family said R5 was not doing well and took her to the local Emergency Department in their own vehicle. E4 said "No, I did not let the PA know." On 10/16/14 at 4:00 PM, Z2 was asked if he had been notified except on Saturday (10/11/14) at 9:30 AM, by staff that R5's condition had not improved or that R5's family had taken her to the local Emergency room on Sunday (10/12/14). Z2 said "No, the only phone call he received about R5 was on Saturday morning." The Facility's policy for Managing Change of Condition documented "To appropriately assess, document and communicate changes of condition to the primary care provider. To provide treatment and services to address changes in accordance with resident needs and existing Advance Directives."	F 157		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to timely assess, monitor, identify risk factors and treat to prevent potential dehydration for 1 of 4 residents (R5) reviewed for hydration in the sample of 9. This resulted in R5 being sent to the hospital with a diagnosis of Acute Renal	F 327		

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F 327	Continued From page 4	F 327		

Insufficiency, Hypovolemic Shock, Hyperkalemia, Urosepsis and Septic shock.

Findings include:

R5's Physician Order Sheet, dated 7/12/14 to 10/12/14, documented under Active Diagnosis, included: Diabetes, Hypertension, Cerebral Artery Occlusion with cerebral infarct and Urinary Tract infection.

R5's Nurse's Note, dated 10/11/18 at 8:30 AM documented R5 left the dining room due to complaints of not feeling well. The Nurse's Note documented R5 had one bout of diarrhea with emesis noted. The Nurse's Note documented R5's vital signs as : Blood Pressure,100/52; Pulse,56; Respirations,16 and Temperature 97.2 degrees Fahrenheit. The Nurse's Note documented at 9:30 AM, E7 Licensed Practical Nurse (LPN) notified Z2, Physician Assistant (PA) on call for R5's Doctor, of R5's complaints and made him aware R5 received the flu shot on 10/10/14. Nurses notes documented Z2 advised E7 to monitor R5 at this time.

R5's Fluid Intake record for 10/11/14 documented R5 had no fluids for breakfast, 480 cubic centimeters (cc) fluids for lunch and no fluids for dinner. There was no other documentation in R5's Medical Record recording R5 had consumed any other fluids that day.

On 10/12/14, R5's fluid intake record documented R5 had 120 cc fluid for breakfast and 120 cc fluid intake for lunch. The was no other documentation in R5's Medical Record recording R5 had consumed any other fluids this day.

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F 327	Continued From page 5	F 327		

R5's Nurse's Notes, dated 10/12/14 at 5:15 PM, documented Z1, Power of Attorney (POA) wants R5 to go to local hospital related to lethargic and cold symptoms. Nurse's notes on 10/12/14 at 5:20 PM, documented R5 went with family to hospital in family's car.

The local Emergency Room lab reports dated 10/12/2014 documented R5's urinalysis results as: color dark yellow, clarity cloudy, leuk (leukocytes) 3+,nitrate positive, protein 3+, ketones trace, blood trace, bacteria 4+. Complete Blood Count documented White Blood Cells 19.3,Hemoglobin 8.7, Hematocrit 31.0. Complete Metabolic Panel documented a Blood Urea Nitrogen (BUN) 67, Creatinine 4.0, Potassium 6.0. The Emergency Departments Physician Impression documented Acute Renal Insufficiency, Hypovolemic Shock, Hyperkalemia, Urosepsis and Septic shock. Hypovolemic Shock is defined as " a medical or surgical condition in which rapid fluids loss results in multiple organ failure due to inadequate circulating volume and subsequent inadequate perfusion.(emedicine.medscape.com, Copyright 1994-2014 by Web MD LLC)".

R5's Nurse's Notes on 10/12/14 at 9:05 PM, documented, the local Emergency Department sent R5 to another Hospital for Renal Failure, Septic Shock and Hypovolemia.

On 10/16/14 at 2:00 PM, E5 Certified Nurse Assistant (CNA) who was assigned to care for R5 on 10/11/14 and 10/12/14 on the 6-2 shift, was interviewed regarding how many times did R5 have an emesis on E5's shift. E5 said, "On Saturday, I would say she vomited three times and had diarrhea four times. E5 said R5's

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F 327	Continued From page 6	F 327		

diarrhea was very watery." E5 said on Sunday R5 had vomited two times and had diarrhea three times.

On 10/16/14 at 2:10 PM, E6 CNA, who was assigned to care for R5 on the 2-10 PM shift, was interviewed regarding how many times R5 had emesis and diarrhea on E6's shift. E6 said R5 had no vomiting and one bout of diarrhea on 10/11/14. On 10/12/14, E6 said R5 complained of nausea a couple of times before she went to the hospital. E6 said on Saturday R5 was very alert and talking but on Sunday she just wanted to sleep. E6 said R5's Husband had been visiting on Sunday and told E6 he was going home to call the boys because he said R5 was not doing well and he had told E6 that R5 had been talking out of her head.

On 10/15/14 at 2:30 PM, E4 LPN, was interviewed and asked if he was the nurse caring for R5 on 10/11/14 and 10/12/14, E4 said yes. E4 was asked to describe R5's symptoms. E4 said R5 had "cold symptoms, when asked to describe the cold symptoms E4 said, generalized weakness, emesis and diarrhea." E4 said, R5 "received the flu shot on Friday (10/10/14) and thought R5's symptoms were related to that." E4 was asked if R5's intake and output was being monitored and E4 said "No, but I am sure she had at least a liter of fluids in on Saturday." E4 was asked if he had notified Z2 on 10/11/14 or 10/12/14 that R5's symptoms were ongoing, E4 said "No". E4 was asked if he had notified Z2 that R5's family said R5 was not doing well and took her to the local Emergency Department in their own vehicle. E4 said "No, I did not let the PA know."

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F 327	Continued From page 7 On 10/16/14 at 3:00 PM, E11, Regional Clinical Director, said "I would expect staff to measure both intake and output for residents who develop symptoms of emesis and diarrhea." On 10/16/14 at 4:00 PM, Z2 was asked if he had been notified except on Saturday (10/11/14) at 9:30 AM, by staff that R5's condition had not improved or that R5's family had taken her to the local Emergency room on Sunday (10/12/14). Z2 said "No, the only phone call he received about R5 was on Saturday morning." The facilities Policy on Intake and Output documented under Basic Responsibility: Nursing Staff. Under Policy:" It is the policy of this facility to monitor intake and output and accurately document when it is determined that monitoring is necessary to evaluate hydration status, compliance with fluid restrictions, or to assist in the assessing and managing fluid needs."	F 327		