STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER AT CENTER GROVE	6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow Physician order [REDACTED]. Finding include: R11's Physician order [REDACTED]. R11's Nurses Note, dated 1/23/2020 at 7:45 PM, written by V8 Licensed Practical Nurse, (LPN), documents, resident observed with increased tiredness and c/o, (complaint of), overall not feeling well Resident is currently on 40 mg, (milligram), [MEDICATION NAME], daily with no K (Potassium), supplement. Upon further investigation resident observed to have labs last drawn on 12/30/2019 with K of 3.2. VS, (vital signs), SpO2, (oxygen saturation), 95% on 3 liters, T, (temperature), 97.7, R (respirations), 16, BP, (blood pressure), 98/50 Heart Rate 66. R11's Nurses Note, dated 1/23/2020 at 7:50 PM, written by V8, documents, (V4, Physician) notified of residents complaint and nurse observation and last lab results and current medications regarding electrolytes levels. R11's Nurses Note, dated 1/23/20 at 7:54 PM, written by V8, documents, New order received from, (V4), to check BMP, (Basic Metabolic Profile), in the morning. R11's Nurses Note, dated 1/25/20 at 3:00 AM, written by V15, Registered Nurse, (RN), documents, Lab values noted, Glucose 544, no hx, (history), of Diabetes, not on steroids or [MEDICAL CONDITION]. Blood glucose check done reading HI. Mediprocity called for (V4)/V13's Nurse Practitioner (NP), waiting call back. R11's Nurses Note, dated 1/26/2020, documents, Resident asleep at start of shift, arousable and communicating during rounds. BS, (blood sugar), checked this all due to change in status and unarousable, BS 427, 911 is called for her to be sent out for eval, (evaluation). On call DR, (Doctor), made aware EMS, (Emergency Medical Services), arrived at 7:00 AM and exited at 7:10 AM, called back at 7:20 AM and stated resident coded in ambulance and her Advanced Directives of DNR (Do Not Resuscitate). R11's Nurses Note, dated 1/26/20 at 7:20 AM, written by V15 RN, documents, Late note for 6 AM 1/26 (should be 1/25): Report given to (V14 Licensed Practical Nurse, (LPN)) awaiting response from (V13 NP). R11's Nurse Note, dated 2/26/2020 at 10 PM, written by V5 RN, documents, late note for 3:45 PM on 1/24/2020. Call answered by this nurse from lab on critical glucose level of 544. Medoprocity sent to (V4) with results. No history of diabetes, not taking any steroids. Resident has been up to eat all meals, responds appropriately to questions, assists in ADL's, (Activity of Daily Living), not currently in any distress. Waiting on follow up on how he wishes to proceed or any new orders. Will closely monitor resident. R11's Physician Order, dated 1/26/2020, documents, Regular [MED] [MED] 10 units SQ, (subcutaneous), now x 1 blood glucose check in one hour, [MEDICATION NAME] 10 units SQ now x 1. R11's Certificate of Death Worksheet, dated January 30,2020, documents, 'date of death ; January 26,2020. Cause of Death: a. Cardiopulmonary Arrest. b. [MEDICAL CONDITION] Part II. Enter other significant conditions contributing to death but, not resulting in the underlying cause given in Part I. [MEDICAL CONDITIONS] Arthritis, [MEDICAL CONDITION], hypertension. Manner of Death: Natural. On 2/27/2020 at 12:05 PM, V1 Administrator, stated, that she has investigated this issue, and this is what I can tell you. On 1/24/2020 at 3:45 PM, (V4), was texted about the lab, the nurse got no response. On 1/24/2020 evening shift, (V16) worked with (R11) and stated, nothing was abnormal it was a normal evening. (V15), told me, on 1/25/2020 at 3 AM, (V15) sees the lab report on the desk, no documentation, it had been reported, she texts out to (V13 NP). Between 3 and 6 AM V15 stated, she got a response from V13 ordering [MEDICATION NAME] 10 units, V15 questions this order asking if V13 meant 10 units of Regular [MED]. V15 stated, she never got an answer back, so the day nurse, (V14 LPN), is told that we are waiting for clarification. V14 stated, (R11) is still fine. (V17 LPN) told me on 1/26/2020 at midnight, (R11) is arousable. V15 stated, she was in the building and came over to follow up on (R11), see what was done and noticed nothing had been followed up on. (V15) told me she texted out to V13 and gets an order to give 10 units of Regular and 10 units of [MEDICATION NAME], this was done a 6:20 AM. Then (R11) started, going down and decided to send her out. On 3/03/2020 at 9:08 AM, V5 RN, stated, I got the call about the critical lab, (blood sugar 544). I called (V4), he said to do BID, (twice a day), blood sugars. (V16 LPN), said she would do the order. She was sitting with me and heard the order it was change of shift. I went down and talked to (R11) about it. She was acting normal. She was alert and orientated as typical, nothing out of the ordinary. I do not remember if I got a blood sugar on her. I did not work with her after that. On 3/04/2020 at 10:13 AM, V14 LPN, stated, The night nurse (V15), did tell me to follow up with, (V13 NP) related to the [MED] order on the morning of 1/25/2020. I must have forgot. (R11) did not show any signs of [MEDICAL CONDITION]. She was alert, no vomiting and at breakfast that morning. Nothing out of the ordinary that shift. I did not get a blood sugar. On 3/04/2020 at 10:40 AM, V4 Physician, stated, that we do our communicating through Mediprocity it is an encrypted text messaging system. On 1/24/2020 at 3:22 PM, I was told about the high blood glucose and I told them to check her blood sugars twice a day. The next Mediprocity text was on 1/25/20 at 4:17 AM, it stated lab glucose was 544 and a blood glucose was reading HI. This message was answered by V13 NP. V13 ordered to give 10 units of Regular [MED] and 10 units of [MEDICATION NAME], (long acting), [MED] and she ordered a Hemoglobin