

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005474</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/06/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF BELLEVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 27TH STREET BELLEVILLE, IL 62226</b>
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S 000	Initial Comments  Complaint Investigation  1646736/IL90073	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.1220b)3) 300.1630d) 300.3240a)  Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant 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. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.  Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>01/09/17</b>
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S9999	Continued From page 1  resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.  Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999			

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S9999	<p>Continued From page 2</p> <p>indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.</p> <p>Section 300.3240 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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to</p> <p>1) provide antibiotic treatment for an infected pressure ulcer for one of four residents (R2) reviewed for pressure ulcers in the sample of 9; and</p> <p>2) assess and provide timely treatment to address potential dehydration for one of five residents (R2) reviewed for hydration in the sample of 9.</p> <p>These failures resulted in R2 being admitted to the hospital with septic shock, possible source left lateral foot ulcer, and severe dehydration</p> <p>Findings Include:</p> <p>1) R2's Electronic Medical Record Medical Diagnosis Form, dated 11/01/16, documents R2 has a Stage 3 pressure ulcer.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R2's Wound Report, dated 11/17/16, documents R2 has an unstageable pressure ulcer on her left lateral foot measuring 0.80 centimeters (cm) length and 1.5 cm width.</p> <p>R2's Culture and Sensitivity Laboratory Form, dated 11/17/16, documents R2 has heavy growth of Proteus Mirabilis in her left lateral foot wound.</p> <p>R2's Physician Order Sheet (POS), dated 11/17/16, documents an order from Z2, Wound Physician, for Cipro (an antibiotic) 500 milligrams (mg) orally twice daily for left lateral foot for 10 days.</p> <p>R2's POS, dated 11/17/16, documents the order from Z3, Nurse Practitioner for Z4, R2's Primary Physician, to discontinue the antibiotic Cipro which was ordered by Z2. R2's POS, dated 11/18/16, documents the order from Z3 for Ertapenem (an antibiotic) 1 gram (GM) intramuscularly (IM) once daily for 14 days.</p> <p>R2's Physician Progress Note, dated 11/18/16, documents R2's wound culture results from her foot as heavy proteus mirabilis. The Note also documents "We will begin Ertapenem 1 Gram daily for 14 days due to poor absorption and deconditioning."</p> <p>R2's Nurses Note, dated 11/20/16, documents a call was received from pharmacy stating Ertapenem is not available in the back up pharmacy and medication will be available tomorrow through regular pharmacy.</p> <p>R2's Nurses Note, dated 11/20/16, documents that Z5, Nurse Practitioner for Z4, was notified the Ertapenem was not available until 11/21/16.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>There is no documentation that Z2, Wound Physician, was ever notified that there was a change in antibiotics or that R2 was not receiving any antibiotics for the infection of the pressure ulcer since 11/17/16. There is no documentation that Z3, who originally ordered the Ertapenem, was notified that it was not available.</p> <p>R2's 11/2016 Medication Administration Record (MAR) documents R2 did not receive Ertapenem 1 GM daily from 11/18/16 to 11/22/16 due to not available until 11/21/16. R2's 11/2016 MAR has no documentation that R2 ever received Ertapenem. R2's 11/2016 MAR has no documentation that R2 received any antibiotic since 11/17/16.</p> <p>R2's Nurses Note, dated 11/20/16, documents R2 has decreased appetite, and medication administration was unsuccessful. "Stat labs were ordered bmp (basic metabolic panel) and cbc (complete blood count) was ordered. (Z5) was notified of lab results. (Z5) was notified medications will start tomorrow."</p> <p>R2's Nurses Note, dated 11/22/16 at 10:44 AM, documents R2 has not been eating, when assisted with feeding and R2 will not take in fluids or medication.</p> <p>R2's Nurses Note, dated 11/22/16 at 1:37 PM, documents R2 is displaying poor appetite, decreased prealbumin. "(R2) is less responsive than her usual, alert to her name. New orders were received send R2 to (local Hospital)."</p> <p>R2's local hospital History and Physical, dated 11/22/16, documents R2 was found to be unresponsive with decreased gag reflex, minimal response to painful stimuli, and R2's temperature</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>was 99. The skin examination on the above form documents an ulceration to the left lateral foot is 3 x 4 cm and 0.4 cm in depth. R2's Sepsis Assessment documents Severe Sepsis signs and symptoms plus organ dysfunction. It also documents R2 has septic shock severe with low blood pressure and low fluid. It documents the possible source of the septic shock as the left lateral foot ulcer. It documents R2 was given Levaquin upon arrival and R2 was also placed on Meropenem and Vancomycin.</p> <p>On 11/30/16 at 8:06 AM, when asked if she was aware that R2 did not receive Ertapenem, Z2 stated "No, I didn't know she didn't receive her Ertapenem, but I didn't order the medication. I haven't seen a wound cause septic shock, but I can't say whether or not her foot wound contributed to septic shock."