

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W 331	Continued From page 12 illness; however they do not always document readings for her review. E2 confirmed that R3 has diabetes and is currently controlled through medication (Diabeta 5mg daily) & diet. E2 stated that R3 has not had issues related to low blood sugar until she was admitted to the ER on 10/15/09. E2 confirmed that facility was unable to produce any blood sugar readings during R3's illness to ensure her blood sugar reading were not abnormal. E2 confirmed that R3 was prescribed Promethazine 25mg tab for nausea on 10/7/09. In addition E2 confirmed that she was not notified that R3 was administered 13 doses of the Promethazine 25mg from 10/8/09-10/13/09. E2 stated she was contacted several times during the 10/8/09-10/13/09 time period concerning staff administering the medication; however was unable to recall dates and time periods of the medication administration. E2 confirmed she had not assessed R3 for responses and/or effects from the medication.	W 331			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1210b) 350.1230d)1)2) 350.1610b) 350.3240a) 350.3750 Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 13</p> <p>involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:</p> <p>b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents.</p> <p>Section 350.1610 Resident Record Requirements</p> <p>b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.</p> <p>Section 350.3240 Abuse and Neglect</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 14</p> <p>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>Section 350.3750 Consultation Services and Nursing Services</p> <p>Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview the facility failed to:</p> <p>1) Ensure that nursing staff thoroughly assess and identify the early signs of dehydration, low blood pressure and low blood sugar for 1 of 1 client (R3) admitted to the hospital since 11/24/09.</p> <p>2) Ensure that staff document an accurate record of fluid/solid food intake, blood pressure, blood sugar and temperature for 1 of 1 client (R3) who was transported to the hospital emergency room</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 15 and placed in the Intensive Care Unit.</p> <p>Findings include:</p> <p>R3, per her "Individual Profile General Data Sheet," no date stated, has a diagnosis of "Severe Mental Retardation, Seizure Disorder, Dystonia, Diabetes Mellitus, Chronic Ear Infection, Beginning Dementia & Hypertriglycemia." R3's DOB is stated as 01/07/60 and she has a family member as guardian. R3's Individual Service Plan (ISP) dated 3/20/09 stated that R3 functions in the Profound range of Mental Retardation. In addition the ISP stated that R3 receives Dilantin 500mg daily to address her seizure disorder and Glyburide 5mg daily to control her diabetes. "Medical History-R3's diabetes appears to be stable. Finger stick test given periodically have resulted in normal results." In addition it was reviewed that R3 has a 2000 calorie/no concentrated sweet diet to address her diabetes.</p> <p>Review of faxed copy "Change of Condition" dated 10/16/09 sent to IDPH. "Re: Change of Condition-On 10/15/09, R3 was admitted to local hospital per her physician's order for a diagnosis of bladder infection. The facility will follow all physician orders upon her return."</p> <p>Review of the hospital ER intake/admission documents dated 10/15/09 at 9:36 PM includes the following information concerning R3. "Admitting Diagnosis:Dehydration/Gastroenteritis/Pneumonia/UTI: The patient (R3) apparently has been ill off and on for 2 weeks with episodes of vomiting. For the last three days, apparently there has been</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 16</p> <p>increased vomiting and development of lethargy on the day of admission with a significant change in mental status. R3 was brought by her attendant into the office at which time her vitals signs were very abnormal with a temperature of 102.5; with a blood pressure systolic was 58, pulse 140. She appeared very acutely ill and in shock. The patient was sent to the ER immediately by ambulance, given IV fluids, 2L rapidly with mild improvement. Evaluation in the ER revealed evidence of a right lower lobe infiltrate in her lung and also a urinary tract infection. The blood pressure remained of low normal and she was admitted to the intensive care unit with a working diagnosis of septic shock and dehydration."</p> <p>"Physical Examination: Vital Signs: The patient is obtunded and now minimally responsive. The blood pressure is 58 systolic. Respirations are 24. Temperature 102.5. Heent: Her color is very poor and the oral mucosa is very dry otherwise, ENT examination not assessed. Heart: Has a tachycardiac rhythm. Lungs: Auscultate with poor breath sounds throughout due to poor respiratory effort. No definite rales or rhonchi. Extremities: Mottled. Admitting Diagnosis: 1. Septic Shock. 2. dehydration. 3. Cardiomyopathy. 4. E. coli sepsis 5. Right nephrolithiasis causing E. coli sepsis. 