A1c (glycated hemoglobin). The nurse questioned the order via Mediprocity and V13 answered to give the 10 units of Regular [MED] and [MEDICATION NAME]. This [MED] order was never carried out until 1/26/2020 at 6:55 AM. That would be when the nurse looked at the order in Mediprocity. The [MEDICATION NAME] and Regular [MED] were given and then she was sent out. There is no harm that the order was 24 hours old because, her sugar at that time was 427. This is the problem with Mediprocity, the nurses must look for the response it doesn't show up that you have a response. (R11) was on a slow decline. She was a lady with no history of diabetes with an elevated blood sugar. I don't think giving the [MED] earlier would have changed the outcome, because there was an underlying severe health process occurring. She had no abdominal pain and no symptoms of Pancreatitis. However, the staff should have a better communication process for follow up. For the blood sugars, the nurse should have carried out the orders to check the blood sugars. On 3/04/2020 at 12:57 PM, V1 stated, When a Doctor gives an order, the nurse should carry it out. The next working day the clinical team reviews the order. I would expect the off going nurse to follow up on orders that need clarified. On 3/04/2020 at 2:25 PM, V17 LPN, stated, I got in report that she was tired and had been in bed. I work the night shift she was arousable at midnight. She refused her medications. She spit them out. When I went in in the morning she was moaning and unarousable. I went to the Supervisor, (V15), she said, get a finger stick. I did I think it was 471. (V15) asked Did she get 10 units of [MED] earlier today (1/25/2020). I looked in her chart and said no nothing is in the chart. (V15) said OK I will take it up with the day nurse (V14). (V14) said, she didn't know what (V15) was talking about. The answer about what [MED] orders came in during the dayshift on 1/25/2020. (V11 LPN) who was taking over the set said I will give it and recheck her in an hour. I realized that we were beyond the point of that and I am going to 911 her out. I was too busy, getting her paperwork and vital signs. I think V11 gave her the [MED]. The EMT's came, she was still unarousable, she coded in the ambulance. The EMT's came back in and told me, they never left the parking lot. On 3/04/2020 at 3:35 PM, V4 stated, that the fact the [MED] was given, while she was unarousable does not change his opinion that the [MED] had nothing to do with her death. During this investigation, attempts were made to contact V15 and V16 without success. On 3/04/2010 at 4:00 PM, V1 stated, We do not have a policy and procedure for

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) entering orders. It's just a process of doing them.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to provide incontinent care timely and completely for 3 of 3 residents (R1, R3, R13) reviewed for incontinence in the sample of 13. Findings include: 1. R1's Admission Record, print date of 03/04/20, documents R1 has [DIAGNOSES REDACTED]. This MDS also documents R1 is always incontinent of urine. R1's Care Plan, dated 01/09/20, documents, Problem: (R1) is always incontinent. Intervention: Check for incontinence; change if wet/soiled. Use pre-moistened wipes for cleaning. On 02/27/20 at 10:05 AM, V18 Certified Nursing Assistant, (CNA), and V19 Registered Nurse, (RN), provided incontinent care for R1. R1 incontinent brief was removed. The brief was wet with urine. V18 cleansed the right and left groin, the pubic area, the labia, the rectal area and then the right and left gluteal folds. V18 failed to cleanse the buttocks or the inner thighs. On 02/27/20 at 2:00 PM V18 was questioned about why she did not cleanse R1's buttocks, V18 stated, I did. V18 was told she just cleansed the gluteal folds not the buttocks, V18 stated, Oh I gotcha. 2. R3's Admission Record, print date of 3/4/20, documents R3 has [DIAGNOSES REDACTED]. R3's MDS, dated [DATE], documents R3 is severely cognitively impaired and is dependant on one staff member for toileting and hygiene. This MDS documents R3 is always incontinent of urine. On 02/27/20 at 1:05 PM, V20, CNA and V21, CNA, provided incontinent care for R3. Her incontinent brief was wet with urine, V20 cleansed the right and left groin area, the pubic area, the labia, the rectal area and then the right and left gluteal folds and the left buttocks. V20 failed to cleanse the right buttocks. 3. R13's Admission Record, print date of 03/04/20, documents R13 has [DIAGNOSES REDACTED]. Requires extensive assist of one staff member for hygiene. The MDS, (Minimum Data Set), also documents that R13 is always, incontinent of urine. On 02/26/20 at 1:10 PM, V22 and V23 both, CNA's, provided incontinent care for R13. Her pants were wet with urine, R12's pants were removed. R12 had on 2 incontinent briefs, one over the other, both were saturated with urine. There was a small amount of feces in the brief, closest to her skin. V23 cleansed the rectal area, rolled R13 over and cleansed the left and right groin area. V23 did not cleanse the pubic area, labia, meatus, inner thighs or buttocks. On 02/26/20 at 1:15 PM, V22 and V23 both stated, they did not put the 2 incontinent briefs on R13, and they do not know when she was changed last. On 03/04/20 at 10:40 AM, V1 Administrator, stated, Two incontinent briefs are not allowed. Staff should be cleansing everything that comes in contact with urine. The facility policy and procedure, dated 06/11/2008, documents, Cleanse the female resident with pre-moistened wipe(s), using a front to back motion. Spread the labia, wipe on one side, then the other, then the middle-wiping from pubic area toward perineum. Cleanse the buttocks, hips, and thighs as necessary to remove all urine or feces.