STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 #1666720/IL 90058- F157 Incident Report Investigation to Incident of 11/8/16/IL90146 -F323	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 157	Continued From page 1	F 157		

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
The facility failed to notify physician and initiate emergency transportation in a timely manner which resulted in a delay in medical treatment for one resident (R3) of three reviewed for change of condition requiring hospitalization.

The findings include:

R3's 9/20/14 Physician Order Sheet (POS) list diagnoses of Acute Chronic Obstructive Pulmonary Disease (COPD), Respiratory Acidosis, and Hypercapea. R3 had a physician order for Oxygen 3 Liters per nasal cannula and CPAP (Continuous Positive Airway Pressure)at night.

R3's Patient Transfer Form dated 9/22/14 documents R3's diagnoses as Diabetes Mellitus, COPD and Congestive Heart Failure (CHF). The transfer form documents R3's vitals and resident condition as "Lethargic unresponsive at times..Blood Sugar 260, Blood Pressure 114/47,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 157	Continued From page 2	F 157		

Temperature 98.9, Pulse 78, Respirations 20 and Oxygen Saturation 96% on 3 liters per minute. "CHART NOT AVAILABLE" was written under other therapy on the Patient Transfer Form.

R3's Nurse's notes dated 9/22/14, 7:15 pm documents "VS (Vital Signs) 114/47-78-20-96% on 3 L (Liters) per N/C (nasal cannula). BS (blood sugar) 260. Res (resident) head drooping to one side et lethargic, unresponsive at other times, arms flaccid. Son here req (requests)be sent to ED (Emergency Department). Dr (Z3), DON (Director of Nurses), Administrator, POA (Power of Attorney) Z1 here with (Ambulance Service) notified. Son here at 8:56 pm upset R/T (related to) res not sent out yet. Chart unable to find. DON stated to go ahead and send out (without) chart at 8:30 pm. Filled out transfer form as much as poss (possible). (Ambulance) here at 8:59 pm for transfer."

The 9/23/14, 7:30 am Nurse's note stated R3 was admitted to the hospital with diagnoses of Respiratory Failure.

The 9/24/16 10:00 PM Nurse's note documents R3 returned to facility at 3:00 PM per ambulance. "Resident is now on full face mask for C-PAP (Continuous Positive Airway Pressure) to be used nightly-Continues on O2 (Oxygen) 3 L per N/C while awake."

The Hospital Discharge Instructions dated 9/23/14 list R3 diagnosis as Acute Respiratory Failure,Acute lower urinary tract infection , COPD with acute exacerbation, and Encephalopathy Allergic.

Z1 stated per telephone conversation on 12/07/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 157	Continued From page 3	F 157		

at 10:30 am that two years ago (2014) Z1 went to visit his father (R3) at the nursing home around 5:30 pm (did not know date). Z1 stated R3 had End Stage COPD and had just gotten back from the hospital a few days earlier. Z1 stated he visited with R3 for a while in his room R3 was in bed wearing oxygen and he talking but was very groggy. Z1 stated he decided to have Nurse E9 check R3's vitals. R3's vitals were extremely low. Z1 did not remember the parameters. Z1 stated he requested R3 be sent out to the hospital immediately. Z1 stated E9 said she would do that and asked if Z1 would be following the ambulance? Z1 stated he told E9 that he would meet R3 at the hospital after running a few errands. Z1 stated this was because he knew R3 would have to go through the Emergency Room first and it would take awhile. Z1 stated he left the nursing home around 6:30 pm.

Z1 stated he arrived at the hospital around 9:00 PM and found that R3 had not been admitted to the hospital. Z1 went back to the nursing home and as he approached the nurses desk E9 stated the ambulance was on its way. Z1 stated he went straight to his father's room and found him in bed "Out of it, it looked like he was dead". Z1 stated he was livid and asked E9 why R3 was still there? Z1 stated E9 apologized and stated that R3's chart was locked up in a room and she did not have the key. Z1 told her "This is not about a chart! It is about life and death!" Z1 stated the ambulance arrived as they were having the conversation and R3 was stabilized and was taken to the ED.

The Ambulance Report dated 9/22/16 documented the request for the ambulance was received at 8:47 pm and the ambulance arrived at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 157	Continued From page 4	F 157		

the facility at 8:56 pm and departed at 9:15 pm. R3's condition was listed as lethargic, conscious, tired. Z1's signature was at the bottom of the page.

On 12/6/16 at 4:20 pm E10 (former staff) stated that she had been the DON in September 2014. E10 did not remember R3 or the specific incident of 9/22/14, but after having the nursing note read to her E10 stated "I would have told E9 to send him right out at that time." E9 stated she is guessing she did not get notified by E9 until 8:30 pm.

On 12/7/16 at 3:30 pm LPN E9 (former staff) confirmed she worked at the facility in September 2014. E9 did not remember R3 or the 9/22/14 incident. E9 did not know when she contacted Dr. Z3. E9 stated if Z3 did not get back to her with orders she would follow what ever the DON told her to do.

On 12/6/16 at 2:30 pm Dr. Z3 stated he did not remember the patient or the specific incident. R3's Vitals and nursing note from 9/22/16 was read to him as well as the information that the chart was not available. Z3 stated he did not know when he was notified. Z3 stated "Whenever any nursing home calls me and tells me a resident is in respiratory distress I would say to send them directly to the ER (Emergency Room). I don't try to treat the resident in the nursing home." Z3 stated waiting 2 hours was too long for a person in respiratory distress.

