

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 Complaint #1741868/IL9275: F157, F309, F323, F441, F505 Complaint #1742027/IL93048: F280, F318, F323 | S 000 | | |
| S9999 | Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210c)d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a)Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest | S9999 | <h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3> | |

| | | |
|---|-------|------------------------------|
| Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/05/17 |
|---|-------|------------------------------|

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 1</p> <p>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>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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.</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 2</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 were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to assess, implement and monitor residents for safe positioning to prevent accidents for 1 of 1 residents (R7) reviewed for supervision in the sample of 16. This resulted in R7's improper positioning which could have contributed to her death.</p> <p>Findings include:</p> <p>In an interview on 4/5/17 at 1:40 PM, via telephone, E17, Certified Nurse Assistant (CNA), stated she was working 10 PM-6 AM on 3/31/17, the night R7 expired. E17 stated the first time she saw R7 that night was at 1 AM. E17 stated she did not receive report on R7 so she wasn't sure what time R7 went to bed. E17 stated she walked into R7's room, R7 was on her left side, and her face was in the pillow. E17 stated she immediately turned R7 on her back, checked for a pulse, and called for a nurse. E17 stated R7's face was smashed like she had been lying in that position for a while. E17 stated R7's right side was extremely cold and her left side was warm, but that could have been due to the way she was laying. E17 stated she did not notice R7's lip color and stated R7 normally has a grayish color which was what she saw when she turned R7. E17 stated E11, Registered Nurse (RN), checked</p> | S9999 | | |

Illinois Department of Public Health

| | | | | | |
|--|--|--|---|--------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 | |
| S9999 | <p>Continued From page 3</p> <p>R7 and said R7 was gone. E17 stated she rounds every 2-2.5 hours depending on laundry situation. E17 stated she started rounds late that night because they had to wait to have enough linens to do rounds and CNA's are doing the laundry. In a follow up interview on 4/11/17 at 1:42 PM, E17 stated she told E11 that she found R7 with her face in her pillow and the pillow was in the wrong position. E17 stated she rolled R7 to her back and checked for a pulse. E17 stated E11 didn't really have a response to R7 being found with her face in the pillow. When asked how pillow was in the wrong position, E17 stated R7's head was contracted or maybe didn't move it real well and that R7's face was in her pillow. E17 stated she doesn't remember observing any more small details of R7's face and that she was turning R7 over at this time. E17 stated E1, Administrator, called her the next day and she told E1 that she found R7 with her face in the pillow. E17 stated she wrote a statement and gave a copy to E1 and E2, Director of Nursing (DON).</p> <p>An untitled handwritten statement by E17 regarding R7's passing was provided by E1 to survey team on 4/5/17. The handwritten statement documents: 4/2/17 Regarding R7: "At approx (approximately) 1 AM, I (E17) walked into R7's room to check and for change her. When I (E17) entered the room, I found (R7) laying on her left side with her (R7's) face in a pillow. I turned (R7) onto her back, checked for pulse, and called the nurse for help. The pillow had what I (E17) can describe as yellow/clear mucus on it. "</p> <p>On 4/5/17 at 9:30 AM, E9, CNA, stated she worked on 3/31/17 11 PM-6 AM, the night R7 passed. E9 stated she went down to help with bed checks and R7 was gone. E9 stated she had</p> | S9999 | | | |

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 |
|--------------------|---|---------------|---|--------------------|
| S9999 | <p>Continued From page 4</p> <p>not seen R7 before bed check at 1:15-1:30 AM. E9 stated R17 found R7 and that she (E9) was across the hall in another room. E9 stated she heard E17 call for the nurse and she (E9) came across the hall and E17 had positioned R7 on her back to check for a pulse. E9 stated E17 had already rolled R7 from her side. E9 stated E17 told her that R7 was on her left side facing door and that R7's face was in the pillow. E9 stated you could tell her face had been in pillow for some time. E9 stated she noticed R7's nose was pushed all the way to the right. E9 stated R7's face was smashed in from being in the pillow. E9 stated R7's bottom half was warm and had blankets on, and R7's upper half was cold. E9 stated R7's coloring was yellow/gray, lips looked a little purple, and there was stuff on R7's pillow case that was a white/yellowish color. E9 stated the substance on the pillow was a little thicker than dried saliva and looked like medicine with vanilla pudding had come up and was dried on pillow. E9 stated staff are supposed to make rounds at change of shift, bed checks at midnight, 2:30-3 AM, and again at 4:30 AM, but they didn't start bed checks until about 1 PM. E9 stated they didn't have any soaker pads and had to do laundry. E9 stated she got here at 11 PM and the report from previous shift was that everyone was fine.</p> <p>In an interview on 4/5/17 at 8:30 AM via telephone, E11, RN, stated there were no signs of trouble for R7 and the first time she saw R7 on the night of her passing was when she pronounced R7 dead. On 4/10/17 at 10:31 AM, during a follow up telephone call, E11 stated R7 had contractures to the left leg and maybe arms. E11 stated R7 had limited movement and needed staff assistance for turning and positioning. E11 stated on the night R7 passed, E17 called for the</p> | S9999 | | |

