STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145611	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JAMES WELLNESS REHAB VILLAS	**1251 EAST RICHTON ROAD CRETE, IL 60417**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify residents' representatives for significant changes in condition. This applies to 2 of 3 residents (R1 and R2) reviewed for changes in condition. The Findings Include: 1). The Face Sheet says R1 was admitted on [DATE] with the following diagnosis' [MEDICAL CONDITION], Ataxia, Altered mental status, [MEDICAL CONDITION], dementia, hypertension, dysphagia, difficulty in walking, hyperlipdemia and weakness. Progress Note dated 4/5/20 at 12:15AM says R1 noted with elevated temperature of 101.8, MD notified, orders received for [MEDICATION NAME] 500 mg daily for 10 days. CXR and CBC, orders carried out. Called X- Ray and place the order for CXR. Progress Note dated 4/5/20 at 8:23AM says. R1 noted in bed. Skin warm and dry to touch. Respirations even and non-labored. One assist with eating. Temp remains elevated and awaiting chest x-ray. Progress Note dated 4/5/20 at 10:15AM says, X- ray called and chest x-ray upgraded to STAT. Progress Note dated 4/5/20 at 10:58AM says R1 noted with altered mental status changes from baseline. Unable to recognize face or location. R1 noted with left facial drooping and blood pressure dropping. 911 called and O2 applied with saturation improving on 5L of .9NSS initiated in left arm. MD notified of assessment and wife notified of assessment. Progress Note dated 4/5/20 at 11:05AM says, 911 team here and resident transferred to hospital. Wife notified of assessment and transfer. Hospital ER report given. There is no documentation of R1's family/representative being made aware of R1's initial change in condition that started at 12:15AM, R1's family was made aware 10 hours later of the need to be transferred to the hospital. On 8/11/20 at 9:35AM, V2(Director of Nursing) said I worked as a nurse for R1 on 4/5/20. V2 said she notified family about sending R1 to the hospital when R1's condition declined. According to the Progress Note this was at 10:58AM on April 5, 2020. On 8/11/20 at 12:34PM, V8 (Nurse) said I remember working with R1 in April when he spiked a temperature at about 12 am in the morning. The aide took the temp it was high so I re-took it and it was high. I called the doctor and the doctor ordered antibiotics, labs and a chest x-ray. The other vitals were good. I gave Tylenol, he was doing ok. I called radiology for the chest-x ray and then I called the family but no one answered. I thought I documented it. I did not put it in an addendum. The Director of Nursing V2 took over for me and I told her to keep an eye on R1. I always document, I thought I documented family notification. I was working my usual shift the night shift. V8 had no response when asked if she endorsed to V2(Director of Nursing) to call the family about the change in condition or put an addendum response in later for family notification. On 8/6/20 at 3:55PM, V14(Family of R1) said They did not let us know what was going on, we could not visit due to the pandemic and they did not let us know about R1's condition. On 8/11/2020 at 4:27PM, V14 said we did not know anything about a fever; at about 10 am on 4/5/20 we got a call about transferring R1 to the hospital. We gave multiple numbers for us to be contacted about R1's condition. The Facility's Policy titled Notification of Resident Change in Condition Policy effective date of 11/2016 says, A Licensed nurse shall promptly inform the resident, consults with the resident's physician and if known, notify the resident's legal representative or an interested family member of: A significant change in the residents physical, mental or psychosocial status, deterioration In health, mental, or psychosocial status in either life threatening conditions or clinical complication and a need to alter treatment significantly. 2). The Face Sheet says R2 was initially admitted on [DATE] and re-admitted on [DATE] with the following pertinent diagnosis' Acute Respiratory disease, Covid-19 and [MEDICAL CONDITION] pneumonia. On 8/5/20 at 12:40PM, R2 was laying in bed. On 8/7/20 at 9:30AM, R2 was sitting up in an adult recliner. R2's Progress Notes were reviewed from 2/1/20 to 8/4/20. Summarized R2 had a change in condition on 4/17/2020 was seen by a health care provider with orders for labs and a chest x-ray. The chest x - ray was positive for Pneumonia, the medical doctor was notified and started R2 on antibiotics, the family was also notified. R2 was treated from 4/19 to 4/29 with antibiotics for pneumonia according to the MedicationAdministration Record. On 5/7/20 R2 was seen by the health care provider again for exposure to Corona-virus and was ordered [MEDICATION NAME] 500 mg daily for 5 days, [MEDICATION NAME] 200 mg a day times 14 days and Vitamin C 500 mg daily times 14 days. The Progress Notes show that R1 was sent out to the hospital on [DATE] for a change in condition and tested positive for Covid-19 while at the hospital. On 8/11/20 at 12:10PM, V9 (Nurse Practitioner) said she is the NP assigned to R2. V9 said she saw R2 again on 5/7/20 and placed R2 on isolation for exposure to Coronovirus, I do not recall if she had it at the time but she was placed on the latest cocktail for Covid-19 which was [MEDICATION NAME], Doxycline and vitamin C. I never communicated with the family about R2. There was no documentation that family was notified of Corona-virus or this treatment that started on 5/7/2020. On 8/12/2020 at 2:22PM, V2 (DON) said there is no documentation for family notification for R2 on 5/7/20 when she was placed on a medication cocktail for Covid-19.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE