Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007843	A. BUILDING: ______ B. WING ______	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

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S 000	Initial Comments Complaint Investigation 2195928/IL137146 2195996/IL137232	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1220b)2) 300.3250a) 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of	S9999	**Attachment A** **Statement of Licensure Violations**	

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the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3250 Communication and Visitation

a) Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. (Section 2-108 of the Act)

These Requirements were not met evidencded by:

Based on interview, and record review, the facility failed to follow their visitation policy by restricting visitation times and visits for three of three residents (R1, R3, R5) reviewed for visitation. This failure resulted in R1 expressing a feeling of being depressed, sad and also feeling unsafe due to visitation restrictions.

Findings include:

R1 was admitted to the facility on 7/28/21 at 7:50PM, with diagnosis of encounter for other orthopedic aftercare, left artificial knee joint, major depressive disorder muscle weakness. R1's minimum data set dated 8/6/21 documents a brief interview for mental status score 15/15 which indicates cognitively intact.

R1's care plan dated 8/6/21 documents R1 has

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mild symptoms of depression. R1 states she "has felt down, has low energy trouble sleeping and poor appetite, feeling unsafe due to visitation restriction". Intervention includes: Encourage family support, and visits to facility.

On 8/31/21 at 4:53PM, R1, who was alert, and oriented at time of interview as well as tearful, states she "feels like her family is being held from her. R1 said the changes in visitation has caused her more stress and sadness, and feeling unsafe due to visitation restriciton. R1 said her husband who she has been married to for over 36 years was not able to visit before 4:30PM during the week due to work. R1 said her husband had to change his work schedule and start work at 4:00AM so he can visit R1 in the afternoon during the week. R1 stated "not seeing her husband makes her feel uncomfortable and feel unsafe". R1 said she and her husband did not receive any notice of changes in visitation until after 8/16/21.

On 8/26/21 at 12:07PM,, V1 (Administrator) said he made changes to the visitation policy starting 8/16/21 due to noncompliance of families during visits.. V1 said prior to 8/16/21 families did not have to make an appointment, they were able to visit in a room with no time restrictions. The new policy limits in room visits to end of life, or bed bound patients. We shorten the time frame for visits in the evening due to staffing. Visits during the week are from 1:00PM to 4:30PM and on weekends from 1:00PM to 3:00PM with 20 minute time limits.
V1 said all families were notified via email of changes to visitation policy and staff passed out the updates when families arrived for their visits.When asked how he ensured all families received an email, V1 said the guidelines are posted on the door. V1 said he banned V23 (R3's

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family) from visitation for 2 weeks after she went into R3's room for a visit unauthorized. V1 said he had no other incidents of noncompliance with V23 but she did not follow the rules and went to R3's room.

R3 was admitted to facility on 6/18/21 with diagnosis of major depressive disorder, hemiplegia following cerebral infraction, abnormal posture and muscle weakness.
R3's minimum data set 6/21/21 documents a brief interview for mental status score 15/15 which indicates cognitively intact.

On 8/31/21 at 4:26PM, R3, who was alert, and oriented at time of interview said he was upset that his wife has been banned from visiting the facility. R3 reported they have been married for 32 years and this is the longest they have been apart since being admitted to the facility. R3 said he feels depressed, misses his wife and feels he is being punished for something.

On 8/31/21 1:13PM, V23(R3's family member) said she went to see R3 on Sunday (8/20/21). V23 said she had an appointment but when she was at the back door there was no receptionist present. V23 stated, "someone finally buzzed her into the building". V23 said she waited by the back entrance and there was no staff present or at the nursing station. V23 said she finally saw a female CNA, she was told she could go to R3's room to drop off items. After a few minutes, a different staff member informed me that I could not visit in the room and I left. The next day V23 said she received a call from V1 (Administrator) informing her that she was not following guidelines and was banned from visiting the facility for two weeks. V23 said she felt afraid and embarrassed. V23 said she did not try to visit

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again because she was unsure of what would happen and feared any retaliation towards her husband or herself. V23 said with the new visiting times it is difficult to come see R3 during the week because V23 works until 5:30PM.

