STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009831	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANSEA REHAB HEALTH CARE	1405 NORTH SECOND STREET SWANSEA, IL 62226

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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. These requirements were not met as evidenced by: Based on record review and interview, the facility	S9999		

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S9999	Continued From page 2 failed to assess and monitor a resident per physician's orders who tested positive for COVID-19 for 1 of 3 residents (R46) reviewed for a change in condition in the sample of 31. This failure resulted in a delay in treatment for R46 and R46's subsequent death. Findings include: R46's Quarterly Minimum Data Set (MDS) dated 5/24/2022 documents he was moderately cognitively impaired. R46's MDS also documents diagnoses include multiple sclerosis, cardiomyopathy, coronary artery disease, hyperlipidemia, vitamin B12 deficiency, vitamin D deficiency, anemia, anxiety, insomnia, cellulitis and urinary tract infection. R46's COVID test specimen was collected on 6/14/2022 and reported on 6/16/2022. The COVID test results documents R46 was positive. R46's Nurse's Notes, dated 6/13/2022 at 10:00 PM documents resident (R46) was moved to room (number) O2 (oxygen) intact 2 L (liters)/NC (Nasal Cannula) VS (vital signs) 98.6, 80, 18, 118/72 and 95% oxygen saturation with O2. CXR (chest x-ray) results rec'd (received): negative for acute cardiopulmonary disease. Res (resident) voiced no C/O (complaint of). R46's Nurse Practitioner Progress Note, dated 6/13/2022 documents reason for visit: nausea and fever. Resident is resting in bed; he appears weak and tired. He reports loss of appetite, nausea and fever. He states he has no desire to eat. Vital signs at 9:21 AM 90/60, 63, 18, 99.8. Notify provider of any acute changes or if oxygen at 2L falls below 90%.	S9999		

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S9999	Continued From page 3 R46's Nurse's Notes, dated 6/14/2022 at 3:00 AM documents VS 98.2, 84, 18, 118/68 and oxygen saturation 94% with oxygen on 2L/NC. R46's Nurse's Notes, dated 6/15/2022 at 11:00 AM documents patient seen by doctor. NO (new order) received faxed to pharmacy labs ordered. R46's Nurse Practitioner Progress Note, dated 6/15/2022 documents reason for visit: nausea and fever. Resident is resting in bed; he appears weak and tired. He reports loss of appetite, nausea and fever. He states he has no desire to eat. Vital signs at 9:52 PM 102/64, 62, 16, 97.8. Notify provider if symptoms persist or worsen. R46's Nurse's Notes, dated 6/17/2022 at 6:10 AM documents resident noted to be pale. Observed resident to not have pulse, respirations or blood pressure, verified with another nurse at this time. R46's Medication Administration Record (MAR), dated 6/2022 documents "vital signs every 4 hours with oxygen saturation." Staff initialed the resident's vital signs were assessed 6:00 AM - 6:00 PM one time on 6/14/2022 through 6/16/2022 and one time 6:00 PM - 6:00 AM on 6/13/2022, but no vital signs were documented. R46's Certificate of Death Worksheet documents R46 died on 6/17/2022 with cause of death being COVID-19. On 8/12/2022 at 2:55 PM, V2 (Regional Nurse) stated when a resident was assessed to have a change in respiratory condition, she expected full vital signs to be assessed which includes blood pressure, heart rate, respirations and oxygen saturation per the facility policy. She also expected staff to document if the resident was on	S9999		

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S9999	Continued From page 4 oxygen and if they were assessed to have labored breathing, shortness of breath and pain. V2 expected staff to follow physician's orders and to document vital signs in the resident's medical record. V2 reviewed R46's June 2022 POS and June 2022 MAR and stated staff should have assessed and documented his vital signs including oxygen saturation in his medical record every 4 hours instead initialing the MAR. V2 stated, a nurse should assess what his respiratory status was and what his oxygen saturation so the nurse would know if they should have notified the physician if the resident's oxygen saturation was below 90%. On 8/17/2022 at 8:50 AM, V47 (Nurse Practitioner) stated physician's orders for vital signs including oxygen saturation % every four hours are standard protocol for COVID positive patients. V47 said she would expect staff to assess and document the resident's vital signs including oxygen saturation % somewhere in his medical record. Staff documenting "vital signs every 4 hours" on the resident's 6/2022 MAR and initialing the box was not acceptable. V47 expected staff to document the resident's vital signs and oxygen saturation % so other staff can monitor how he is doing. A "magic cup" (high protein, high calorie supplement) was ordered because R46 was not eating well. V47 said she expected staff to document the resident's intake and output in his medical record. V47 expected staff to check on COVID positive residents every 1 - 2 hours to ensure the resident hasn't had a change in condition. V47 stated she expected staff to notify the resident's physician or nurse practitioner if the resident had a change in medical condition. V47 stated, if necessary, she would have ordered the resident (R46) to be transferred to the hospital for further evaluation	S9999		

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S9999	Continued From page 5 and treatment. If staff would have notified the resident's physician or nurse practitioner of a change in medical condition it could have affected the outcome of the resident health status. V47 stated, the lack of assessment and documentation of R46 does not show evidence that physician ordered monitoring of the COVID positive resident occurred. The facility's Notification for Change in Resident Condition or Status policy, revised 12/7/2017, documents the facility staff shall promptly notify appropriate individuals of changes in resident's medical condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been any symptom, sign or apparent discomfort that is: sudden in onset, a marked change (i.e., more severe) in relation to usual signs or symptoms, unrelieved by measures already prescribed. A significant change in the resident's physical condition. A need to transfer the resident to a hospital/treatment center. Onset of temperature of a temperature two degrees higher than baseline. (A) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	S9999		