Illinois Department of Public Health

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|---|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|--|-------|--|--|
| S9999 | <p>Continued From page 5</p> <p>nurse and she (E11) went to R7's room. E11 stated R7 was already on her back and E11 checked for pulse, breath sounds, rise of chest, and then pronounced R7 at 1:15 AM. E11 stated R7 did not have any coloring to her face. E11 stated R17 told her that R7 was found on her side and that she (E17) had rolled her to her back. E11 stated E17 told her R7 was on her side with a pillow behind her head. E11 stated she contacted E7, Licensed Practical Nurse (LPN), and told him of R7's passing. E11 stated E7 informed her to do certain paperwork and who to contact.</p> <p>R7's Nurses Notes, dated 4/1/17, documents: "Writer called to (R7's) room, (R7) had to (sp) pulse, no breath sounds and no heartbeat when auscultated. Time of death called at 0115. Writer notified Power of Attorney (POA) and states he is not going to come in, county coroner notified, MD (Medical Doctor) notified, DON notified, and administrator all notified of (R7's) passing."</p> <p>On 4/5/17 at 2:13 PM, E16, CNA, stated that she cared for R7 routinely. E16 stated she worked 2 PM-11 PM on 3/31/17 and cared for R7. E16 stated R7 was one of the 1st residents to lie down. E16 stated she laid R7 down at 6:30 PM, did a bed check at 9:30 PM and again at 10:40 PM. E16 stated at 10:40 PM, R7 was lying on her left side, facing door and she (E16) had used a bath blanket under R7's left knee to prevent R7 from rolling. E16 stated R7 did not really roll in bed and when you position R7 she would stay in that position 9 out of 10 times. E16 stated last year she (E16) had found R7 with her face in a pillow laying sideways and had turned and propped her (R7) better so R7 wouldn't roll back onto it. E16 stated she does rounds every 2 hours at least and reported off to E17, CNA and E9, CNA. E16 stated R7 was still breathing and</p> | S9999 | | |
|-------|--|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|---|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 6</p> <p>awake looking at ceiling at 10:40 PM when she (E16) checked on her. E16 stated R7 seemed normal that evening and ate 100% of dinner. E16 stated R7 was dependent on staff for all ADLs, turning and repositioning, and was not aware of a certain side that R7 could not lay on. E16 stated she had been out of the building on leave for a month and no one brought to her attention if there were changes. E16 stated R7 was a side to side turn.</p> <p>On 4/5/17 at 9:00 AM, E7 stated he cared for R7 and that she was a total assist with ADLs and did not speak. E7 stated when he spoke with E11, Registered Nurse (RN) that morning, she said something about a pillow, that R7's head was half on, half off and R7's head was like she (R7) had moved into it. E7 stated he told E11 to notify the doctor, coroner, and family, and there was a sheet to sign and to give coroner specifics. E7 stated E11 was new and wanted to know about policy.</p> <p>R7's undated current Face Sheet documents she was a 95 year old resident with diagnoses including Alzheimer's, osteoporosis, and anxiety. R7's Physical Therapy Plan Care, dated 11/10/15, documents a treatment diagnosis of contracture, left knee.</p> <p>R7's Death Certificate, signed by Z2, Medical doctor on 4/3/17, documents the date of death as 4/1/17 cause of death as multiorgan failure. The death certificate further documents the coroner was not notified.</p> <p>R7's Quarterly Minimum Data Set (MDS), dated 1/27/17, and R7's Annual MDS, dated 10/28/16, both document R7 is totally dependent upon two staff members for bed mobility and has lower</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|--|-------|--|--|