The facility "Change in a Resident's Condition or Status" policy dated 12/15 states "Our facility shall promptly notify the resident, his or her Attending Physician and representative (sponsor)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 157	Continued From page 5 of changes in the residents's medical/mental condition and/or status (e.g.,changes in level of care..). The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a need to transfer the resident to a hospital/treatment center and or instructions to notify the physician of changes in the resident's condition. "	F 157		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 323	Continued From page 6	F 323		

Based on record review and interview, the facility failed to evaluate potential risk for injury and implement interventions to prevent falls for one resident (R2) of four residents reviewed with a history of falls in a sample of 5 residents. This resulted in a subsequent fall with serious injury and death.

Findings include:

R2's Physician's Order Sheet (POS) dated 9/16 documents diagnoses including: Urinary Incontinence, Long Term Use of Anticoagulants, Chronic Pain, Arthritis, Anemia, and Atrial Fibrillation.

R2's POS for 9/16 documents physician's orders for Warfarin 4 milligrams (mg) daily by mouth on Sunday, Tuesday, and Thursday and 5 mg daily by mouth on Monday, Wednesday, and Friday. R2's POS also document's a physician's order for aspirin 325mg daily.

R2's emergency department discharge summary dated 9/29/16 at 6:29PM documents that R2 was evaluated for "back contusion and fall".

R2's Computerized Axial Tomography (CT) scan results on 10/1/16 documents "fell two days ago".

There were no nurse's notes or other facility documentation related to a fall or emergency department visit by R2 on 9/29/16.

On 12/7/16 at 9:30 AM E2 Director of Nursing (DON) provided a "Fall Occurrence Investigation Report" dated 9/30/16 signed by E3 Registered Nurse (RN), Care Plan Coordinator which documented "Tripped over walker." E2 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 323	Continued From page 7	F 323		

there is no further documentation for the 9/30/16 fall.

There is no documentation of a fall assessment following the 9/29/16 fall. R2's plan of care 10/13/16 stated R2 "at risk for falling related to incontinence, potential for knee pain, needs assistance with interventions including 1/2 side rail for mobility, wears glasses, assure floor is free of glare, use handrails, keep bed in lowest position, provide stand by assistance with transfers. These approaches were dated 11/20/15. There was no documented updated interventions added to the care plan following the 9/29/16 fall. There was no root cause analysis documented for the 9/29/16 fall.

The facility's "Falls-Clinical Protocol" revised 10/2010 documents "For an individual who has fallen, staff will attempt to define possible causes with in 24 hours of the fall...the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling."

On 10/13/16 Physical Therapist documented " (R2)presents to therapy with a decline of gait and transfers due to weakness and poor balance." Physical Therapy was discontinued on 10/27/16.

On 11/6/16 at 6:20 PM E20 RN documented in nurse's notes and event report that E20 checked on R2 who had been eating dinner in R2's room after E20 heard a loud crash. R2 was found lying partially behind the door with bleeding from R2's head. The tray table and walker were documented as laying on their sides not far from R2. Nurse's note documents that E20 applied direct pressure to head wound to stop bleeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 323	Continued From page 8	F 323		

and that E20 delegated a Certified Nurse Aide (CNA) to call an ambulance. Nurse's note by E20 also documents that R2 was alert, and oriented when ambulance arrived and transported R2 to the emergency room.

On 12/5/16 at 3:50 PM E20 stated that E20 was a float nurse on the evening of 11/6/16. At around 6:15 PM E20 heard a crash in R2's room. E20 found R2 lying on her left side partially blocking the entrance door. R2's head was lying on the tray with a small amount of blood under R2's head. E20 donned gloves and put pressure on the area of R2's head that was bleeding with a damp wash cloth. E20 dispatched a CNA (can't remember who) to call 911 and tell the operator that there was a head wound with bleeding. E20 remembered that R2 was taking Warfarin. E20 stated E20 did not hear a personal alarm and E20 doesn't remember if R2 had one or not. E20 stated that R2 told E20 at that time that R2 was trying to push her dirty dishes out in the hall when R2 fell.

The CT scan report of R2's head on 11/6/16 documented "2 centimeter by 1.5 centimeter epidural hematoma right hemisphere involving temporal and parietal region. Appears to be a subdural component also."

On 11/6/16 at 11:45 PM E21 Licensed Practical Nurse (LPN) documented in R2's nurse's notes "admitted to hospital traumatic head injury and concussion."

Nurse's note 11/7/16 at 15:07 PM documents that R2 returned to the facility with a diagnosis of intracranial bleed. The note stated R2's family did not want any extra ordinary measures taken. R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 323	Continued From page 9 had physician's order for hospice care. On 11/8/16 at 4:28 AM nurse's note documents that R2 expired at the facility. On 12/7/16 at 9:20 AM Z2 Medical Doctor (MD) stated that the fall R2 sustained on 11/6/16 at the facility was the cause of R2's Epidural Hematoma and that the Epidural Hematoma was the cause of R2's death. Z2 stated that R2 was at high risk for bleeding related to R2's anticoagulant medication and should have been on fall precautions. R2's death certificate dated 12/01/16 documents cause of death (11/08/16) as acute intracranial and epidural hemorrhage.	F 323		