STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006779	A. BUILDING: _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LAWN RESPIRATORY & REHAB	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation #2296525/IL150230	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 Findings 300.3240a) 300.3240b) 300.3240c) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) These Requirements were NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to keep a resident free from abuse	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

by staff being rough while providing care and speaking to resident in a rude and disrespectful manner. This failure applied to one (R71) of 19 residents reviewed for abuse and resulted in R71 feeling sad and anxious due to how R71 was treated by staff.

Findings include:

On 08/31/22 at 04:45 PM R71 stated V24 (Certified Nursing Assistant) who was a large woman rough handled her while providing care. R71 stated while V24 and another CNA were providing her with incontinence care, V24 grabbed her right leg that is typically sore aggressively causing her pain. R71 stated she groaned in pain and asked V24 to lower her leg. R71 stated she cried because of the pain she was feeling from V24 forcing her right leg up. R71 stated V24 responded to her complaints of pain by stating "what are you some kind of Diva?" R71 stated she would never know what kind of mood V24 would be in. R71 stated V24 would say crying made her angry and would tell her she will walk out on you if you cried. R71 stated she would be afraid and would know what to expect from V24 depending on her mood. R71 stated some of the staff were upset with her for complaining about V24. R71 stated she felt sad because the aide was working with V24 during the incident and was helpful to her during the ordeal and told the police everything she observed was suspended.

Facility incident investigation report dated 08/16/2022 documents R71 alleged that staff V24 (Certified Nursing Assistant) handled her roughly and spoke to her inappropriately; staff was immediately placed on suspension pending investigation; V24 was interviewed and admitted

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S9999	Continued From page 2 to mumbling "you're being a diva" under her breath but did not think R71 heard her nor did she think it was inappropriate; V24 did state she never handled R71 roughly; R71 reported another staff was present during the incident, intervened and took over her care; local police were notified; R71 later complained of pain and nursing attempted to have R71 x-rayed but she refused and stated she was no longer in pain; she had no concerns during later follow up on her condition; V24 was unable to return to the facility. On 09/01/22 at 11:03 AM V2 (Director of Nursing) stated V24 (Certified Nursing Assistant) was permanent staff. V2 stated V24 did have some previous issues and complaints of residents reporting she was kind of rough with care which is why she was let go due to too many complaints. Employee Disciplinary Action Form dated 05/31/2022 documents on 05/25/2022 it was reported by a resident that V24 (Certified Nursing Assistant) was discourteous towards her. V24 has been named in several unsubstantiated allegations relating to inappropriate behavior. The facility's Abuse Policy reviewed 09/01/2022 states: "It is the policy of this facility to prohibit and prevent resident abuse and mistreatment." "Supervisors will monitor the ability of the staff to meet needs of residents: Staff understanding of insensitive handling or impersonal care will be corrected as they occur." Facility Incident Investigation Report dated 08/16/2022 requested 09/01/2022 was not provided by the facility by the time of the survey exit.	S9999		

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S9999	Continued From page 3 (B) 2 of 3 Licneiusre Violations 300.610a) 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. This Requirement was NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to follow their policies and procedures for fall prevention by not developing a comprehensive and individualized plan of care for a resident admitted at risk for falls and failed to evaluate and modify interventions following an unwitnessed fall. This failure applied to one (R19) of one resident reviewed for fall interventions and resulted in R19 requiring emergent transfer to hospital as a result of a head injury. Findings include: R19 is a 92-year-old female with a diagnoses	S9999		