On 8/26/21 at 12:07PM, V1 (Administrator) said he made changes to the visitation policy starting 8/16/21 due to noncompliance of families during visits. V1 said prior to 8/16/21 families did not have to make an appointment, families were able to visit in room with no time restrictions. The new policy limits in room visits to end of life, or bed bound patients. We shorten the time frame for visits in the evening due to staffing. Visits during the week are from 1:00PM to 4:30PM and on weekends from 1:00PM to 3:00PM, with 20 minute time limits.
V1 said all families were notified via email of changes to visitation policy, and staff passed out the updates when families arrived for their visits.When asked how he ensured all families received an email, V1 said the guidelines are posted on the door. V1 said he banned V23 (R3's family) from visitation for 2 weeks after she went into R3's room for a visit unauthorized. V1 said he had no other incidents of noncompliance with V23 but she did not follow the rules and went to R3's room.

On 8/26/21 at 1:20PM,, V6 (Assistant Administrator) said there was not a receptionist on Unit 2 that day.

On 8/26/21 at 2:19PM, V7 (Admissions) said she was working on 8/22/21 and was on Unit 2 and observed R3 was not in the dining room for his visit. V7 said she went to R3's room and found V23 who stated R3 did not want to get out of bed and that she knew the policy and was leaving. V7

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S9999	Continued From page 5 said V23 had on a mask and left willingly when notified that visitation could not take place in the room with no concerns. R5 was admitted to the facility on 2/26/21 with a diagnosis of anxiety and schizophrenia. R5's minimum data set 7/15/21 documents a brief interview for mental status score 7/15 which indicates severely impaired. On 8/27/21 at 2:28PM, V16 (R5's family member) said she is R5's power of attorney. I was told R5 wasn't coming out to visit (on 8/27/21) and we would have to go into R5's room. During the visit, my mask slid down due to the ear loops being too large. V16 said she was confronted by V1 (Administrator) who said, this is the very reason, I stopped in room visits. I can stop you from visiting R5. I can make it so you can't come in to visit. You have to get out of R5's room. I don't allow room visits. Normally when I come, I take R5 outside for fresh air. The receptionist said, no outside visits today. Visits are from 12:00 PM,-4:00PM, which is an inconvenience time for me. V1 (Administrator) said, we can only come from 12:00PM,-4:00PM, for twenty minutes increments. I did not have privacy in the dining room or enough time to visit. Im unable to visit R5 tomorrow because I would have had to make the appointment before noon today even if the slots are open for tomorrow. It's frustrating when I can't see R5. R5's care plan documents R5 has verbalized mild symptoms of depression. Under interventions documents: Encourage family support and visits. Updated visitation policy dated 8/13/21 documents all visitation except end of life ends at 8:00PM.	S9999		

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General visitation guidance- required visitation documents: facility shall not restrict visitation without reasonable clinical or safety cause. A nursing home must facilitate in person visitation consistent with applicable CMS regulations. According to CMS guidance, visitation should be person centered; consider the residents physical, mental and psychosocial well-being and support their quality of life.

On 9/1/21at 12:04PM, V1 (Administrator) said there has been no banned visits for any families except for R3. V1 said R5's family received a verbal warning after being found in R5's room without wearing a mask properly. When asked why R5's family was given a verbal warning and R3's family was banned, V1 replied R5's family was instructed to go to the room by staff and R3's family went into unauthorized area without waiting for staff.

On 9/1/21 at 1:29PM, V1 (Administrator) presented an email that was sent to families on 8/16/21 but was unable to show all the recipients.

(B)

(Violation 2 of 2)

300.610a)
300.1210b)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

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S9999	Continued From page 7 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 care needs of the resident. These Requirements were not met evidencded by: Based on interviews, and record review, the facility failed to timely provide pain medication to one (R1) resident following post-operative procedure to her left knee. This failure resulted in the resident being in pain 10/10 for over 12 hours for one of three residents reviewed for pain. Findings include: R1 was admitted to the facility on 7/28/21 at 7:50PM, with diagnosis of encounter for other orthopedic aftercare, left artificial knee joint,	S9999		

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major depressive disorder muscle weakness. R1's minimum data set dated 8/6/21 documents a brief interview for mental status score 15/15 which indicates cognitively intact.

