

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2020
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NAME OF PROVIDER OR SUPPLIER WINDSOR ESTATES NSG & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 SOUTH LAVERGNE COUNTRY CLUB HILLS, IL 60478
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(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
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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)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 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/23/20
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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect 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>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to obtain physician orders for 1 resident (R124) prior to pain medication administration, failed to ensure narcotic pain medication was timely reordered for 2 residents (R74, R124) and failed to administer pain medication as prescribed to 3 residents (R74, R124, R342) in the sample reviewed for pain. These failures resulted R342 sustaining pain rated "6" on a 10-point pain scale, R124</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>sustaining pain rated "15" on a 1-10 scale, and R124 reporting depression related to pain.</p> <p>Findings include:</p> <p>1. R124's diagnoses include Chronic Pain Syndrome.</p> <p>R124's (1/24/19) POS (physician order sheet) includes: Norco 10/325 mg every 8 hours as needed for pain.</p> <p>R124's (6/17/19) care plan states: Administer analgesic medications as ordered by physician.</p> <p>On 01/06/20 at approximately 9:24 am, R124 appeared uncomfortable, reporting she was in pain and that the nurse was aware. R124 stated she asked for Norco last night and was told there were none left and was given Tylenol instead. R124's POS does not include Tylenol. V7 (Registered Nurse) entered the room and stated the facility ran out of R124's Norco. R124 responded, "What are you doing about it because I'm in a lot of pain." V7 stated she would call the doctor to renew the prescription. R124 reported head and back pain rated 12 on a scale of 1-10, which was causing depression.</p> <p>R124's (January 2020) Controlled Drug Record affirms Norco was administered twice daily from 1/1/20-1/4/20. On 1/5/20 (6am) there were zero amount left.</p> <p>On 01/07/20 at 1:51 pm, V29 (Licensed Practical Nurse) stated R124 asked her for Norco during the 8:00am medication pass however the medication had not arrived yet from the pharmacy. The night nurse gave Tylenol for pain because they were still out of the Norco.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On 1/07/20 at 1:53 pm, R124 was restless, appeared uncomfortable, and stated, "I'm in pain." Surveyor inquired what her pain was rated on a scale of 1 to 10. R124 responded "15." R124 stated she cannot eat because of pain. R124's lunch was untouched.</p> <p>On 01/07/20 3:56 pm, V31 (Medical Director) stated physician orders are required prior to medication administration and should be followed. The expectation is for the nurse to assess the patient, document pain level and administer medication as warranted.</p> <p>The facility's Emergency Use Medication List affirms Norco 10/325 mg was available.</p> <p>On 1/08/20 at 10:24 am, V2 (Director of Nursing) reviewed R124's (January 2020) POS and affirmed Tylenol was not prescribed.</p> <p>2. R342's diagnoses include but are not limited to multiple sclerosis.</p> <p>R342's POS (Physician Order Sheets) include (1/5/20) Methadone HCL tablet 50mg (milligrams) every 8 hours for pain.</p> <p>On 1/6/20 at 9:46am, R342 was lying in bed and appeared uncomfortable. R342 stated, "I'm in a lot of pain in my neck and my tailbone. I've got two bulging discs and have arthritis in my neck where most of the pain is." Surveyor inquired what R342's pain was currently rated on a 1-10 scale; R342 responded, "About a six."</p> <p>On 1/6/20 at approximately 9:49am, surveyor inquired when R342 last received pain</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>medication. V4 (Licensed Practical Nurse) reviewed the EMR (Electronic Medical Record) and stated, "He hasn't had anything for pain. He has methadone every eight hours scheduled for 6am, 2pm, and 10pm." V4 reviewed R342's controlled substance (Methadone) sign out sheet and stated, "Last night at 10pm was the last dose he received."</p> <p>On 1/6/20 at 9:51am, surveyor inquired about R342's positioning. V4 stated, "It looks uncomfortable; he needs to be repositioned."</p> <p>R342'S (January 2020) MAR (Medication Administration Record) and controlled substance log affirm Methadone was not administered on 1/6/20 (at 6:00am) as prescribed.</p> <p>The "Administering Pain Medications" policy (revised 4/2007) states: Follow the medication administration guidelines in the policy entitled Administering Medications. The resident's experience of pain is highly individual and subjective. Pain is whatever the resident says it is. Identify individuals who have pain or who are at risk for having pain. This includes a review of known diagnoses or conditions that commonly cause of predispose residents to pain. Identify the nature and severity of pain including characteristics. Use a standardized pain assessment instrument appropriate to the resident's cognitive level.</p> <p>3. On 01/07/20 at 10:00 AM R74 complained of severe pain on Friday 1/3/2020. R7 stated that he went without a pain patch for a whole day. R74 stated the pain was so severe that he was crying. R74 stated the nurses did not re-order his pain medication on time. R74 stated, "The nurses are not doing their job in getting the medication re-ordered by the doctor on time."</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>R74's Electronic Medical Record showed that on 1/3/2020, R74's Fentanyl patch was not administered to R74 and was documented as refused. R74's controlled drug receipt record/disposition record showed that the last Fentanyl patch was administered on 12/31/19 at 6:00am and the next dose was administered on 1/4/2020. R74 has an order for Fentanyl patch 100MCG/HR (Microgram) every 72 hours.</p> <p>V2 (Director of Nurses) stated the Fentanyl was not available because it was not reordered until 1/4/2020. V2 presented the copy of the order dated 1/4/2020.</p> <p>On 1/7/2020 at approximately 1:00pm, V35 (Pharmacist Customer Service) stated that two (2) of ten Fentanyl patch medications ordered were delivered to the facility on 1/4/2020 at 6:35pm. V35 stated the remaining will be delivered on 1/8/2020.</p> <p>R74's plan of care initiated 8/30/2018 focus on R74 being on pain medication therapy related to chronic pain and the goal includes but is not limited for him to be free of any discomfort.</p> <p>The facility policy titled "Receiving Controlled Substances" with no revised date, documented that controlled substances are re-ordered when a four (4) day supply remains to allow for transmittal of the required written prescription of the pharmacist.</p> <p>(B)</p>	S9999		
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