STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011837	A. BUILDING: _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	3360 FRANCIS LANE JOLIET, IL 60432

(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) COMPLETE DATE
Z 000	COMMENTS Complaint#1672371/IL85210 Statement of Licensure Violations	Z 000		
Z9999	FINDINGS 350.620a) 350.1210 350.1220j) 350.3240a) 350.3240c) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B) c) A facility administrator who becomes aware of	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to ensure services were provided to avoid physical harm and failed to follow their policy of abuse/neglect when: R5 developed sepsis from stage three and stage four decubitus wounds, was hospitalized and then sent to hospice and died on 5/03/16. Findings include: R5 is a 52 year old Caucasian male with a Axis 2 diagnosis of Profound Intellectual Disability and an Axis 3 diagnosis of Downs Syndrome, Congenital Heart Disease and Mild Aortic Valvular Stenosis. Facility Nursing Notes are as follows: 1) On 3/27/16, R5 was transported to the local hospital emergency room at 8:15pm and admitted for fatigue, weakness, inability to walk, leaning to one side and altered mental state. 2) On 3/31/16, R5 was discharged from local hospital back to the facility at 8:00pm, still unable to walk. 3) On 4/01/16, R5 had an appointment with the Adult Down Syndrome clinic at 11:50am. Recommendations included a thickened liquid diet to prevent chocking and antibiotics due to a decline in overall health. R5 continues to not	Z9999		

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Z9999	Continued From page 2 walk. Notation about skin only states that R5 has bluish/purpleish coloring to the feet due to slow circulation. Nursing home placement is suggested per E3; Program Director. 4) On 4/05/16, a special team meeting was held to discuss nursing home placement due to R5's progressive "Alzheimer's" and Congenital heart disease. Documents sent to skilled nursing home for admission there. 5) On 4/08/16, R5 was seen at the onsite facility wellness center by Z4 (Nurse Practitioner) who works directly under E8 (Medical Director) for an annual physical examination. Z4 documented redness around the scrotal region, history of fluid buildup surrounding the testicles and check marks were documented in front of scars, testes and lesions on the document. Z4 recommended transferring R5 to hospice care per Z3 (Physician at Down Syndrome Clinic). On 4/29/16 at 2:45pm, an interview was held with Z4. Z4 confirmed that he did not do a full body assessment on R5 on 4/08/16 and 4/14/16 and that both were partial. 6) On 4/14/16 at 8:30a.m., E5 (Licensed Practical Nurse) documented that R5 had a "sore on his right inner buttock approximately three quarters of a centimeter area with redness and swelling and two small abrasions on his testicles. Referral was made to Z4 for R5 to be seen on 4/14/16 ... To check sacral area/back area ... R5 was seen by Z4 on 4/14/16 and Z4 stated back skin, small size stage 1/ early stage 2 pressure ulcer, less than an inch at right gluteal region. Apply dressing with protective barrier cream, reposition every two hours, monitor changes, maintain proper hygiene, change diapers regularly and refer to wound clinic."	Z9999		

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Z9999	Continued From page 3 7) On 4/15/16, a "Staff Meeting" was held and an in-service training was conducted to instruct staff to rotate/turn/reposition R5 every two hours and to change his diaper often. E5 documented at 10:38p.m., "Wound, affected area covered in feces, was cleaned and given a new diaper. Saline wound wash was applied and abrasions on testicles have opened up and bleeding, dressing applied. E5 again instructed Direct Support Persons (DSP) on the pm shift to continue to reposition R5 every two hours, change diapers as soon as they become soiled and applied gauze dressing. Documentation was not produced that physician was notified of change in medical condition 8) On 4/16/17, no documentation was noted regarding the wounds. During an interview held with E6 (Registered Nurse (RN Supervisor)) on 4/29/16 at 1:15p.m., E6 stated: "I am the RN over the LPN's. I first observed the wounds on 4/16/16 for R5 while changing him. I cleaned it, put barrier cream on it per Z4's wound care instructions. I educated the DSP's to reposition every two hours in bed and in chair to avoid pressure points. I did not document my findings/treatment of the wounds, stage the wounds in degree of severity or notify the doctor." 9) On 4/17/16 at 3:00p.m., E5 documented "sore has large amount of bloody drainage, two sores on testicles, bloody drainage. Cleaned all three with saline, new dressing and instructed DSP's to continue to reposition and change dressing when soiled." No Documentation was produced that physician was notified of change in medical condition. 10) On 4/18/16 at 9:00a.m., E5 documented	Z9999		

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Z9999	Continued From page 4	Z9999		

"right buttock wound and two wounds on testicles all have continued to get worse. Pus and bloody drainage seen from all three wounds. Call placed to Z4 on 4/18/16 to notify him that (R5) was not discharged as planned on 4/15/16 and wounds have gotten worse ... Z4 responded in person on 4/18/16 and instructed E5 to continue to keep wounds as clean as possible and that if R5 was not discharged on 4/19/16, then he will discuss sending R5 to wound care".

11) On 4/19/16, R5 was discharged to a skilled nursing home per facility "Healthcare LTC Discharge" document. Facility was not able to reproduce a discharge summary outlining R5's reason for discharge and current medical status and there was no documentation present in R5's record indicating that the guardian and receiving facility were notified about the wounds at any time.

12) On 4/28/16, R5 was discharged from the local hospital to "Hospice" for individuals facing a life limited illness.