| S9999 | <p>Continued From page 7</p> <p>extremity impairments on both sides of the body. Both MDS' document the Brief Interview of Mental Status as disabled/blank. The Staff Assessment was completed and R7's cognitive skills for daily decision making is documented as impaired. Both MDS' further document R7 did not have any swallowing difficulties.</p> <p>R7's Care Plan, dated 11/06/13 with a Target date of 4/26/17, documents: "Focus: (R7) has potential for impairment to skin integrity" and continues "requires assist with bed mobility. Interventions/Tasks: Encourage and assist with repositioning at least every 2 hours. The resident is in low bed with low air loss mattress. Turn and repositioned every 2 hours. Focus: (R7) is a moderate risk for falls r/t (related to) unaware of safety needs. Intervention/Tasks: (R7) needs prompt response to all request for assistance. Low bed with alternating air loss mattress. Focus: (R7) has an Activity of Daily Living (ADL) self-care performance deficit r/t (related to) dementia. Interventions/Tasks: Bed mobility: (R7) request assistance by 2 staff to turn and reposition in bed every 2 hours and as necessary." The Care Plan does not document R7's contractures or specific positioning required with her contractures.</p> <p>R7's Physician Progress Note, dated 10/26/16, documents: "(R7) has contracture on the L (left) hand...Exam of the L hand reveal hand is contracted."</p> <p>R7's Physical Therapy (PT) Plan of Care, Initial Assessment, dated 11/10/15, documents, R7's treatment diagnosis: contracture, left knee. Reason for Referral: R7 now requires skilled PT to increase flexibility and Range Of Motion in bilateral LE (lower extremities) to improve the</p> | S9999 | | |
|-------|--|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 |
|--------------------|---|---------------|---|--------------------|
| S9999 | <p>Continued From page 8</p> <p>level of independence and strength to maintain upright posture and joint integrity. Functional Deficit Other: R7 requires position in the wheelchair frequently due to improper posture.</p> <p>R7's Occupational Therapy (OT) Plan of Care, Initial Assessment, dated 3/31/16, documents R7's treatment diagnosis: pain in right hand, pain in left hand. Medical History related to diagnosis/Condition: bilateral hand contracture with observed pain with movement. Underlying Impairments Other: Both hands contracted, right tighter than left...Hands not used in a function manner... Holds hands fist...Stiff shoulders, but not as resistive or painful with shoulder range compared to hand range...will add position goals.</p> <p>R7's Restorative Progress Notes, dated 11/14/15, documents, R7 d/c (discharged) from ambulation d/t (due to) LLE (left lower extremity) contracture keeps knee in flexed position, R7 is now in G/C (geriatric chair) with pillows for positioning.</p> <p>R7's Nurses' Notes, dated 2/25/17, documents: "(R7) has been placed on Passive Range Of Motion, has limitations to both UE (upper extremity and LE (lower extremity), will continue at this time and re-assess next review.</p> <p>R7's Physician Order Sheet (POS), dated 3/31/2016, documents: OT 10 x in 6 weeks as needed for hand splinting, positioning, gentle upper extremity ROM." R7's POS, dated 3/2016, documents R7 was a pureed diet.</p> <p>R7's March 2017 meal intake form documents on 3/31/17, R7 consumed 25% of breakfast, 100% of lunch and supper is not documented. On 4/11/17 at 1:00 PM, E1 stated the computers were down on 3/31/17 and R7's evening meal</p> | S9999 | | |

