

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/25/2017
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NAME OF PROVIDER OR SUPPLIER PAXTON HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1240 NORTH MARKET STREET PAXTON, IL 60957
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S 000	Initial Comments Complaint #1760349 / IL 91165	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 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/07/17

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S9999	<p>Continued From page 1</p> <p>of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>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.</p> <p>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.</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 regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to recognize and thoroughly monitor changes in condition for one of three residents (R1) reviewed for changes in condition in the</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>sample of three. These failures resulted in a delay in treatment and R1 being hospitalized for acute renal failure.</p> <p>Findings include:</p> <p>R1's Medication Review Report dated 1/24/17 documents R1's diagnoses including Alzheimer's Disease, Diabetes Mellitus with Hyperglycemia, Sleep Apnea, Hypertension, Heart Failure, Anxiety, Major Depressive Disorder and Dementia with Behavioral Disturbance. This report documents an order for labs including a Complete Metabolic Panel (CMP), and Complete Blood Count (CBC).</p> <p>R1's laboratory report dated 1/4/17 documents results as follows:</p> <p>WBC (White Blood Count) 10.9 K/ul (cubic milliliter) Hemoglobin 9.3 GMS/DL (grams per deciliter) Hematocrit 33.8 % (percent) BUN (Blood Urea Nitrogen) 40 MG/DL (milligrams per deciliter) Creatinine 1.2 MG/DL Potassium 5.1 MEQ/L (milliequivalents per liter)</p> <p>R1's Electronic Records document R1 had one loose bowel movement on 1/13/17, two on 1/14/17, one on 1/15/17 and three on 1/16/17.</p> <p>R1's Electronic Records document R1's percentage of meals eaten 1/13-1/16/17 as 0-25% for all three meals each day.</p> <p>R1's Nutrition Risk Assessment dated 1/6/17 documents estimated daily nutritional needs for R1 including 2275-2730cc fluids.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>R1's Electronic Records document R1's 24 hour fluid intakes as follows:</p> <p>1/13/17- 140cc (cubic centimeters) 1/14/17- 540cc 1/15/17- 200cc 1/16/17- 840cc</p> <p>R1's Progress Notes dated 1/13/17 document R1 had three emesis and two episodes of diarrhea. Resident was yelling loudly and that family was notified of R1 not feeling well.</p> <p>R1's Progress Notes dated 1/13/17:</p> <p>10:41am, 5:40pm, 5:41pm, 5:42pm, 5:43pm, 7:59pm and 8:00pm documents R1 was having nausea and vomiting.</p> <p>9:51pm documents R1 had vomiting early in the shift and was awake briefly then went right back to sleep. R1 ate no solid food and had a few sips of soda. There is no documentation the physician was notified of R1's condition on 1/13/17 regarding R1's condition after an order for Zofran was obtained at 10:41am.</p> <p>R1's Progress Notes dated 1/14/17:</p> <p>6:28pm documents R1 was sick and sleeping.</p> <p>10:04pm documents, "... Unable to arouse {R1} to take {R1's} medication."</p> <p>R1's Progress Notes dated 1/15/17:</p> <p>12:50pm documents R1's blood sugar 91 and R1 is not eating lunch and that R1's insulin was not given.</p>	S9999		
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S9999	Continued From page 4 7:25pm-8:14pm document R1's medications were not given. There is no documentation of R1's condition from 8:14pm until 1/16/17. R1's Progress Notes dated 1/16/17: 8:27am documents R1 did not eat breakfast. 6:00pm documents R1 is ill and not eating well and insulin was held. 9:54pm documents R1 "still remains sleepy and lethargic this eve (evening)." R1's Progress Notes dated 1/17/17: 12:14am documents that at 11:30pm, R1's vital signs including a blood pressure of 90/40 and Oxygen Saturation of 76%. This note also documents, "Nasal cannula removed and mask put on... Blood pressure at this time (12:14am) 100/60..." 1:39am documents R1's vital signs at 1:10am including a blood pressure of 86/40 and an Oxygen Saturation of 87%. This note also documents, "O2 at 2L (liters) per mask. {R1} lethargic not responding to stimuli" and that the ambulance was called to transport R1 to the hospital. There is no documentation in R1's medical records that Z1, R1's Physician was notified of R1's condition from 1/13/17 through 1/16/17 including cognition changes, vital signs, low fluid and food intake, and nausea, vomiting and loose stools. R1's Emergency Room laboratory report dated	S9999		

