STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000269	A. BUILDING: _____ B. WING _____	C 12/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(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
S 000	Initial Comments Investigation of Complaint 1676921/IL90275	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

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)

THESE REGULATIONS WERE NOT MET AS

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S9999	Continued From page 2 EVIDENCED BY: Based on interview and record review the facility failed to notify the physician of a resident's significant change of condition. This failure resulted in a delay in obtaining hospital treatment, a delay in stabilizing the resident's abnormally high blood pressure and resulted in seizures and admission to the intensive care unit. This applies to 1 of 3 residents (R1) reviewed for change of condition in the sample of 8. Findings include: On December 8, 2016, at 11:15 AM and 2:05 PM, E3 (RN) stated she was caring for R1 on November 26, 2016 on the day shift. E3 stated that she was new to the facility and not really familiar with R1's baseline. E3 stated that she learned in report that R1, who has some periods of confusion, had become more confused the night prior and had been up all night. R1's physician had been called the prior evening and labs were ordered which had been drawn, and results were pending. That morning, R1 was more difficult to arouse, but she took her morning medication. Her blood pressure was very high; E3 stated she thought it was around 191/76. E3 stated she documented this on R1's dialysis communication sheet but neglected to document it in R1's record in the computer. According to E3, R1 was groggy, but she put it down to R1 being up all night. E3 stated she did recognize that R1's blood pressure was high, and she went and looked at R1's blood pressure history and noted an occasional high reading at other times. When the transportation ambulance arrived somewhere	S9999		

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S9999	Continued From page 3	S9999		

around 10:30 AM or so, R1 was even less responsive; she would open her eyes to her name being called, but she was not speaking. E3 stated she did not call E2 (DON, Director of Nursing) (it was a Saturday and E2 was not in the building), nor did she call R1's physician; she stated she knew R1 was being transported by ambulance and if anything happened, could be taken to the hospital. E3 had the ambulance crew take her to dialysis.

Facility Weights and Vitals Summary Report for R1 from October 1, 2016 through November 8, 2016 reflects a range of blood pressure readings for R1. The lowest reading was 110/66. There were 3 abnormally high readings, one of 200/88 on October 20, 2016 and one of 198/84 and then 176/88, both on October 11, 2016. Most readings were in the normal range.

Nursing note dated November 26, 2016 authored by E3 timed at 1:15 PM as a late entry reads, "Resident confused with mild altered mental status. Vitals WNL (within normal limits). Labs ordered, awaiting results. Upon dialysis transport arrival, resident appearing to have increased altered mental status." A note timed at 12:15 PM documents that R1 was sent out for dialysis and dialysis sent R1 to the hospital, where R1 was admitted.

At 1:30 PM on 12/8/16, Z3 (Patient Care Manager of Dialysis Unit) stated that when R1 arrived at their dialysis unit on November 26, 2016 she was unresponsive. Their dialysis staff did not feel that R1 was stable enough for her treatment and felt that she required evaluation in the hospital. Since the ambulance transport team was only a basic ambulance service, they put R1 in a dialysis chair and the dialysis staff called 911. According to Z3,

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R1's blood pressure on the transfer communication form from the facility was documented as 191/82. Z3 did not know what happened to the dialysis communication form, but thinks it went to the hospital with R1.

On December 8, 2016 at 2:55 PM, Z2 (Dispatch Manager for Ambulance Transport Company) stated she had spoken to her crew regarding the transfer of R1 to the dialysis center on November 26, 2016. The crew had concerns that the resident did not seem her usual self but the nurse had told them to take R1 to dialysis. Z2 stated that they provide basic transportation service, and the crew on November 26, 2016 consisted of an EMT (Emergency Medical Technician) and a medic.

Non-emergency Transport Form from transport company dated November 26, 2016 documents the following for R1: "crew dispatched for a 73 year-old female. Upon arrival patient not responding to us. Nurse states she had an Ativan. We awoke her to have her fall back asleep. Told to bring her to dialysis anyway, so we monitored her en route. Turn care over to RNs." This form also shows R1's mental status to be "no verbal response"; R1 was noted to respond to pain.