6. Chronic ear infection status post bilateral PE tubes. 7. Hypertriglyceridemia.</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 17</p> <p>Procedures: Included right ureteral stent placement."</p> <p>"Hospital Course: The patient was admitted to ICU, started on IV fluids, pressors and broad-spectrum antibiotics. Diabetes was controlled with a sliding scale insulin and oral medications.</p> <p>Cultures grew E. coli both urine and blood. Right ureteral stent was placed for nephrolithithiasis presumed focus of infection."</p> <p>Requesting Physician-Consultation: States-"R3 was placed on non-rebreathing mask. R3 had a Diabetes stick monitored at the scene, which was 164. The IV fluids were started on route to the ER. Upon arrival into the ER, it was noted that her blood pressure remained very low, she remained very tachycardiac. R3's blood pressure was 77/43. She was extremely weak and intubated and very lethargic. Further evaluation in the ER included chemistry evaluation; sodium was 150, potassium of 3.2, chloride was 115, CO2 of 23, BUN was 43, creatinine of 2.1, blood sugar was 44, calcium was 9.5, CBC revealed a white count of 4000, hemoglobin of 9.7, platelet count was 99,000 with 74% neutrophils and 4% bands.</p> <p>Urinalysis revealed a very cloudy urine with trace occult blood, negative for ketones and protein and glucose, positive nitrates, positive leukocyte esterase was noted.</p> <p>The patient had a chest x-ray done in the ER, which appeared to have possibly a lingular infiltrate.</p> <p>R3 was started on dopamine in order to support her blood pressure. R3 was also given several amps of Dextrose 50 in an effort to improve her blood sugars. R3 was given a dose of Levaquin</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 18</p> <p>750mg. R3 was admitted to the ICU and she was on 10 mics of dopamine with fluids running at about 150cc an hour and Accu-Checks continued to reveal low blood sugars. R3 was administered Dextrose 50 according to the hypoglycemia protocol. Vancomycin was also added to her antibiotic regimen.</p> <p>Impression:</p> <ol style="list-style-type: none"> 1. Sepsis secondary to urinary tract infection. 2. Possible viral gastroenteritis. 3. Non anion gap metabolic acidosis. 4. Severe dehydration. 5. Hypotension secondary to sepsis on pressors. 6. Acute renal insufficiency, possible prerenal azotemia from severe dehydration. 7. Anemia. 8. Thrombocytopenia. 9. Mild rhabdomyolysis. 10. Hypokalemia secondary to diarrhea and vomiting. <p>Recommendations:</p> <ol style="list-style-type: none"> 1. At this point will continue IV fluids with D5 normal saline. 2. Will continue Accu-checks q. 2 hours to ensure that her blood sugars have stabilized. 3. Continue antibiotics with Levaquin and also Vancomycin. 4. Blood cultures and Urine cultures-pending. 5. Will repeat electrolytes. 6. Titrate had dopamine for systolic blood pressure greater than of equal to 90mm Hg. 7. Check CAT scan of the chest and abdomen. <p>Laboratory Impression:</p> <ol style="list-style-type: none"> 1. Acute renal failure. 2. Urosepsis shock. 	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 19</p> <p>3. Dehydration. 4. Cardiomyopathy/congestive heart failure. 5. Right ureteropelvic obstructing stone. 6. Right mild to moderate hydronephrosis. 7. Leukopenia. 8. Thrombocytopenia. 9. Diabetes."</p> <p>Review of facility "Quality Assurance Meeting Notes," no date, stated: "R3 remained home on 9/29/09; throwing up-not feeling well; placed on clear liquid diet."</p> <p>Review of facility "Progress Notes" dated 10/7/09 (no time stated) authored by E3 (Direct Support Staff-DSP). "R3 is home from workshop because of vomiting. I called R3's doctor's office because although several residents had thrown up for a couple of days and are now well and attending workshop, R3's flu like symptoms are still present. I asked the doctor's nurse if R3 should come in for a visit and the nurse asked if R3 had a temperature; which R3 had a regular temperature. The nurse informed E3 that she would consult the doctor and call back. The nurse called back and let E3 know that the doctor would like R3 to try an anti-nausea medication before coming in."</p> <p>Review of facility "Progress Notes" dated 10/7/09 (no time stated) authored by E2 (Registered Nurse-Consultant): "Contacted by E3 (DSP) to inform R3 having some episodic n/v. The doctor had been contacted and new order received for Coripazine (medication for nausea) 10/8/09 (no time stated) Visit made to facility. R3 up to sofa in living room area. No distress noted. R3 remained alert; no vomiting and none reported per staff this evening. Staff encouraged</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 20</p> <p>to call nurse if vomiting returns or worsens. Staff voice understanding & agreement & plan."