STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146019	A. BUILDING _____ B. WING _____	C 10/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASH CHRISTIAN RETIREMENT	**216 COLLEGE BOULEVARD CARMI, IL 62821**

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F 000	INITIAL COMMENTS Complaint 1655774/ IL89056	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. This REQUIREMENT is not met as evidenced	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	F 157		

by:
Based on interview and record review, the facility failed to promptly notify the physician of significant changes and ongoing concerns by the residents family for 1 of 3 (R3) residents reviewed for physician notification in the sample of 3.

Findings include:

On 10/6/16 at 2:45 PM, E5, Registered Nurse, stated Z2 (family of R3) had expressed concerns to her in regards to a change noted in R3 and thought that she was possibly getting too much pain medication. E5 states this concern was brought to her attention a couple days after R3's admit to the facility (R3 admit to the facility 9/19/16 per facility records). E5 says R3 did appear lethargic, complained of being tired, and had altered speech with what E5 interpreted as a drawn accent but thought she had always talked that way. E5 says she did not contact the physician with the family members concerns or her own observations because R3 was on the same pain medications she had been taking at home. E5 says she questioned R3's lethargic status at times due to R3 being observed to "perk up." E5 says R3 seemed to be drinking and eating ok and at times requested extra ice to have with her soda's.

On 10/6/16 at 3:05 PM, E6, Certified Nurse Assistant (CNA), who has worked directly with R3 since admit (R3 admit to the facility 9/19/16 per facility records) until the time R3 was transferred to the hospital (R3 transferred to the hospital 10/4/16 per facility records) says she had seen a decline in R3's health that included confusion, and speech that was hard to understand. E6 says R3 did seem lethargic, but would awaken

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F 157	Continued From page 2 easily. E6 says she expressed her concerns about R3's decline, specifically R3's confusion to nursing staff (Specific nursing staff not given). On 10/6/16 at 3:20 PM, E7, CNA, states he has worked directly with R3 since admit (R3 admit to the facility 9/19/16 per facility records). E7 says during the last 2 weeks, he has noticed a rapid decline in R3 and has reported his concerns to nursing staff (Specific nursing staff not given). E7 says R3 had become very confused and would think people were sitting in her room that were not there. A couple days before R3's transfer to the hospital (R3 transferred to hospital 10/4/16 per facility records), E7 says R3 had a very poor appetite and fluid intake. On 10/7/16 at 10:50 AM, E8, CNA, states she always works the hall R3 resided on and had noticed a rapid decline and changes such as confusion, seeing things that weren't there, and inability to follow commands or use call light. E8 says she had immediately reported her concerns to the nurse (Specific nursing staff not given). E8 says around 10/1/16 she noticed a big decline in R3's appetite and fluid intake. On 10/7/16 at 11:10 AM, E9, Registered Nurse, says she does not work regularly with R3. E9 says approximately a couple weeks after R3's admit (R3 admit to the facility 9/19/16 per facility records), was walking out the door one evening, Z2, family member had stopped her and asked if R3's medication could be making her confused. E9 directed the family member to R3's nurse on duty (specific nursing staff not given). E9 says she was aware that R3's family member had called the facility frequently with medication and money concerns.	F 157		

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F 157	Continued From page 3 On 10/7/16 at 11:45 AM, E2, Director of Nursing (DON), who has only been the DON since 9/19/16, says she has had one complaint since starting this position from R3's family member regarding nurses not responding properly to concerns brought up. E2 says she spoke with the nurses regarding the concerns that were brought up and asked the nurses to look into it. E2 says her expectation would be that if a CNA reports concerns to the nurse, she would expect the nurse to assess and call the doctor if they agreed. E2 says she does morning rounds which includes talking to the nurses to find out things going on in the facility. E2 says on 10/3/16 was when the nurses had reported R3 was sick. On 10/06/16 at 12:00 PM, Z1, physician, states that she has personally examined R3 at the facility a couple of times (9-20 and 9-27-16) since her admit here (R3 admit date 9/19/16 per facility records). Z1 states she does not recall the facility notifying her of any concerns family had with pain medications or mental status changes. Z1 says the facility had notified her right before transfer to the hospital of R3's lethargic status, but Z1 thought it may be antibiotic related (R3 transfer date to hospital 10/4/16 per facility records). Z1 states during her examinations of R3 she did not note any slurred speech, lethargy, or hallucinations. Review of R3's progress notes do not indicate this policy was followed, as no progress notes were noted within the first week of R3's admit (R3's admit to facility 9/19/16 per facility record). Further review of Progress Notes do not mention ongoing family reported concerns, monitoring of those concerns, or how the concerns were	F 157		

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F 157	Continued From page 4 addressed which E2, E5, and E9 all confirm family had reported their concerns and observations of declining health to facility staff. The facility's Change In Condition policy with a revision date of 12/7/11 was reviewed on 10/7/16. The policy states physician notification is to include but not limited to: significant change in resident's physical, mental, or psychosocial status, and unusual or violent behavior. The policy also states that the nurse will document in the clinical record and documentation and assessment will be ongoing until condition is stabilized. The policy also goes on to say all significant changes will be recorded on the 24 hour report.	F 157		