STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003511	A. BUILDING: _____ B. WING _____	C 02/05/2022

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GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

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S 000	Initial Comments Complaint Investigation: 2290892/IL143117	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) 300.1210 b)4) 5) 300.1210 c) 300.1210 d)1)2)3)6) 300.3220 f) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

2) All treatments and procedures shall be administered as ordered by the physician.

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

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resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

This REQUIREMENT is not met as evidenced by:

A. Based on observation, interview, and record review, the facility failed to provide care and assistance in accordance with the resident's plan of care and to meet the resident's need to have two staff assist with transfers and other ADL's (activities of daily living) for one (R1) of three residents reviewed for accidents. This failure resulted in R1's emergent transfer to local hospital, where R1 was diagnosed with an acute elbow fracture.

B. Based on interview and record review, the facility failed to provide timely interventions and care for a resident who complained of pain for multiple days for one (R1) of three residents reviewed for nursing care. This failure resulted in R1 being in severe pain while waiting three days for an x-ray, then being emergently transferred to local hospital, and diagnosed with an acute right elbow fracture.

C. Based on observation, interview, and

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S9999	Continued From page 3 record review, the facility failed to assess and manage a resident's pain consistent with the plan of care and failed to follow-up on pain interventions for one (R1) of three residents reviewed for pain management. This failure resulted in R1complaining of extreme pain for multiple days without adequate pain relief related to a fractured elbow. D. Based on observation, interview, and record review, the facility failed to ensure that the resident's plan of care included the most recent hospice plan of care and coordination of care between the facility and hospice agency in order to maintain the resident's well-being and management of pain. This failure applied to one (R1) of three residents reviewed for hospice and resulted in delayed treatment for comfort care and pain management for R1 who sustained a right elbow fracture. Findings include: R1 is a cognitively impaired with diagnosis listed in part with Parkinson's disease, anxiety disorder, hypertension and chronic pain. R1's most recent quarterly MDS (Minimum Data Set) assessment dated 12/7/21 shows R1 to have a BIMS score of 5 demonstrating severe cognitive impairment. This same assessment shows R1's activities of daily living in regard to bed mobility and transfer ability as totally dependent requiring a minimum of 2-person assist to reposition in bed and transferring between surfaces (i.e. bed to chair). R1's ADL (activities of daily living) care plan initiated 2/2/21 reads in part, "I have limitations with my ADLs because I have arthritis,	S9999		

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Parkinson's, anxiety, and right shoulder pain. Approaches: Transfer me with dependent staff assistance via mechanical lift; Reposition me in bed with extensive/dependent staff assistance of 2; Assist me with my toileting needs with extensive/dependent staff assistance of 2 to be changed when in bed."

R1's skin care plan initiated 9/21/21 reads in part, "I am at risk for skin tear due to fragile skin. I've had history of skin tear on my left leg, scraped it on the edge of chair. Approaches: Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface; Use long sleeves clothing for extra protection of the limbs; Use padding such as pillows, extra linen or other devices to protect limbs during transfers and turning and repositioning."

R1's care plan dated 12/15/21 reads in part, "Terminal condition and currently under the care of hospice. Goal: (R1) will be kept comfortable as manifested by no signs or symptoms of pain. Approaches: Monitor for complaints of pain or discomfort and reposition or medicate PRN as needed. CNA (Certified Nurse Assistant) to report signs and symptoms of discomfort to nurse. Assess pain level using 1-10 scale and then reassess and document effectiveness; Reposition every 2 hours if unable to reposition or move themselves; Nurse to assess and start treatment and call MD as per protocol."