Illinois Department of Public Health

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|---|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 9</p> <p>wasn't able to be documented and that dietary had forgotten to mark the intake form. In a previous interview on 4/5/17 at 2:13 PM with E16, CNA, stated R7 ate 100% of the supper meal on 3/31/17</p> <p>An untitled, undated, document given by E21, Certified Nurse Assistant-Restorative Aide, stated the untitled document is known as the Wing Sheet and describes residents' ADL status. The document states R7: "Use pillows for proper positioning, assist (R7) with all ADLs."</p> <p>On 4/5/17 at 9:16 AM, E8, CNA, stated she cared for R7 and that she was a total assist with ADLs. E8 stated she never saw R7 move in bed but was not saying that she couldn't move. E8 stated R7 could not move legs and had one leg that was contracted and had the appearance of a flamingo.</p> <p>On 4/5/17 at 10:00 AM, E6, CNA, stated R7 was totally depended on staff.</p> <p>On 4/5/17 at 11:00 AM, E13, CNA, stated E17 told her that R7 had suffocated. E13 stated E17 found R7. E13 stated R7 was unable to move herself and was lying on the wrong side. E13 stated R7 was only to be position on her left side and was pretty sure it was the left side.</p> <p>On 4/5/17 at 12:55 PM, E14, CNA, stated R7 was total care and was not able to move her upper and lower extremities. E14 stated R7 had one lower leg that was contracted and that R7 had a side that she laid better. E8 stated R7 laid on a pillow and was one that needed pillow positioning on both sides.</p> <p>On 4/10/17 at 2:00 PM, E22, CNA, stated R7 was</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 10</p> <p>contracted to the point that she couldn't do anything for herself. E22 stated R7 was dependent upon staff for all ADLs. E22 stated R7 had to be positioned with a pillow under her leg to keep her from rolling on her stomach, and another pillow on her back.</p> <p>On 4/10/17 at 9:30 AM, E21, Restorative CNA, stated R7 was an extensive assist with all ADLs. E21 stated R7 had contractures and limitations to left lower extremity and bilateral hands. E21 stated R7 had limitations on all her extremities, upper and lower, and was unable to move herself in bed. E21 stated you have to use pillows for positioning and staff is expected to have pillows in back, between legs, and one across chest area to lay arm on. E21 stated R7 had a pressure relieving mattress which was an alternating air loss mattress. E21 stated R7 gets Passive Range of Motion to all extremities. On 4/11/17 at 12:15 PM, during a follow up interview, E21 stated the facility used to have an assessment for restorative services before they went to computer system. E21 stated that therapy will write to continue ADLs for residents. E21 stated she had a Wing Sheet that she designed that facility uses and documents each resident's ADLs. E21 stated she is not allowed to physically move residents neck, so when she asked R7 to move her neck, R7 did not. E21 stated R7 was unable to communicate and she cognitively couldn't follow directions. E21 stated R7's leg was drawn up in a flexed position and therapy had tried a brace in the past, but did not work so we were using pillows for positioning. E21 recalls having training on R7 positioning, specifically, but unsure of date. E21 stated that she assumed that other staff would train new employees. E21 stated the pillows were to keep R7 comfortable and prevent skin breakdown. E21 stated R7 did not have any</p> | S9999 | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 11</p> <p>swallowing issues, was a pureed diet, and ate good when she wanted. E21 further stated R7 was unable to make needs known, but was able to grimace.</p> <p>On 4/10/17 at 10:45 AM, E7, LPN, stated he is the restorative nurse and doesn't do an assessment on R7 for restorative. E7 stated it's just in his head and he writes the program off what he sees. E7 stated R7 had bilateral PROMs for programming.</p> <p>On 4/5/17 at 1:40 PM, via telephone, E17, CNA stated she was familiar with R7 and was a total care, needed turning and repositioning and had contractures. E17 stated R7 was not able to move in bed and if she was a positioned a certain way, R7 would roll to the other side. E17 stated R7 was not supposed to be on her left side because R7 had a head contracture and if not positioned properly, R7's faced would go into the pillow. E17 stated she had previously seen R7 do this other times. E17 stated she had seen R7's face in the pillow when she cared for her many times after rolling side to side for incontinent care. E17 stated R7's face would be in the pillow when she was on her left side.</p> <p>On 4/5/17 at 9:30 AM, E9, CNA, stated she took care of R7 and that she was totally depending on staff. E9 stated R7 could move arms a little bit, but was only able to move one foot on lower extremities. E9 stated R7 had one leg contracted.