FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED IL6009567 B. WING 11/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14792 CATLIN TILTON ROAD **GARDENVIEW MANOR** DANVILLE, IL 61834 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S 000 Initial Comments S 000 Complaint Investigation 2167998/IL139700 S9999! Final Observations S9999 Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) Section 300.610 Resident Care Policies 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 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 Attachment A accident, injury or change in condition at the time Statement of Licensure Violations

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of notification.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DA1	(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED						
		IL6009567	B. WING		11	C 11/05/2021						
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GARDENVIEW MANOR 14792 CATLIN TILTON ROAD												
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S9999	Continued From page 1		S9999									
	Nursing and Person b) The facility seare and services to practicable physical well-being of the reseach resident's complan. Adequate and care and personal coresident to meet the care needs of the resident to meet the care needs of the resident to mursing care shall in following and shall be seven-day-a-week be a) Objective a resident's conditionemotional changes, determining care resident's medical evaluation are sident's medical evaluation of the service of the resident's condition are sident's medical evaluation, of the service of timeline diarrhea, and severe affects one resident reviewed for timeline five residents. The condition are residents. The conditions are sidents.	shall provide the necessary of attain or maintain the highest of attain and psychological sident, in accordance with a properly supervised nursing are shall be provided to each of total nursing and personal esident.  Subsection (a), general esident, subsection (a), general esident, subsection (a), general esident, subsection and particular, as a means for analyzing and as a means for analyzing and quired and the need for unation and treatment shall be eff and recorded in the ecord.  The are not met as evidenced by:  and record review, the facility of and failed to provide timely care, and intervention when and failed to provide timely care, and intervention when a sample list of delay in treatment resulted in the elieved severe abdominal fore being sent to the hospital										

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: \_\_\_ C B. WING \_ IL6009567 11/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

GARDENVIEW MANOR			14792 CATLIN TILTON ROAD DANVILLE, IL 61834				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PR REGULATORY OR LSC IDENTIFYII	ECEDED BY FULL	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 2		S9999	ill			
	Findings Include:  R1's Physician's Order Summidocuments R1 was admitted to						
	9/23/21, and includes the followard of t	wing diagnoses: thy, Muscle ulty Walking. R1's ed 9/30/21,	y <b></b>				
	R1's Care Plan, updated 10/4/ "(R1) will be short term here in will be discharged to assisted	the facility. (R1)					
	Rt's progress notes documen	t the following:					
	On 9/30/21 at 11:47 PM, documents, "Diarretwo days. Denies being preser recent medication changes." In (anti-diarrheal) was ordered at	y V5, Nurse rhea present for nt on admission. No modium					
	ON 10/20/21 at 1:31 PM, by (Nurse (RN) documents, "(R1) episodes of emesis during shift severe upper abdominal pain. (V5) Nurse Practitioner (called no response at this time. (R1) a small portion of breakfast an (R1) is currently participating in and states she felt as if she is again." No vital signs or abdomestic patterns of the state of t	has had three it and complains of (V7) tried to notify and texted) with stated she only ate d felt nauseated. In therapy services going to throw up					
	are documented.	miai assessilietii(					
	On 10/21/21 at 1:29AM, docume bright green emesis x4 (four time the day. Took bedtime medical of water. Able to tolerate well.	mes) throughout tion with small sip					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING: \_\_ B. WING IL6009567 11/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14792 CATLIN TILTON ROAD GARDENVIEW MANOR DANVILLE, IL 61834 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 complain of left upper abdominal pain/stomachache. Stomach X-rays done. Results to follow: No abnormal calcifications are noted. No bowel obstruction, possible early fecal impaction." R1's X-ray report confirms a Kidney. Ureter, Bladder Xray (KUB) was done at the nursing home at 9:08PM, with the results as documented in the progress note. No vital signs or abdominal assessment are documented. On 10/21/21 at 8:37AM, by V7, Registered Nurse (RN), documents, "(R1) severe abdominal pain (R1) states the pain is more localized to the left side. (R1) describes it as aching and constant. (R1) states she feels as if she will throw up. PRN (as needed) Zofran (antinausea medication) administered by mouth (R1) refused breakfast and insulin coverage during shift. (V7) notified (V5) Nurse Practitioner. who ordered a onetime Dulcotax (laxative) suppository 10 Milligrams (V5) will be in to further assess (R1's) condition." No vital signs or abdominal assessment is documented. On 10/21/21 at 1:43PM, by (V6), Nurse Practitioner, documents, "This is a 77-year-old female, seen today lying in bed. She is not progressing with therapy; is not standing, walking, or transferring. She has also been acutely sick the last 2 days. She has increased weakness. nausea, vomiting, and acute abdominal pain. (R1) is crying with pain this AM and has had several episodes of green bile emesis since yesterday. Communication with medical: (R1) will be sent to the hospital for further evaluation." On 10/21/21 at 2:23PM, by V7, documents, "(R1) complains of severe abdominal pain that is constant. Abdomen is distended. Hyperactive

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bowel sounds are present in all four quadrants.

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6009567 11/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14792 CATLIN TILTON ROAD GARDENVIEW MANOR DANVILLE, IL 61834 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD) BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 4 S9999 (R1) describes it as aching and rates the pain 8/10. (R1) had two small emesis noted during shift. (R1) states she had a bowel movement yesterday and that her bowels have been moving okay. Notified (V5) Nurse Practitioner of (R1's) current condition. Suppository administered as ordered for one-time use. (V5) requested (R1) be sent out to hospital. (R1) wants to be sent out. Family notified." On 11/3/21 at 11:10AM, V11, Certified Nurse's Aide (CNA), stated, "I took care of (R1) quite a bit. She had a lot of diarrhea. It could be pretty explosive at times." On 11/3/21 at 11:30AM, V10, CNA, stated, "(R1) used to complain that her stomach hurt a lot and she wouldn't eat. That was pretty much all the time." On 11/2/21 at 10:54AM, V4, R1's family member. stated, "They told us at the hospital (R1) got there about three days too late. I just wish they would have sent her sooner." On 11/2/21 at 11:15AM, (V7), Registered Nurse (RN), stated, "On the day I sent (R1) to the hospital I was frustrated. (R1) just didn't look good. She had been complaining of severe abdominal pain for a day or two. I had tried to call (V5). Finally, I had even talked to (V5). (V5) said she would see (R1) when she came to the facility. I didn't think (R1) could wait so I asked (V6) the rehabilitation Nurse Practitioner to look at (R1). (V6) agreed (R1) was acutely ill and in severe pain and needed to go out. (V6) called (V5) and we finally got the order to send (R1) to the hospital. I felt terrible. (R1) was laying in her bed crying in pain." When asked what time (R1)

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actually went out (V7) stated, " think it was between 9:00AM and 10:00AM on 10/21/21. The last entries by (V6) and me were probably made

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