R1's progress notes of 1/28/22 at 9:28 PM written by V6 (Registered Nurse/RN) read in part, "Late Entry: patient was asked about what happened to (R1) right elbow to be bruised, patient states (R1) does not remember anything and denies anybody hurting (R1). Patient also refused (R1's) hand to

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S9999	Continued From page 5 be immobilized in a sling to prevent pain with movements especially when repositioning a patient. Will continue to monitor." X-ray service company showed date of service on 1/30/22 at 7:16 PM, three days after V6(RN) called for x-ray company to x-ray R1's arm and elbow area. X-ray result interpreted by V18 (doctor) showed "Impression: Proximal ulnar acute fracture." A facility incident report reads in part, "Description of occurrence: 1/31/22, 8:22 PM-X-ray result of the right elbow: proximal ulnar acute fracture. Orders to transfer resident to hospital via ambulance." Records from the hospital showed the ambulance arrived at the facility on 1/30/22 at 10:29 PM to transport R1 to the hospital emergency department. Hospital records read in part, "Date of service: 1/30/22 11:47 PM. Patient is a 84 year old female with past medical history of Parkinson disease, depression, recurrent urinary tract infections, dementia. Alert, oriented x 2 at baseline the present to emergency department for evaluation right elbow fracture from the nursing home. Per nursing home staff, patient getting changed and getting rolled to her side and is excellently (sic) rolled into the wall as her bed abuts the wall. Patient complained of pain in her right elbow, x-ray performed today shows fracture and she is sent in for further evaluation." On 2/1/22 at 9:30 AM, V3 (Assistant Director of Nursing/Nursing Supervisor) stated upon interview, "I sent public health the initial investigation of R1's incident but the administrator	S9999		

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and director of nursing are also doing the investigation in to how R1 got a fracture. We are interviewing all the nursing staff to see who took care of (R1) to find out how it happened. " Surveyor asked whether the facility determined whether this was a fall or any form of abuse, V3 stated, "We don't know yet." Surveyor asked how R1 is generally assisted with ADLs (activities of daily living). V3 stated, "(R1) is pretty much extensive assist with everything. We normally get (R1) up every day and place (R1) on (R1's) chair (geriatric recliner) and then (R1) goes back to bed after lunch." Surveyor asked how this is done. V3 stated, "We use a (mechanical) lift." Surveyor asked how many people are required to do this for R1. V3 stated, "There should be 2 staff." Surveyor asked if R1 was able to move in bed by self. V3 stated, "No (R1) cannot move by herself, (R1) needs 2 people." V3 (Assistant Director of Nursing/Nursing Supervisor) stated upon interview, "R1 is on hospice and (R1) was sent out Sunday 1/30/22 due to a fracture." Surveyor asked how often hospice came to care for R1. V3 stated, "I know they keep a hospice binder upstairs, but I think they haven't been here awhile."

On 2/1/22 at 9:45 AM, surveyor went to R1's previous bedroom after R1 transfer to the hospital. R1's room was situated near the furthest end of the hall. In the room were two metal beds that were both aligned and propped against the wall. The metal frame of the bed was exposed and had a blue foam mattress that appeared stripped down after R1 was hospitalized. The wall adjacent to R1's bed was marred with stains, scratches, holes and peeling paint. V5 (LPN/licensed practical nurse) was asked to identify which bed R1 was in. V5 pointed to the bed closest to the window and stated, "That was

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(R1's) bed. We have always put the bed right next to the wall so (R1) don't fall on the right side and we put a mat on the other side so (R1) don't fall. There is no one in the other bed because (R1) was on isolation." Surveyor asked whether R1 ever rolled out of bed to warrant the bed being wedged against the wall and fall mat. V5 stated, "No I don't think so, (R1) does not move very much." Surveyor asked whether there was any type of padding used to protect the resident as the bed appeared to have exposed metal parts, V5 stated, "We have long sleeves on the resident all the time." Surveyor asked about R1's ADLs. V5 stated, "(R1) is hospice and (R1) is mostly total assist. I always check on (R1) and hospice comes too." Surveyor asked to clarify what total assist meant. V5 stated, "(R1) need 2 people to help (R1) with everything." Surveyor asked how often hospice came to care for R1. V5 stated, I'm not sure because sometimes they come when I am not here, but I have not seen the nurse for a while."