</p> <p>Review of facility "Progress Notes" dated 10/14/09 (no time stated) authored by E3. "As of today R3 is still showing flu-like symptoms such as lethargy and dry-heaving/vomiting as told to us via a phone call from the day training provider. Although this anti-nausea medication R3 has been taking helped for a few days and her symptoms and illness seemed to go away, R3 is now showing the symptoms again. Considering R3 has been on the medication for several days and now the symptoms are back and I have scheduled an appointment with her doctor for 10/16/09 @ 10:45AM."</p> <p>Review of facility "Progress Notes" dated 10/15/09 (no time stated) authored by E3 (DSP). "On 10/15/09 R3 was brought home from workshop @ 1:30PM with a temperature of 102.5. R3 was shaking and pale. I called her doctor at 1:35PM and asked if she needed to be seen sooner than her appointment time tomorrow 10/16/09 @ 10:15PM. I told the nurse that now on top of her existing symptoms for which she was to be seen tomorrow (10/16/09)-nausea, dry heaving, etc. R3 now has a fever. The nurse asked if she could be brought in to be seen by the doctor at 3:00PM."</p> <p>Review of facility "Progress Notes" dated 10/15/09 (3:00PM) authored by E4 (DSP). "Team Leader E4 took R3 to her physician, because E3 had to pick up R3 from workshop due to R3 having a temperature of 102.5. The physician requested that an ambulance be called and R3 be looked at by a Physician at the local hospital. At approximately 4:06PM R3 was put on the</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 21 ambulance, R3 made it to the ER at approximately 4:16PM."</p> <p>Review of facility "Progress Notes" dated 10/15/09 (4:20PM) authored by E5 (DSP). "At approximately 4:20PM I arrived at the hospital where R3 was still in the ER. At that time they had only informed us that R3 was in shock and her blood pressure was very low. They also said R3 was severely dehydrated. They started R3 on a liter of fluids. Around 5:00PM they drew blood and got a urine sample for testing. About a half hour later they came back and said her blood sugar was 44, so they gave her some medicine and a popsicle. They also replaced her fluids with another liter. At approximately 6:00PM they gave R3 a liter of fluid with sugar in it to help her raise her blood sugar. R3's blood pressure was not going up on her own, so they also gave her another IV with medication to raise her blood pressure. At 7:15PM they came back with the results from R3's tests and stated she had pneumonia. R3 also had gone in shock caused by a severe bladder infection and it had become septic."</p> <p>Review of facility "Progress Notes" dated 9/30/09 (no time stated) authored by E2 (RN). "9/30/09-quarterly assessment completed. Vital signs-122/80; 20; 80; weight #157." There was no note concerning 9/29/09 entry concerning illness and resulting in a clear liquid diet. The "Quarterly History of Illness, Operation, Injury" section stated "None."</p> <p>Review of facility "Acceptance Of The Diet" sheet dated 10/12/09-11/2/09 (no times stated) for R3. It was reviewed that there was documentation from 10/12/09-10/15/09.</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 22</p> <p>The 10/12/09 dinner section notes R3 receiving "broth, crackers, juice and clear liquids." The 10/13/09 dinner section notes-milk. The 10/14/09 dinner section notes-broth, crackers, juice and clear liquids. The 10/15/09 breakfast section notes-juice and toast.</p> <p>There was no evidence of amounts of liquid/solid consumption on the "Acceptance Of The Diet" sheet for entries made from 10/12/09-10/15/09. There was no reproducible evidence of food/liquid consumption from 9/29/09-10/11/09. In addition there was no evidence of meal/liquid consumption at the day training provider from 9/29/09-10/16/09.</p> <p>Review of "Nursing Services policy no. 7.02 revised 11/08." "The facility shall provide services necessary to meet individual's needs and to comply with licensing standards. All individuals shall receive proper treatment of minor accidents and/or illnesses through the R.N. Consultant. Purpose: To provide quality health care 24-hours per day to individuals in need. Procedure: The RN Consultant, licensed in Illinois, shall provide care for minor illnesses, injuries and emergencies and provide health care information for Individual Service Plan for each individual in the facility. The following procedures shall be used to report minor illnesses or injuries to the RN Consultant. a. DSP observes, or individual approaches DSP with a minor illness or injury. b. DSP relays the symptoms to the RN Consultant via telephone, if immediate need or in writing and documents on a Progress Note (GP-15) when appropriate. c. RN Consultant shall make a decision based on</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 23</p> <p>given information and the DSP shall document RN's responses.</p> <p>d. If the individual requests a PRN medication from the standing orders, the DSP shall document the date and time the individual took the medication, as well as the response or effects in the appropriate area on the Medication Administration Record (MAR).