</p> <p>On 11/30/16 at 10:48 AM, E7, Licensed Practical Nurse (LPN), stated "I don't remember the date, but I faxed the order off. The medication was to begin on the evening shift. I didn't know anything about the pharmacy not having the medication."</p> <p>In an interview on 11/30/16 at 2:00 PM, E6, Minimum Data Set Coordinator, stated "(R2) had Cipro on the 18th, and she was suppose to start Ertapenem on the 19th. (Z5) was notified the medication was not available."</p> <p>The Facility Pressure Ulcer Policy, dated 06/2015, documents to prevent or reduce the incidence of pressure ulcers with pressure ulcer defined as any lesions caused by unrelieved pressure.</p> <p>2) R2's Electronic Medical Record Medical Diagnosis Form, dated 11/01/16, documents R2</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>has in part diagnoses of Unspecified Dementia and Hemiplegia.</p> <p>R2's Minimum Data Set (MDS), dated 09/22/16, documents R2 needs extensive assistance with eating.</p> <p>R2's Physician Order Sheet (POS), dated 11/1/16, documents R2's diet is pureed with regular consistency liquids.</p> <p>R2's Dietary Progress Note, dated 11/7/16 documents R2's sodium was 150. The Note did not document any recommendations to address R2's elevated sodium level. The website Mayo Clinic, <a href="http://www.mayoclinic.org/diseases-conditions/dehydration/diagnosis-treatment">www.mayoclinic.org/diseases-conditions/dehydration/diagnosis-treatment</a>, documents "A normal sodium level is between 135 and 145 milliequivalents per liter (mEq/L) of sodium." The website documents "To help confirm the diagnosis and pinpoint the degree of dehydration, you may have other test such as : Blood tests. Blood samples may be used to check for a number of factors, such as the levels of your electrolytes - especially sodium and potassium - and how well your kidneys are working."</p> <p>R2's Physician Progress Note, written by Z4, R2's Primary Care Physician, dated 11/16/16, documents R2's lab results were reviewed and her sodium was 164, blood urea nitrogen (BUN) was 22 (normal 8-20 milligrams per deciliter, mg/dL) , potassium was 3.2 ( normal 3.6 to 5.2 millimoles per liter, mmol/L). The Note documents "(R2) has poor fluid intake, likely related to dehydration. R2's potassium is 3.2, and we will add potassium chloride 20 meq daily." There were no recommendations as to how the facility should address R2's elevating sodium</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>level and potential dehydration.</p> <p>R2's Nurse's Note dated 11/20/16 at 11:26 AM documents R2's appetite is decreased, and medication administration was unsuccessful. R2 pocketed her medications in her cheeks. R2's medical doctor was paged.</p> <p>R2's Nurse's Note dated 11/20/16 at 11:45 AM documents the facility received a call back from Z5, Nurse Practitioner (NP) of Z4, and stat orders for a Basic Metabolic Panel (BMP) and Complete Blood Count (CBC) were given.</p> <p>R2's Laboratory Report/ BMP, dated 11/20/16, documents R2's sodium level as 175 mEq/L, BUN 32 mg/dL, and potassium 3.6 mmol/L.</p> <p>R2's Nurse's Note dated 11/20/16 at 9:47 PM, documents, Z5 was notified of lab results. At this point, no recommendations or new orders were received to address R2's abnormal laboratory results.</p> <p>R2's Nurse's Note dated 11/22/16 at 10:44 AM documents R2 has not been eating even when assisted with feeding. R2 "Will not take much fluids or her medications."</p> <p>R2's Nurse's Note Dated 11/22/16 at 1:37 PM documents R2 is displaying poor appetite and a decreased pre-albumin, and she is less responsive than usual. The Nurse's Note documented R2 is usually alert to her name. Z3, Z4's Nurse's Practitioner, was notified, and R2 was sent to a local hospital. This was 15 days after the facility noted/documentated R2 had an elevated sodium level.</p> <p>R2's Local Hospital History and Physical (H&amp;P)</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>dated 11/22/16 documents upon presentation to the emergency department R2 was found to be unresponsive with decreased gag reflex and a minimal response to painful stimuli. The H&amp;P documented R2 was given a 1 liter normal saline bolus and 2.5 lactated ringers. The H&amp;P documented despite all of the fluids R2 was still hypotensive at 62/40. R2 had severe electrolyte derangements including hypernatremia, hyperchloremia, and hypokalemia. R2 also had elevated cardiac biomarkers.</p> <p>R2's local hospital lab report, dated 11/22/16, documents R2's sodium at 240, potassium at 3.3, and BUN at 63, and a repeated lab had sodium of 170.</p> <p>R2's local hospital nephrologist consult (Z10 nephrologist), dated 11/24/16 documents R2's free water deficit was close to 6 liters at admission. The Consult documented "At this time I recommend consideration of a hypotonic fluid that will give her free water for the correction of the deficit."</p> <p>On 11/30/16 at 9:45 AM Z1, R2's daughter stated "I visited the facility from November 11-13, and my mother never had water on her tray or in her room. We had to obtain water from the nurses medication cart."</p> <p>On 11/30/16 At 3:45 PM E2, Director of nursing stated "water pitcher should be checked once per shift, and in between shifts if needed."</p> <p>On 11/30/16 at 10:30 AM, Z6, Medical Director stated "I was not notified about (R2's) dehydration, but a delay in treatment could have contributed to her dehydration."</p>	S9999		
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S9999	Continued From page 9  The facility Intake and Output Policy, dated 06/2015, documents "If a resident has no intake and or output for a shift alert the health care provider."  (A)	S9999		
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## IMPOSED PLAN OF CORRECTION