Emergency Room (ER) Physician Documentation for R1 dated November 26, 2016 documents that R1's Blood Pressure upon arrival was 182/104. ER record notes that R1 was sent for normal dialysis treatment and found to be unresponsive. Ambulance personnel advised ER staff that upon their arrival at the facility, R1 was unresponsive. R1 was not able to answer questions. She was also noted to be "twitching". Upon re-evaluation, R1 was having jerking of her body intermittently and was not verbally responsive. Clinical

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S9999	Continued From page 5	S9999		

Impression was Hypertensive encephalopathy with seizures, end-stage renal disease on hemodialysis, hyperkalemia and Leukocytosis. R1 received intravenous (IV) Keppra to control seizures as well as medication to lower her blood pressure. She was admitted to the intensive care unit. Consultation note of November 27, 2016 documents that R1's highest blood pressure reading thus far had been 242/121. On November 27, 2016, R1 was awake but not making eye contact nor speaking. The jerking movements were lessened, having responded to medication. The facility's Progress note of December 1, 2016 timed at 8:05 PM reflects R1 was re-admitted to the facility.

R1's Admission face sheet provides numerous diagnoses for R1 including end-stage renal disease, diabetes, hypertensive kidney disease, atrial fibrillation, chronic obstructive pulmonary disease; there is no diagnosis indicating a past history of seizures.

On December 8, 2016 at 3:20 PM, Z1 (MD for R1) stated he was not contacted on November 26, 2016 regarding R1's elevated blood pressure. Z1 stated that he should have been contacted. Had he been contacted and told that R1 had such a high blood pressure and decreased responsiveness, he would not have sent her to dialysis. According to Z1, in that situation, he would err on the side of caution and have her evaluated in the hospital first. If the ER felt she was stable enough, she could go to dialysis later. Z1 stated that if she was alert enough to take oral medication, he may have ordered medication be given at the facility.

On December 14, 2016 at 10:40 AM, E2 stated that when R1's blood pressure was very high on

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S9999	Continued From page 6	S9999		

November 26, 2016 and she had decreased responsiveness, E3 should have contacted someone; she could have called me (E2), I am always available by phone, or she could have spoken to other staff more familiar with R1. E2 further stated E3 should have contacted R1's physician.

Facility policy entitled "Functional Impairment-Clinical Protocol" was provided by E1 (Administrator) when asked for the facility policy on Change of Condition. This policy states that staff will monitor and discuss the resident's functional progress during therapy and in general; it does not address an acute change in a resident's condition, nor does it instruct nursing staff to notify the physician for a change in medical condition. It does not indicate what constitutes a change in condition. On December 15, 2016 at 12:05 PM, E1 stated that this was their only policy on change of condition and agreed that it did not direct staff to call the physician for a change in medical condition.

R1's current MAR (Medication Administration Record) reflects that R1 is now on Keppra 500 mg daily for seizures. Prior to this, R1's MAR did not reflect any medications for seizures. On December 15, 2016 at 12:00 Noon, E2 confirmed that R1 had not had seizures previously, and had returned from the hospital on Keppra.

(A)

IMPOSED PLAN OF CORRECTION

Citadel Care Center - Kankakee
Complaint Survey 1676921/IL90275, exit date 12-19-2016

300.610a)
300.1010h)
300.1210b
300.1210d)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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

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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.

Section 300.3240 Abuse and Neglect

Attachment B
Imposed Plan of Correction

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 physician notification of residents who experience a change in condition will be reviewed and revised as necessary. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident legal representative and family member when there is a significant change in the resident condition (physical, mental, or psychosocial status – i.e., deterioration in health, mental, or psychosocial in either life threatening conditions or clinical complications); a need to alter treatment (i.e., 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.

II. The facility will provide education for nursing staff on proper nursing assessments and implementation of interventions for those residents experiencing a change in condition; physician notification of residents who experience change in condition; and consequences of failure to notify physician of change of resident condition.

III. All nursing staff will be in-serviced on the facility's policy for physician and legal representative notification of change in condition. The in-service will include, at a minimum, assessment of resident experiencing a change in condition and identifying resident changes or indicators that may require reassessment or other interventions to prevent injury or death. Additionally, in-servicing will be conducted regarding notification of the Director of Nursing (DON) and/or designee on call after hours and on weekends regarding resident change in condition to ensure thorough assessment and notification have been done to resident.

IV. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

V. Documentation of in-service training will be maintained by the facility.

VI. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

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