STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Final Observations Licensure Violations: 300.610a) 300.1210a) 300.1220b)3 300.3240a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable	S9999		

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S9999	Continued From page 1 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to identify, assess and develop a plan for unplanned weight loss. This failure resulted in one resident, R21 sustaining a significant weight loss without facility knowledge or interventions to prevent additional weight loss. This applies to one resident (R21) out of 15 residents reviewed for weight and nutrition from a total sample of 29. The findings include: R21's admission face sheet shows diagnoses including osteoarthritis, Alzheimer's Dementia, hypertension, neuropathy, atherosclerosis and	S9999		

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esophageal reflux. R21's September physician order sheet shows that R21 is on a general diet with health shakes at 10:00am and 2:00pm dated 02/13/14 and monthly weights.

On 09/10/2014 at 2:40pm R21's weight was 92.0 pounds using the sitting scale by E10 (Certified Nurse's Aide). E7 was present during the weight.

R21's weight record shows the following weights:
Date: 06/11/2014 Weight: 110 pounds
Date: 06/18/2014 Weight: 94.40 pounds
Date: 07/01/2014 Weight: 108 pounds
Date: 08/01/2014 Weight: 108 pounds
Date: 08/27/2014 Weight: 89 pounds
Date: 09/03/2014 Weight: 88.6 pounds

There was a weight loss of (19.4 pounds) 17.96% in one month from 08/01/2014 to 09/03/2014. R21 ' s last nutritional note/assessment was noted in the electronic medical record dated 2-25-14 as a " late entry " . No documentation or assessment of R21 could be located during the chart review since the 2-25-14 entry. The weight loss noted from August 1 to August 27 of 19 pounds was not assessed by the facility.

On 09/10/2014 at 11:30am E6 (Registered Dietician) stated that she was not aware of any weight loss for R21. E6 stated that she has not seen R21 for a nutritional assessment prior to today's visit since her weight had been stable for the past six months. E6 stated that she visits the facility approximately four times a month and her last two visits to the facility were on 08/20/2014 and 08/27/2014. E6 stated that when the facility identifies a weight loss they should notify her right away.

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S9999	Continued From page 3 On 09/09/2014 at 12:50pm R21 was in the first floor dining room during lunch. R21 was observed folding a slice of bread and then taking a small bite out of it. R21 would then set the bread down and occasionally pick up a fork and move the food around on the plate. R21 picked up the bread again folded it several times and took another small bite. R21 then stacked two food bowls with food remaining in them on top of her slice of ham on the plate. At 12:58pm E8(Certified Nurse's Aide) removed R21's lunch dishes to the soiled tray cart. E8 stated that she was not aware of any eating or weight issues with R21. E8 also stated that R21 usually eats about 25% of lunch meals. On 09/10/2014 at 8:30am E21 stated that she thinks she ate breakfast already but cannot remember what she ate. On 09/10/2014 at 12:05pm R21 was sitting in the first floor dining room during lunch. R21 was observed moving food, which consisted of noodles and Swedish meatballs, around on her plate with a fork. R21 also picked up a breadstick, buttered it, looked at it, then set it back down on her plate. R21 drank from a cup and then moved the food around on her plate again, picked up the bread stick then placed it back down. At approximately 12:30pm E9 (Certified Nurse's Aide) removed R21's tray of food from the table and placed it on the soiled tray cart. E9 stated that R21 meal intake depends on how her mood is that day, some days being better than others. E9 stated that the nurse's aides will document how much the residents eat. When E9 was asked how much R21 consumed for lunch, she stated that she would have to look at her tray to determine it. E9 then went to the soiled meal cart and removed R21's tray. E9 stated that she would	S9999		

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estimate that R21 ate 40% of her meal since a couple of meatballs and a couple of grapes were eaten. The meatballs were slightly separated on the plate. The noodles and the vegetables were untouched.

On 09/10/2014 at approximately 1:30pm E7(Assistant Director of Nursing) stated that the nurse's aides should use the Dietary Intake Guide posted in the facility to assess how much the resident had consumed. The Dietary Intake Guide indicates that overestimating the resident's total consumption is a common error, especially when food is pushed around the tray. The Dietary Intake Guide shows that the meal intake would be recorded at 0% if the resident consumed only one or two bites of each item. E7 stated that if there are weight discrepancies a reweigh should be done. E7 said that if there is a significant weight loss then the facility would notify the doctor and the dietician.

On 09/10/2014 at 2:50pm E11(Licensed Practical Nurse) stated that she had not noticed any changes with R21. E11 said that she makes sure that the residents are eating by making sure that they are in the dining room. She said that the nurse's aides usually assess how much food the resident's are eating. E12 (Certified Nurse's Aide) said that R21 needs reminders to get up and eat but R21 is independent in eating and doesn't need assistance. E12 said that the nurse's aides record the meal consumption but they do not record if the resident had consumed or refused any health shakes or supplements.

On 09/10/2014 at 2:55pm E7 was asked for copies of R21's last monthly meal intake record. On 09/10/2014 at approximately 3:00pm E3 (Director of Nursing) confirmed the request for

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S9999	Continued From page 5 R21's last monthly meal intake record. The meal intake record was not received. The facilities Weight Management Policy dated 06/2012 shows that all significant or trending weight changes must be investigated by the facility to determine the possible cause, determine the plan of action, document the investigation and notify the physician and responsible party. The policy also shows that an evaluation of significant weight change form will be completed any time there is a noted significant or trending weight fluctuation and referred to the dietician. (B)	S9999		