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S9999	Continued From page 6 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. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide supervision to prevent falling for 1 of 2 residents (R34) reviewed for supervision in the sample of 31. This failure resulted in R34 falling and being sent to the Emergency Room (ER). R34 sustained a right acute femoral neck fracture.	S9999		

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S9999	Continued From page 7 Findings include: R34's Quarterly Minimum Data Set (MDS), dated 1/4/2022 documents R34 is cognitively impaired, uses no mobility devices, not steady, only able to stabilize with staff assistance for walking, moving on and off the toilet, surface to surface transfers and moving from seated to standing position. R34's MDS document R34 requires limited assistance of staff with one-person physical assist for transfers and walking. The MDS documents R34 is totally dependent with one-staff person physical assistance for toileting and personal hygiene. The MDS documents R34 has had no falls. R34's Fall Risk Assessment, dated 1/4/2022, documents R34 is at risk for falls. R34's Care Plan, documents R34 is a high fall risk without device, unsteady gait & needs staff assist to maintain balance. R34's Care Plan Goal documents R34 approaches uses 1 assist and gait belt for all ambulation. Use additional assist as needed when resident is not feeling well, feeling weak or dizzy. Observe for and educate on proper technique and use of device. Monitor resident for signs of fatigue during ambulation. Fall risk assessment quarterly and as needed with change in condition or fall status. Inform MD (physician) of any falls, including report of injuries. Request MD review of medications and conditions during nursing home visit especially after falls. Encourage resident to sit in areas well supervised by staff that also afford opportunity for increased socialization and distraction. Toilet per schedule and as needed when restless or agitated. Encourage resident to wear a brief during daytime hours to minimize risk of slipping	S9999		

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on wet floor during toileting. Encourage and assist placement of proper non-skid footwear. Observe for non-verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended.

R34's Nurse's Note dated 2/5/2022 at 4:30 PM documents "This nurse was called to patient room, stated pt was walking from bathroom lost balance fell to floor. This nurse observed pt in sitting position on floor. Pt able to perform ROM (range of motion) without difficulty. Pt was able to stand without discomfort. Assisted to bed. Placed call to on call MD (physician) awaiting return call. 5:00 PM on call MD call back new order x-ray to right hip (2 views.) Call to x-ray company made aware of new x-ray orders. Will send next available technician."

R34's Physician's Order Sheet (POS) dated 2/5/2022 documents "STAT (immediately) x-ray of right hip (2 views) T.O. (telephone order) from physician. No scheduled or when necessary (PRN) pain medication ordered."

R34's Nurse's Notes dated 2/5/2022 at 6:15 PM X-ray company here to complete x-rays.

R34's X-Ray Patient Report, dated 2/5/2022 documents reason for x-ray: pain, s/p (status post) fall, limited ROM (range of motion), difficulty with ambulation. Clinical indication: pain. Findings: acute femoral neck fracture noted.

R34's Nurse's Notes dated 2/5/2022 at 10:30 PM documents result of x-ray of right hip shows sacute hip fx (fracture.) Resident complaint of pain, Tylenol given. Doctor gave orders to send resident to hospital for tx (treatment) and eval (evaluation.) Family called with message left on

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machine after no answer. Ambulance called for transport. Vital signs documented.

R34's POS, dated 2/5/2022, documents send to ER (emergency room) R/T (related to) hip fracture.

R34's Incident Report Form - IDPH Notification, dated 2/6/2022 documents alleged fall with injury. X-ray obtained and revealed right acute femoral neck fracture. Investigation initiated. Final report will be sent. Res was hospitalized on 2/5/2022 at 10:40 PM. Physician notified 2/5/2022 at 5:00 PM and family notified on 2/6/2022 at 6:30 AM.

On 8/16/2022 at 9:45 AM, V16, Certified Nurse's Aide (CNA) stated R34's ambulates with a gait belt because her gait is unsteady.

On 8/16/2022 at 9:50 AM, V35, CNA, stated R34 has good and bad walking days. Some days she (R34) is steady and other days she is unsteady on her feet. V35 stated, on R34's unsteady walking days she needs more staff assistance when up walking, usually one staff with a gait belt.

On 8/16/2022 at 2:15 PM, V27, CNA, stated she was assigned to R34 on 2/5/2022. She went to get R34 up for supper and assisted R34 to ambulate to the bathroom. V27 stated she always ambulated with R34 because R34 had an unsteady gait. V27 stated, while R34 was in the bathroom V27 left the room to get a washcloth and returned within 30 seconds. V27 stated R34 was on the floor. V27 reported incident to the nurse (name unknown.) V27 stated she knew not to leave R34 on the toilet by herself, but she was going to be right back. V27 stated she told the nurse she (V27) was in the room when the resident (R34) fell because she didn't want to get

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S9999	Continued From page 10 in trouble. On 8/16/2022 at 12:02 PM, V2 (Regional Nurse), stated she expected staff to ambulate with residents that need assistance. V2 stated, when a resident is weak, she expects staff to ambulate the resident with a gait belt and 1-2 staff. V2 stated she didn't have additional information specific to the fall or injury R34 sustained. V2 stated she expected the resident's care plan to be updated with how they transfer. The Facility's Fall Prevention Policy, revised 11/10/2018 documents "To provide for resident safety and to minimize injuries related to falls, decrease fall and still honor each resident's wishes/desires for maximum independence and mobility. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting any new interventions will be written on the care plan." (A)	S9999		