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S9999	Continued From page 4 history of Cognitive Communication Deficit, History of Falling, and Chronic Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity who was originally admitted to the facility 06/24/2022. R19's Admission Fall risk review dated 06/24/2022 documents a score of 12 with high risk for falls, is non-ambulatory, incontinent, has gait/balance issues including a balance problem while standing/walking, decreased muscular coordination/jerking movements, and has 3 or more health conditions. On 08/29/22 at 12:30 PM Observed R19 with a large area of bruising on right side of her face. R19 stated she slipped and fell about a week ago. R19's Current care plan documents she is at risk for falls related to: a History of Falls, Cognitive Impairments, Requiring assistance with activities for daily living and for transfers and mobility related tasks, Incontinence of Bowel, Incontinence of Bladder, and Decreased Strength and Endurance, Impaired Gait and Balance, General weakness, as well as Diagnoses of; A fibrillation, Heart Failure, Acute Kidney Failure, Muscle Wasting and Atrophy, Dysphagia, Lack of Coordination, Need for Assistance with Personal Care, Protein Calorie Malnutrition, and Recent history of COVID 19 with interventions including: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance; Complete the Fall Risk Review per the facility protocol; I would like staff to review information on my past falls and attempt to determine the cause of my fall(s). Record possible root causes on my care plan.	S9999		

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S9999	Continued From page 5 Alter/remove any potential causes if possible. Educate me, my family, caregiver and Interdisciplinary Team as to the continued risk factors and interventions used to help prevent future falls; Nursing Staff will complete a Fall Risk Assessment per Facility Fall Protocol; Follow the facility Fall Protocol; right side floor mats. R19's Fall Observation Incident Report dated 08/15/2022 documents R19 was observed on the floor after an unwitnessed fall, was evaluated and noted with a large lump to the right side of her forehead, right cheek red and swollen, and a small lump on the back of the right side of head; R19 was unable to describe what happened, was confused and disoriented; emergency medical services was called; R19 was sent to the hospital. R19's Post Fall risk review dated 08/15/2022 does not include notes of any incidents or concerns; and documents a final score of 7 with a score of 10 or above being higher risk. R19's Hospital Record dated 08/15/2022 documents her chief complaint as a fall with head injury with History of Present Illness information including: head injury to right side of forehead, onset sudden with trauma. Presents to emergency department after suffering a head injury; mechanical fall at nursing home hitting the right side of her forehead, arrived with hematoma (bruise) to right forehead and back of head; patient is not anticoagulated; Emergency Medical Responders documented she recalled the incident, was alert and oriented, and reported that she tripped and fell from walking. R19's Hospital Discharge Summary dated 08/15/2022 documents she was discharged with a diagnosis of head injury.	S9999		

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S9999	Continued From page 6 On 08/31/22 at 10:26 AM V28 (Corporate Vice President/Registered Nurse) stated she observed a bruise on R19's face and was informed by the resident and staff that it was the result of a fall she experienced 10 days ago. On 09/01/22 at 09:57 AM V2 (Director of Nursing) stated R19's fall assessment was done on admission. V2 stated R19 is not on any blood thinners. V2 stated R19 still has a bruise on her face from her fall. V2 stated V29 (Licensed Practical Nurse) was speaking about R19's bruise yesterday and stated at the time of her fall she had some swelling around her eye and cheek area. V2 stated R19 had not had any falls prior to this incident. V2 stated she is not sure why fall mats were only recommended for one side of R19's bed. V2 was unable to provide a root cause analysis or contributing factors for R19's fall. V2 stated after a resident falls a root cause analysis is performed and the care plan is updated to include findings. V2 was unable to explain how R19's fall risk decreased per her 08/15/2022 fall risk review completed after her fall. V2 stated there should have been personalized interventions in R19's care plan to prevent her from falling and there are not currently any personalized fall interventions included in her care plan for fall prevention. V2 was unable to identify any personalized interventions that may prevent R19 from falling. V2 stated an internal report dated 08/16/2022 documents per the interdisciplinary team the resident will be educated regarding mobility safety. The facility's Fall Policy reviewed 09/01/2022 states: "The purpose of our Fall Prevention and Management Program is to:	S9999		