13) On 4/29/16 at 8:54a.m., an interview was held with Z1. Z1 stated that she received a phone call from Z5 on 4/19/16 at 12:35pm stating that R5 was at their skilled nursing facility and needed to be transferred to this local hospital due to numerous stage three and stage four decubitus wounds that they are not able to treat. Z1 further stated that R5 was admitted to this local hospital on 4/19/16 to the Intensive Care Unit with a diagnosis of Sepsis; a life threatening response to an infection which can lead to death. Z1 stated that she contacted Z2 (Guardian) to notify her and she (Z2) was in shock, stating that she had not been notified by the facility where R5 had been living about any wounds and change in

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Z9999	Continued From page 5 medical condition related to the wounds. 14) On 4/29/16 at 1:05p.m., an interview was held with E5 via telephone. E5 stated that she first observed the wound on R5 on 4/14/16 and verbally instructed the DSP's to keep the wound clean and reposition R5 every two hours. E5 stated that on 4/17/16 when she saw the wound again, "it had gotten much worse, had opened up from the superficial wound on 4/14/16". E5 stated that on 4/18/16 she contacted Z4 because she was not sure if he knew that R5 had not been discharged to the nursing home on 4/15/16 because the nursing home called to reschedule the discharge date for R5 to 4/19/16 and asked us to bring R5 then because they were having a survey done on that day. In an Interview with Z5 and Z6 on 5/4/16 at 1:25p.m., Z5 and Z6 confirmed that this statement was not true. 15) On 4/29/16 at 1:15p.m., an interview was held with E6 (RN). E6 stated "anything high priority especially medical should be included on the transfer/discharge form to the receiving facility. They should have been made aware of the wounds, however I did not fill out the form. It would have been E5. I did not review the transfer/discharge forms as I do not think that our policy states that I need to." 16) On 5/03/16 at 10:00a.m., surveyor contacted Z2. Z2 stated that she was unaware of any wounds on R5 and that she had not been notified by the facility that (R5) had any decubitus wounds. Z2 stated "I was in shock when I received a call from the nursing home that (R5) was sent to. (Z6) notified me that (R5) was being sent to the hospital regarding multiple wounds. This was my first knowledge of any wounds." Z2 stated that she could not not talk now because	Z9999		

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Z9999	Continued From page 6 she just received information that (R5) had passed away today". 17) On 5/03/16 at 11:58a.m., an interview was held with E1 (Administrator) and E2 (Director of Nursing). Both confirmed that Z2, Z4, Z5 and E8 should have been notified about the serious change in health status for R5, and confirmed that the facility should have been able to reproduce documentation showing that physician orders were followed regarding repositioning, aggressive treatment, followup wound care, guardian notification, and failed to follow their policies on "Abuse/Neglect, Nursing Services and Discharge/Transfer. E1 and E2 stated that the receiving facility should have received written notification as well regarding R5's serious medical issues prior to discharge there and upon discharge to the nursing home. 18) On 5/03/16 at 1:25p.m., an interview was held with Z5 via telephone. Z5 stated "We agreed to accept (R5) into our facility for a decline in cognition. We did not know anything about the numerous wounds and there was no documentation provided to us upon admission of R5 at our facility on 4/19/16. Z5 documented on facility "Nurses Notes" dated 4/19/16 at 12:35pm, "Left message to have facility charge nurse call me since no report was given to us regarding residents wounds and no record of it from the paperwork given upon transfer. E5 called back and stated that she was aware of the wounds since 4/14/16 and last saw the wounds on 4/18/16 but did not do anything about it or have any treatment ordered. [E5] Stated, he is transferring to your facility and you can take care of it ... I then informed her (E5) that you discharged a resident with multiple decubitus stages three and four wounds to our facility	Z9999		

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Z9999	Continued From page 7 without covering the wounds except in his diapers with no documentation or treatment at all. (R5) was taken the the emergency room and admitted into the Intensive Care Unit on 4/19/16 at 2:00pm." (A)	Z9999		

IMPOSED PLAN OF CORRECTION
NAME OF FACILITY: Trinity Living Center#3-14G259
DATE AND TYPE OF SURVEY: 05/12/2016 Complaint# 1672371/IL85210

Licensure Violations:
350.620a)
350.1210
350.1220j)
350.3240a)
350.3240c)

Section 350.620 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1210 Health Services
The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:
Section 350.1220 Physician Services
j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days
Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
c) *A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.* (Section 3-610 of the Act)

This will be accomplished by:

I. The facility will review policy and procedures on all nursing services including: notification of physician for change in condition, decubitus ulcer: assessment, prevention and intervention, abuse and neglect and make policies available to all staff, residents and public, at a minimum the following:
   A. Assessment, recognition, and notification of change in resident's condition
   B. Appropriate reporting, documentation and transfer procedures for staff.
   C. The facility's responsibilities to prevent further potential abuse and or neglect while the investigation is in progress.

II. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:
   A. How to identify and report change of resident conditions and implement facility policies on nursing services.
   B. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
   C. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   D. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

I. The following actions will be taken to prevent re-occurrence.
   A. The above In-Service Education will be reviewed with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations regarding nursing, physician and health services (reporting and follow-up) are followed.

III. Documentation of in-service training, assessments and related follow up actions will be maintained by the facility.

Attachment B
Imposed Plan of Correction

IV. The Administrator, the facility representative will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Corrections.