</p> <p>On 4/5/17 at 1:13 PM, E1, Administrator, stated she received a phone call about 2:45 AM on 3/31/17-4/1/17 from E11 stating R7 had passed away around 1 AM. E1 stated she spoke with E16, after receiving a phone call that E16 was</p> | S9999 | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|---|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 12</p> <p>upset about R7's passing and that she put R7 to bed. E1 stated E16 stated she had to turn R7 every 2 hours, R7 had to be on a certain side, and also that E16 couldn't find a pillow and had rolled up a bath blanket to put under R7's arm to help her stay on her side. E1 stated there were all kinds of rumors about R7 suffocated. E1 stated she contacted E17 because she was the staff member that found R7. E1 stated E17 offered to write up a statement and that E1 said okay. E1 stated she did not think any more of it or that anything was wrong. E1 stated she did not investigate or document any other conversations with staff members regarding R7's passing. On 4/11/17 10:30 AM, E1 stated E17 did not say anything to her about R7's face in the pillow. Reviewed the untitled document with E1 that was written by E17 that states R7's face was found in the pillow. E1 stated she didn't see that and that E17 slid it under her door.</p> <p>On 4/5/17 at 2:55 PM, E2, DON, stated she was familiar with R7 and had contractures to bilateral hands. E2 stated R7 did not have any other contractures and was total care. E2 stated she was out of town when R7 passed. E2 stated E11 called her to notify her of R7's passing and that R7's head was rumored to be in pillow. E2 stated E11 wasn't concerned, so I wasn't concerned. During a follow-up interview on 4/11/17 at 11:00 AM, E2 stated R7 did not have any swallowing issues and was a pureed diet and crushed medications due to dentures. E2 stated R7 was not able to talk for the last year and family had told her this as well. E2 stated R7 had reverted to Spanish words. E2 stated she could get R7 to engage with a smile at times in the dining room, but couldn't respond to questions. E2 stated R7 was unable to use the call light. E2 stated the facility does not have a rounding policy, but</p> | S9999 | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 13</p> <p>knows night shift staff rounds every 2 hours. E2 stated she expects days/evening staff to round every hour, but there is no policy to keep staff accountable and she would like to implement that. When asked if E2 had been told if R7's face was found in the pillow, E2 stated all she knows is that R7 was found on her side and that she has not talked with E17 who found R7. E2 stated E11 told her of the rumors that R7's faced was in the pillow the following Monday. E2 stated she expects staff to position R7 with pillows, turn and reposition side to side, and additionally with R7's contractures, she doesn't know what they should be doing. E2 stated a pillow between R7's contracted legs to help prevent rubbing of skin in contracted areas. E2 agreed R7's Care Plan does not reflect R7's functional status and contractures.</p> <p>On 4/10/17 at 12:18 PM, Z3, Coroner, stated he doesn't think he was notified of R7's death. Z3 stated he doesn't log any information unless he responds to call. Z3 stated it's hit and miss with facilities contacting him with deaths. Z3 stated "I wish they would." R7's death certificate was reviewed with Z3 which documents the coroner was not notified. Z3 stated that he was not notified then.</p> <p>On 4/5/17 at 3:30 PM, Z2, Medical Doctor, stated he was notified of R7's passing. Z2 stated staff just said she passed away and he didn't think much of it. Z2 stated he was not told staff found R7 in a pillow with facial markings on her. Z2 stated he was unsure if coroner was contacted, but most certainly could have done an autopsy if the information was given to him. Z2 stated it was possible that if R7's face was in the pillow, it could have attributed to her death. Z2 stated all he knew was that staff had said she had passed</p> | S9999 | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 | |
|--|--|---|---|--------------------|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 |
| S9999 | <p>Continued From page 14</p> <p>away. Z2 stated he saw R7 a few months ago. Z2 stated R7 had contractures on one of her hands, but was unsure which side. Z2 stated he didn't think R7 could move in bed and if she could it was very little. Z2 stated R7's face in pillow could be a contributing factor to her death.</p> <p>On 4/10/17 at 2:50 PM, E1 stated she did not have a policy on notification of death or a restorative policy.</p> <p>The Manufacturer's Low Air Loss Mattress System policy, dated 2014, documents: "Warning: Close supervision is necessary when this produce is used by, on, or near children or invalids."</p> <p>The Facility's Protocols for Accident/Incident Reports Policy, dated 7/7/2009, documents: "Accidents/Incident Reports: I. Will be completed by floor supervisor prior to the end of shift, but as quick as possible. Other reports that will be completed as necessary." The policy continues, "II. Administration will decide if an investigation needs to be started immediately or if it can wait to the next business working day."</p> <p style="text-align: center;">(A)</p> <p>300.610a) 300.1010h) 300.1210d)2) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the</p> | S9999 | | |