R1's admission nursing assessment dated 7/28/21 under pain documents: Is the client experiencing pain? Yes; Pain Intensity 10/10 which indicates worst possible pain; please describe pain. Sharp pain in her left leg. R1's wound assessment dated 7/29/21 documents: admitted with left leg surgical site measuring length 30cm x width 30cm.

R1's admission note dated 7/28/21 9:00PM, R1 was discharged from local hospital. R1 is alert and oriented times four, able to verbalize needs, complaining of pain to left knee 10/10. Left knee with non-removable surgical dressing, with wound vac and left knee brace.

On 8/31/21 at 4:53PM, R1 who was alert, and oriented at time of interview said on admission she was having pain 10/10 in her left leg. R1 reported her last pain medication was given at the hospital around 2:00PM. R1 said she was begging staff for any pain medication and was told they were waiting for orders, or they did not have orders for pain medication. R1 said she was not able to sleep due to the pain. R1 reported she finally received medications sometime in the late morning the following day.

On 8/31/21 at 2:11PM, V2(DON) Director of Nursing, said they need an prescription to have medication released from the pharmacy and/or convenience box. V2 said they were waiting for a script and once the script was sent, the pharmacy notified facility that R1 had an allergy to morphine and needed an ok from the doctor to dispense

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the oxycodone. Once they received the ok the medication was sent and taken from the convenience box. V2 said she is unsure why medication was not documented when given or if they the nurse informed the doctor of the delay of pain medications or if any alternatives were given or offered besides Tylenol. V2 was unable to provide any pain assessment for R1 after 7/28/21 to 7/30/21.

On 8/31/21 at 3:22PM, V24 (pharmacist) said they received oxycodone prescription for R1 at 8:00PM on 7/28/21. At 11:00PM, they attempted to call facility due to morphine allergy to see if it was ok to send oxycodone but there was no answer. At 2:48AM, facility nurse said R1 received medication in the hospital and it was ok to be dispensed. V24 said they did not need a doctor to clarify an allergy since resident was taking it at the hospital. R1's pain medication was removed from convenience box on 7/29/21 at 9:44AM.

R1's progress noted dated 7/29/21 at 4:30AM, documents: Received R1 in bed. R1 is new admit had knee replacement surgery was given Tylenol for pain at 1:00AM, was somewhat effective. Pharmacy called to check on status of oxycodone, stated they had to verify allergies to morphine, resident stated she was taking oxycodone in the hospital, pharmacy informed said they will be sending it out with next delivery. All needs met. No signs of pain or distress.

R1's medication administration record dated July 2021 documents: oxycodone 5mg as needed starting 7/28/21. Record documents first dose of oxycodone was given on 7/30/21 at 4:15AM. There was no documentation of any pain medications given prior to 7/30/21 at 4:15AM

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R1's admission hospital paperwork documents: R1 was treated for left knee extensor mechanism mesh reconstruction with orders for oxycodone 5mg every four hours as needed for post-surgical knee pain. Under medications dated 7/28/21, documents last oxycodone was administered at 13:56.

Pharmacy notes dated 7/28/21 documents R1 prescription for oxycodone dated 7/28/21 from local hospital. Pharmacy notes dated 7/28/21 at 11:45PM, attempted to call facility about morphine allergy no answer for four minutes.
On 7/28/21 at 2:48AM, spoke to facility nurse that R1 received oxycodone in the hospital. Pharmacy notes dated 7/29/21 at 9:46AM, document R1 needs pain medication urgently removed one oxycodone tablet (from convenience box at the facility).

Facility pain policy titled Pain- Clinical Protocol dates 3/2019 documents: The nursing staff will assess each individual for pain upon admission, at quarterly review, whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location. Intensity, frequency, pattern and severity. Staff will use a consistent approach and standardized pain assessment instrument appropriate to the resident's cognitive level. The staff will reassess the individual pain and related consequences at regular intervals at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. The staff will evaluate and report residents use of standing and as needed analgesics.

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