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S9999	<p>Continued From page 5</p> <p>1/17/17 documents results as follows:</p> <p>WBC 25.6 th/cmm (measurement) Reference Range (RR) 4.5-11.0 Hemoglobin 7.5 g/dl (grams per decaliter) (critical value) RR 11.7-15.7 Hematocrit 23 % RR 35-47 BUN 157 mg/dl (critical value) RR 7-18 Creatinine 5.2 mg/dl RR 0.6-1.0 Potassium 6.5 mmol/L RR 3.5-5.1</p> <p>R1's Emergency Nursing Record dated 1/17/17 documents Z3, Emergency Room Registered Nurse received report from the facility. This report documents Z5, R1's Husband stated he eats lunch with R1 daily and the last time Z5 was able to have a conversation with R1 was two days ago. This report also documents R1 does not withdraw from pain.</p> <p>R1's Emergency Report dated 1/17/17 documents R1 presented for the last three days with altered mental status and decreased intake by mouth. This report also documents R1 has a low blood pressure, low O2 sats, lethargic for the last 3 days. The report documents, "... PREMILNARY DIAGNOSIS: The patient is in very bad shape, pre-agonal... Diagnoses: 1. Multi (multiple) Organ Failure 2. Acute on Chronic Kidney Injury 3. Hyperkalemia... Hypotension... Hospice is on consult..."</p> <p>R1's Weights and Vitals Summary report dated 1/24/17 document vital signs for 1/10/17 and 1/17/17, but do not document vital signs for 1/11-1/16/17 for blood pressure, pulse, respirations and temperature.</p> <p>The facility's untitled vital sign log dated 1/14/17 and 1/15/17 do not document R1's blood</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>pressure, pulse or respirations for those days. The vital sign log dated 1/16/17 does not document R1's blood pressures for night or evening shift. This log also does not document R1's pulse or respirations on 1/16/17.</p> <p>On 1/24/17 at 2:00pm, E3, Certified Nursing Assistant (CNA) stated E3 had cared for R1 on 1/14/17, 1/15/17, 1/16/17 on day shift. E3 stated R1 was lethargic and "not taking much fluids." E3 stated that R1 was "just off." E3 stated on 1/16/17 R1's condition was about the same and that E3 attempted to push fluids for R1 but R1 "just wasn't drinking." E3 stated "everyone (nursing staff) knew {R1} was sick; just assumed it was the flu."</p> <p>On 1/24/17 at 2:30pm, E4, CNA stated she had cared for R1 on 1/13/17 and assisted with R1's cares on 1/14/17 on the evening shift. E4 stated on 1/13/17, R1 was vomiting and having loose stools and that E1 did not get out of bed that evening. E4 stated R1, "was not really responsive." E4 stated she had given R1 a half can of lemon lime soda but R1 vomited the soda back up right away. E4 stated she had told E11, Registered Nurse (RN) R1 was "still throwing up." E4 stated she was instructed by E11 to keep R1 in bed. E4 stated R1 is typically "very verbal and very loud" and that was not how R1 was. E4 stated on 1/14/17 R1 had not had any improvement. E4 stated R1 would usually assist with cares but was too weak. On 1/16/17, E4 stated she began work around 2:00pm and R1 was "not really responsive." E4 stated R1 had a "big" change/decline from when she worked on 1/14/17 and came back to work on 1/16/17. E4 stated on 1/16/17 R1 would not respond to R1's name. E4 stated she spoke with E12, Treatment Nurse and that E6, Licensed Practical Nurse</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>(LPN) was aware of R1's condition. E4 stated that R1's fluid intake was accurate at 120cc (cubic centimeters) for the entire evening shift on 1/16/17.</p> <p>On 1/24/17 at 11:30am, Z2, Paramedic stated Z2 was a paramedic who responded to the facility's call to transport R1 to the Emergency Room on 1/17/17. Z2 stated when the paramedics arrived to the facility on 1/17/17 around 1:30am, Z2 initially could not get a radial pulse or blood pressure on R1 which typically indicates the blood pressure is below 80 systolic. Z2 stated R1 had a "{simple} mask at 2 Liters only" and that "a mask is (to be set at) a minimum of four to six liters" otherwise the patient will start to "suffocate" due to not receiving the appropriate concentration of oxygen. Z2 stated R1's pupils were pinpoint and the unnamed staff stated R1's condition had been like it was for atleast two days. Z2 stated Z2 gave some fluid, enough to be able to obtain a blood pressure.</p> <p>On 1/24/17 at 2:50pm, E6, Licensed Practical Nurse (LPN) stated she was R1's nurse on 1/14/17, 1/15/17 and 1/16/17 on evening shift. E6 stated R1 was "sick with flu like symptoms." E6 stated R1 was typically active and talkative. E6 stated that R1 "mainly slept a lot" on 1/14/17. E6 stated she could not remember if any other staff had come to her regarding R1's condition. E6 stated the staff were performing vital signs the days she had her but that E6 could not remember what the vital signs were. E6 stated vital signs should be documented in the computer. E6 stated she did not update Z1, R1's Physician regarding R1's condition on 1/14/17, 1/15/17 or 1/16/17.</p> <p>On 1/24/17 at 3:10pm, E7, Certified Nursing</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>Assistant (CNA) stated she cared for R1 on 1/15/17 evening shift. E7 stated she was told in report by E3, CNA who cared for R1 on day shift that R1 had been lethargic. E1 stated R1 was not R1's self and that R1 didn't wake up with repositioning and was "not responsive." E7 stated E6, Licensed Practical Nurse was aware of R1's condition and that E7 spoke with E6 a couple times regarding R1's condition. E7 stated R1 had a large amount of foul smelling loose stool and that R1 was clammy and sweaty. E7 stated, "... {R1} seemed so lifeless to me {E7}..."