Illinois Department of Public Health

| | | | |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|--|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|--|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 15</p> <p>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.</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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: 2)All treatments and procedures shall be administered as ordered by the physician.</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 were not met as evidenced by:</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|---|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 16</p> <p>Based on interview and record review, the Facility failed to timely treat an abnormal laboratory result for anticoagulant (blood thinner) therapy for 1 of 3 residents (R2) reviewed for anticoagulant therapy in the sample of 16.</p> <p>This failure resulted in R2 being admitted to the hospital with Supratherapeutic INR (International Normalized Ratio) and Hematuria (blood in the urine).</p> <p>Findings include:</p> <p>R2's Health Status Note, dated 4/3/17 at 13:22 (1:22 PM), documents, "BRB (bright red blood) in toilet this a.m. no BM (bowel movement) present, appears to be coming from urine, no hemorrhoids observed. res (resident) does complain of pain when peri area touched. VSS (vital signs stable). afebrile. res has increased weakness and decreased appetite."</p> <p>R2's Order Note, dated 4/3/17 at 13:39 (1:39 PM), documents, in part, "fax returned for (Z4) regarding hematuria, new order for UA/CS (urinalysis /urine culture and sensitivity) and BMP (basic metabolic profile)."</p> <p>R2's Health Status Note, dated 4/4/17 at 11:22 (AM), documents, in part, "Had large amount dark red urine in toilet this AM faxed (Z4) up date and that U/A & C&S sent this AM spoke with daughter she requested that we send to local hospital. (Z4's) office notified, ambulance called transported to local hospital by stretcher left at 1010 (AM)."</p> <p>R2's Hospital Summary, dated 4/6/17, documents, in part, "Hospital Summary: I was in the hospital because : Blood in my urine The</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 |
|---|---|

| (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 |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 17</p> <p>medical name for this condition is: Supratherapeutic INR, Hematuria."</p> <p>R2's Lab Report, dated 3/2/17, documents on 3/2/17 at 3:07 AM, R2 had a Prottime and INR laboratory test collected. On 3/3/2017 at 9:00 AM, R2's Prottime and INR were resultued to the facility. This Lab Report has a handwritten note, dated 3/3/2017, documenting, "Called and faxed to (Z4, Physician)." This same Lab Report has another handwritten note, dated 3/24/17, documenting, "Refaxed D/T (due to) no MD (medical doctor) response please address Thanks (signed with initials). Is on Coumadin 3 mg (milligrams) Tue (Tuesday) - Sun (Sunday) and 4 mg on Mon (Monday)." This Lab Report has a third handwritten note, dated 3/24/17, documenting, "Change dose to 4 mg Sat (Saturday) & Sun (Sunday) and 3 mg M-F (Monday thru Friday) recheck INR in 2 weeks. (signed by Z4, Physician)."</p> <p>R2's Hospital INR result, dated 4/4/17, documents, "Prothrombin time >80.0 seconds HI (high) INR >9.5."</p> <p>On 4/10/17 at 9:05 AM, E2, Director Of Nurses (DON), stated, "Coumadin orders should be called to the doctors office. If no response in 2 days, the day nurse should follow up on it."</p> <p>On 4/11/17 at 11:45 AM, Z4, Physician, stated "(R2) has a history of high INR's, she fluctuates. I have theories, but I am not sure why she fluctuates, could be medication administration, diet, or weight gain or loss. This is the first time her INR was this high at a 9 though. I am talking with the family to see if the risks outweigh the benefits for R2's Coumadin use. I was unaware that the Prottime INR lab was from 3/2/17 when I</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007470 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | | (X3) DATE SURVEY COMPLETED C 04/13/2017 |
|---|--|---|---|--------------------|---|
| NAME OF PROVIDER OR SUPPLIER PLEASANT HILL VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST NORTH STREET GIRARD, IL 62640 | | |
| (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 | |
| S9999 | Continued From page 18 changed her Coumadin dose on 3/24/17. I would have never changed it. I would have immediately told them to recheck her labs before I changed anything. I address every lab that is faxed to my office before I leave for the day. If the facility did not hear from me within 24 hours, I expect them to call my office. This is a huge problem. You do not fax me, get no reply then hold a lab for 3 weeks, and then fax it to me again. This could have contributed to the high INR." The facility's undated PHYSICIAN FAILURE TO RETURN CALL OR DEAL WITH A RESIDENT PROBLEM POLICY documents, "Procedure: If an attending physician fails to return a call in a timely manner or refuses to deal with a resident problem, the Director of Nursing or his/her designee and/ or the Administrator is to be contacted. If this situation presents an emergency, the Medical Director may be contacted for further instructions." (B) | S9999 | | | |