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S9999	Continued From page 7 Provide appropriate interventions to prevent falls. "Through an interdisciplinary approach, this facility will provide fall prevention and implement interventions to prevent falls as much as possible. The facility will achieve these goals through: Interventions that are implemented based upon the identified risk factors." Fall Prevention includes: "Implement individualized approaches/interventions based upon resident risk." "Interdisciplinary care plan is implemented for residents at risk and may include: Supervision as appropriate." (B) 3 of 3 Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)1 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	S9999		

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S9999	Continued From page 8 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These Requirements were NOT MET as evidenced by: Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for preventing and minimizing pain by not ensuring that pain was adequately controlled by not ensuring that pain medication was available to be administered as ordered. This failure applied to two (R33 and R49) of two residents reviewed for pain management and	S9999		

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S9999	Continued From page 9	S9999		

resulted in R33 and R49 experiencing pain greater than a level ten for multiple days.

Findings include:

Reviewed grievance/concern log entry for R33 dated 06/21/2022 that showed R33 was "concerned that he doesn't have anymore Tramadol for pain and the PRN (as needed) Tylenol and Ibuprofen is not helping". Staff called pharmacy to follow-up with refill request, informed medication would be delivered that evening. R33's log dated 08/30/2022 showed same concerns with pain medication again not being available.

On 08/30/22 at 08:59 AM, R33 said he had not received his pain medication (Tramadol 50mg) for "a couple of days." He then rated his current pain level as "10" on numerical scale from 0-10. At 09:05 AM, observed V4 (Registered Nurse) administer to R33 Ibuprofen 200mg two tablets in place of his scheduled pain medication (Tramadol 50mg) which was unavailable for morning dose administration. V4 said the pain medication was reordered on 08/29/2022 and should've come in.

On 08/30/2022 at 3:20 PM, R33 said he isn't always receiving Tramadol two times a day, hasn't received it all on some days, then said the ibuprofen doesn't help his pain. R33 then said he gets upset and feels sad when he does not receive his Tramadol twice everyday.

Reviewed R33's active physician's orders that showed orders for Tramadol 50mg one tablet by mouth every twelve hours for pain (active 07/26/2022), diclofenac sodium gel 1% apply to left knee topically twice daily for arthritis (active 07/26/2022), and gabapentin 300mg give one

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S9999	Continued From page 10	S9999		

capsule by mouth three times a day for neuropathy (active 07/26/2022).

Reviewed R33's medication administration record (MAR) for August 2022 that showed diclofenac sodium gel 1% was not administered at 1700 (5:00 PM) on 08/09 and was not administered at 0900 (9:00 AM) on 08/12, 08/25, and 08/30. MAR showed that R33 was not administered Tramadol 50mg at 0900 on 08/12 and 08/30 and was not administered at 2100 (9:00 PM) on 08/28. MAR also showed R33 was not administered gabapentin 300mg capsule at 0900 and 1300 (1:00 PM) on 08/12.

Requested copies of R33's Tramadol controlled substance logs for the last three months. Facility provided logs for June and July 2022 only. Reviewed log with date received of 07/18/2022 that showed R33 only received one dose of his scheduled Tramadol 50mg on 07/26/2022 at 5:00 PM. Reviewed R33's electronic medication administration record for August 2022 that showed R33 is scheduled to receive Tramadol 50mg at 9:00 AM and 9:00 PM daily.

Reviewed R33's care plan last revised 07/27/2022 that showed he is at "increased risk for alteration in pain/comfort" related to recent history of fall with fracture, history of spinal fusion, past medical history of arthritis and gastroesophageal reflux disease with interventions to administer analgesic (pain) medication as ordered per plan of care.