</p> <p>On 1/24/17 at 10:10pm, Z3, Emergency Room Registered Nurse stated while a patient in the Emergency Room, R1 was unresponsive the entire time. Z3 stated, "We (Emergency Room staff) were all a little taken back due to {R1's} BUN (blood, urea, nitrogen lab) being so high..." Z3 stated R1 was "pretty dry (hydration)" and that they had to perform R1's temperature axillary as oral was not accurate due to R1's dry mucous membranes.</p> <p>On 1/25/17 at 11:35am, E10, Registered Nurse (RN) stated she was R1's nurse on day shift on 1/14/17, 1/15/17 and 1/16/17. E10 stated she was notified in report the morning of 1/14/17 that R1 was having loose stools and nausea and vomiting. E10 stated R1 had eaten some food during her shift on 1/14/17 but R1 did not eat well on 1/15/17. E10 stated, "We (staff) document the important things." E10 stated the CNA's are responsible for documenting blood pressure, pulse, respirations and temperature.</p> <p>On 1/25/17 at 11:20am, Z1, R1's Physician stated he would expect to be notified for a resident's change in condition. Z1 stated he did not have any office documentation that they were ever</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>notified of R1's condition between 1/13/17 through 1/16/17. Z1 stated if he would have been notified he would have given orders for labs or sending to the emergency room if the family agreed. Z1 stated the last time he had seen R1 was on 12/5/17.</p> <p>The facility's Physician Notification of Resident Change in Condition dated 11/3/16 documents, "... To provide guidelines for staff to follow to ensure that there is appropriate physician notification of any change in a resident's condition... The residents attending physician will be notified of changes that occur in the resident's condition by Licensed Personnel as warranted. Physician notification is to include, but not limited to the following... Significant change in vital signs... B/P (Blood Pressure) (Systolic... < (under) 90...) O2 (oxygen) sat (saturation) - < (under) 90%... Acute onset of 3 or more loose stools... Persistent or recurrent vomiting (2 or more within 12 hours)... Signs of an infectious process... Refusal to take prescribed meds (medications)... Abrupt significant change in cognitive functions... It is the responsibility of the Charge Nurse to notify the physician of any change in a resident's condition... It is the responsibility of the DON (Director of Nursing)/Designee, through monitoring of the 24 hour report to ensure that physicians have been notified of condition changes in residents... When a change has been noted in a resident's condition, the Charge Nurse must assess the resident, document the change in the resident's medical record and notify the resident's attending physician..."</p> <p>The facility's Vital Signs policy dated 1/15/98 documents, "Purpose: To provide Nursing staff with guidelines... It is the responsibility of the Nursing staff to obtain vitals on all residents</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>indicated. It is the responsibility of the Charge Nurse to ensure the vitals are obtained and documented accurately.</p> <p>The facility's Intake and Output Measurement policy dated 3/6/15 documents, "... To maintain an accurate measurement of the resident's intake... to assess fluid balance... An accurate record of the resident's fluid intake... will be recorded... It is the responsibility of all nursing personnel to obtain intake... It is the responsibility of the Charge Nurse to document intake... in designated area... Measure and record... all intake... Charge Nurse is to notify physician of any abnormality..."</p> <p>The facility's Meal Intake policy dated 5/15/14 documents, "Purpose: To provide a way for the facility to monitor residents intake, when intake has noted to have declined... Meal intake... will be monitored for amount of food consumed at each meal (meal) for residents... when intake is noted to be below 75% of the meal offered... If the resident is consistently refusing meals... the physician... must be notified... Close observation of Diabetics intake is recommended, as the refusal of meal... will affect blood glucose levels..."</p> <p>The facility's Oxygen Administration Policy dated 12/27/02 documents, "... The purpose of this procedure is to provide guidelines for oxygen administration. To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues... It is the responsibility of the Charge Nurse to ensure that residents who have an order for oxygen are receiving the proper amount via the proper way... Place the appropriate device on the resident's head... Adjust the device so that... the proper flow of oxygen is being administered..."</p>	S9999		
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