</p> <p>e. Follow-up shall be carried out by the RN Consultant within 48 hours, or immediately when necessary.</p> <p>f. The PRN medication program will be reviewed with the individual each time he/she takes the medication.</p> <p>i. If symptoms worsen at any point, the RN Consultant shall be notified for further instruction/follow-up."</p> <p>Review of the MAR for 10/09 it was reviewed that R3 received "Promethazine Tab 25mg (Take 1 tablet by mouth every 4-6 hours as needed for Nausea)."</p> <p>10/8-7:00(no indicator of AM/PM). 10/8-8:30PM 10/9-6:00AM 10/10-6:00AM 10/11-6:00AM 10/11-8:30PM 10/12-6:00AM 10/13-4:00PM 10/13-9:00PM 10/14-6:00AM 10/14-4:00PM 10/14-8:30PM 10/15-6:00AM</p> <p>There was no additional information contained in the 10/09 MAR for any responses and/or effects of the Promethazine 5mg tab. In addition there</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 24</p> <p>was no information concerning contacting the RN Consultant within 48 hours of consuming the medication. There was no documented consultation with the RN Consultant as recorded on a "progress note-(GP-15)" for R3's "flu-like symptoms such as lethargy and dry-heaving/vomiting" on 10/14/09 and R3's return from workshop on 10/15/09 with a temperature of 102.5 that resulted in admission into the local ER and then placement into the ICU for admitting diagnoses of E. coli sepsis (Right nephrolithiasis causing E. coli sepsis), Pneumonia, gastroenteritis, UTI, low blood pressure and dehydration.</p> <p>Interview with E1 (Admin) on 11/3/09 at 10:30AM. E1 confirmed that R3 had an extended illness from 9/29/09-10/15/09. E1 stated that R3 had received a clear liquid diet on several occasions and there was documentation available for the time periods of 10/12/09-10/15/09. However the documentation did not contain specific information concerning specific quantities of food and liquid measurements during the illness. E1 confirmed that staff failed to document R3's diet from 9/29/09-10/12/09, and that staff failed to document R3's temperature reading during her illness from 9/29/09-10/15/09. In addition there was no documentation to address staff assessing R3's above normal temperature readings. E1 confirmed that R3 has diabetes and is currently controlled through medication (Diabeta 5mg daily) and diet. E1 stated that R3 has not had issues related to low blood sugar for a prolonged period of time. E1 confirmed that facility was unable to produce any blood sugar readings (via accu-check) during R3's illness or any readings in recent history. E1 stated that the</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	<p>Continued From page 25</p> <p>facility utilizes a lab for R3's blood sugar readings. However was unable to produce any readings to address R3's blood sugar readings prior to hospitalization. E1 confirmed that R3 was prescribed Compazine 25mg tab for nausea on 10/7/09. In addition E1 confirmed that R3 was administered 13 doses of the Promethazine 25mg from 10/8/09-10/13/09. The facility was unable to produce any documentation to address the responses and/or effects from the medication. In addition there was no evidence of contacting the RN consultant in reference to the 13 doses of the Promethazine as required by the facility policy 7.02-Nursing Services. E1 stated that there was no policy for staff to follow concerning how staff are to monitor clients with Diabetes and no policy for staff to follow concerning clients with Diabetes and how to monitor their blood sugar when they are ill.</p> <p>Interview with E2 (RN) on 11/12/09 at 2:00PM. E2 confirmed that R3 had an extended illness from 9/29/09-10/15/09. E2 stated that R3 had received a clear liquid diet on several occasions and there was no documentation available for her to review on her visits in 10/09. E2 stated that staff are to monitor vital signs during client illness; however they do not always document readings for her review. E2 confirmed that R3 has diabetes and is currently controlled through medication (Diabeta 5mg daily) and diet. E2 stated that R3 has not had issues related to low blood sugar until she was admitted to the ER on 10/15/09. E2 confirmed that facility was unable to produce any blood sugar readings during R3's illness to ensure her blood sugar reading were not abnormal. E2 confirmed that R3 was prescribed Promethazine 25mg tab for nausea on 10/7/09. In addition E2 confirmed that she was</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/24/2009
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 808 SOUTHWEST PLACE EDWARDSVILLE, IL 62025		
(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) COMPLETION DATE	
W9999	Continued From page 26 not notified that R3 was administered 13 doses of the Promethazine 25mg from 10/8/09-10/13/09. E2 stated she was contacted several times during the 10/8/09-10/13/09 time period concerning staff administering the medication; however was unable to recall dates and time periods of the medication administration. E2 confirmed she had not assessed R3 for responses and/or effects from the medication. (A)	W9999			