Bria of Belleville, Belleville

Complaint Survey 1646736/IL90073, exit date 12-6-2016

300.1010h)  
300.1210b)  
300.1210d)3)  
300.1210d)5)  
300.1220b)3)  
300.1630d)  
300.3240a)

### **Section 300.1010 Medical Care Policies**

h) The facility shall notify the resident's physician of any accident, injury, or significant 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. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

### **Section 300.1210 General Requirements for Nursing and Personal Care**

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

### **Section 300.1220 Supervision of Nursing Services**

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in

the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

**Section 300.1630 Administration of Medication**

d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

**Section 300.3240 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)

This will be accomplished by:

- I. Policies and procedures for assessment and change in resident's condition will be reviewed and revised as necessary. Policies and procedures for managing residents who have abnormal lab values will be reviewed and revised as necessary.
- II. The facility will provide education for nursing staff on resident assessments including but not limited to: head to toe assessment for change in resident's physical, mental or psychosocial status, documentation of interventions utilized, monitoring for effectiveness of interventions utilized, and consequences of failure to notify physician of change of resident condition.
- III. The facility will provide in-services for nursing staff on the following:
  - Identifying residents with potential for being affected by deficient practice (change in condition, abnormal lab values) by review of assessments, interventions, and updating care plans.
  - Physician notification of resident change in condition, residents with abnormal lab values, and medication orders that cannot be filled due to unavailability from pharmacy;
  - Notification of Medical Director when issues and concerns are not addressed by residents personal physician; and
  - Quality Assurance (QA) tools with documentation and monitoring of compliance. All issues and concerns will be corrected immediately and reviewed during the QAPI meeting.
- IV. Documentation of education and in-service training will be maintained by the facility.
- V. The Regional Director, Administrator, Director of Nursing and Quality Assurance Committee will monitor Items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of this Imposed Plan of Correction.