Reviewed R33's pain assessment dated 08/30/2022 at 10:34 that showed R33 has a scheduled pain medication regimen, receives as needed pain medications as well. Assessment also showed that R33 reported having frequent

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S9999	Continued From page 11 pain in the last five days and rated pain scale at "10" on a numerical scale of 1-10 with moderate intensity. Reviewed facility's undated medication administration policy that showed nurses administer medications according to times documented on the medication administration record (MAR) and medications that are refused or not administered should be documented with reason for missed dose. No documentation found regarding multiple missed doses of R33's pain medications and/or pain gel. 2. On 08/30/22 at 09:50 AM R49 stated she has been waiting on her narcotic pain patch since Friday. R49 stated V5 (Licensed Practical Nurse) paged the doctor about this and has not gotten a response. Observed R49 crying stating "I'm just in so much pain." R49 stated she is in so much pain she gets jitters. Observed R49 hunched over to her right side with expressions of pain on her face. R49 stated her pain level has been over 10 consistently. R49 stated her back, arm, hands, and neck are in pain. R49 stated she has had brain and spine surgery. R49 stated she hasn't slept because of her pain, and she is tired. R49 stated the nerves in her body are going crazy because of the pain. R49's current physician order documents an active order effective 05/24/2022 for monitoring and recording pain scale every shift; and an active order effective 08/08/2022 for application of one 25mcg narcotic pain patch topically every 72 hours for pain. R49's current care plan documents she is at risk for reoccurrence of increased uric acid and flare ups of painful joints related to Gout and at	S9999		

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S9999	Continued From page 12 increased risk for alteration in pain/discomfort related to impaired mobility with interventions including: Complete the Pain assessment upon Admission, Re-admission, Quarterly and as needed for new onset of pain; Medications as ordered per physician; Report any changes to physician; Assess and document the frequency and intensity of the pain symptoms. Use the residents verbal reports and staffs clinical judgement for the assessment; Monitor for verbal and nonverbal expressions of pain; Administer analgesic medication as ordered per plan of care; Offer as needed analgesic medication prior to activities of daily living/rehabilitation, wound care etc. and as indicated for pain management. R49's August 2022 Medication Administration Record documents she did not receive her narcotic pain patch scheduled for application topically every 72 hours from 08/07/2022 - 08/10/22, and 08/26/2022 - 08/31/2022. R49's Medication Administration Progress note dated 8/8/2022 05:46 documents narcotic pain patch 25 mcg/hour scheduled every 72 Hour to be applied transdermally for pain was not available. Called pharmacy and was notified it needs signed script. R49's progress notes from 08/26/2022 - 08/31/2022 does not document an attempt to administer her narcotic pain patch nor the status of the medication. R49's Narcotic Pain Patch Pharmacy orders requested from the facility 09/01/2022 was not provided at the time of exiting the survey. On 09/01/22 at10:48 AM V2 (Director of Nursing) stated R49 receives a narcotic patch for pain. V2	S9999		

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S9999	Continued From page 13 stated per R49's medication administration record she did not receive her narcotic pain patch from 08/07/2022 - 08/10/22, and from 08/26/2022 - 08/31/2022. V2 stated R49 received the patch on 08/04/2022 at night and should have received it again on the 08/07/2022. V2 stated R49 should have received her narcotic pain patch during those times. V2 stated the concern with R49 not receiving her scheduled narcotic pain patch would be experiencing pain. V2 stated there was a strong possibility there had been an ongoing issue with obtaining a prescription from the physician. V2 stated there has been a delay in having the physician sign for the prescription and difficulty with contacting the physician. V2 stated the nurse should requested a refill before R49 completely ran out of her narcotic pain patch. The facility's Pain Management Policy reviewed 09/01/2022 states: The facility's mission is to promote resident comfort. The purpose of the policy is to accomplish that mission through an effective pain management program, and providing our residents the means to receive necessary comfort. "We will achieve these goals through: o Preventing and minimizing anticipated pain when possible. o Using pain medication judiciously to balance the resident's desired level of pain relief with avoidance of unacceptable adverse consequences. "For the purpose of this policy, pain is defined as (whatever the experiencing person says it is, existing whenever the experiencing person says it does)."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006779	A. BUILDING: _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 14 (B)	S9999		