Hospice binder presented to surveyor showed the last visit by the hospice CNA was on 1/19/22 at 6:30 AM and was provided a bed bath, lotion, nail care and transfer to the chair. This same hospice binder showed the last visit occurred 10 days prior by the hospice nurse RN to be on 1/22/22. Surveyor asked V5 who the nurse's signature that was dated 1/22/22. V5 stated, "That's V16 (RN)"

Further review of R1's hospice binder and facility progress notes show no coordination of care between hospice agency and the facility.

On 2/1/22 at 9:55 AM, interview with V4 (Certified Nurse Assistant/CNA) stated, "I work with (R1) often. (R1) was in bed when I bring (R1) food and I put (R1) up in bed. Most of the time (R1) we

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S9999	Continued From page 8 put (R1) in (R1's) chair (geriatric recliner) because it is easier to feed (R1) when (R1) is up. When (R1) is in bed I will use (R1's) draw sheet to move (R1) in bed, that's when (R1) screamed in pain when I turned (R1). (R1) wore sleeve so I looked at it and it was red and swollen so I told nurse." Surveyor asked how she normally transfers R1 from the bed to geriatric-chair. V4 stated, "I use a sling and put it on (R1) in bed, then I use the (mechanical lift) to transfer (R1) to the geriatric-chair." Surveyor asked if anyone helped her do this. V4 stated, "No, I did it myself." Surveyor asked when R1 is in bed, how many staff it took to move R1 in bed. V4 stated, "I did it myself. I move (R1) with the sheet and (R1) turn and I change the diaper this way or when I have to put sling under (R1). We always do it this way." On 2/1/22 at 10:20 AM, interview with V7 (CNA) stated, "I worked with R1 2 days ago on the 7-3 shift. (R1) was in (R1's) chair (geriatric recliner) already when I saw (R1) because the night shift CNA dresses (R1) up and puts (R1) on the chair already. I saw (R1) one time when (R1) was sliding down from (R1's) chair and (R1) was screaming help. I pulled (R1) back up and I put (R1) back in bed so (R1) don't fall." Surveyor asked how she did this. V7 stated, "I used the (mechanical) lift." Surveyor asked whether anyone assisted her with the mechanical lift. V7 stated, "No I did this myself. (R1) didn't fall or anything and I didn't bang (R1's) arm or anything when I did it." Surveyor asked if she noticed the swollen arm when providing R1 care. V7 stated, "No I didn't see anything, when I change R1 (incontinence brief) R1 didn't say anything. (R1) just shouts that (R1) is in pain but (R1) always complain of pain." Surveyor asked if she moves R1 herself when she changes R1 in bed. V7	S9999		

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S9999	Continued From page 9 stated, "Yes, I do it myself all the time." Facility's interviews with staff showed R1 was complaining of severe pain beginning on 1/25/22 and with the facility attributing this pain as R1's usual behavior: A statement from V9 (CNA.) taken by facility, read in part, "Last time resident seen: 1/25/22 at 3 AM, (R1) usually complain of pain on right shoulder. (R1) always scream at me and say, don't touch me and sometimes (R1) hits (R1's) right elbow with (R1's) stronger side to the wall because (R1) doesn't want to be touched, even you're not touching (R1) yet." Review of pain assessments on 1/25/22 show 0-zero listed pain during both afternoon and night shifts with no other additional PRN (as needed) pain medications as ordered or interventions provided to alleviate R1's pain. A statement from V11 (CNA) taken by facility reads in part, 1/26/22. 3-11 shift CNA Facility asked V11 if R1 complained of pain and V11 stated "no" but her usual behavior was that she does scream. Facility asked V11 whether R1's incontinence brief was changed during her shift on 1/26/22 and V11 replied in her statement that resident had refused (R1's) diaper change at that time. The facility did not inquire further with V11 as to the reason R1 refused to be changed or whether it was due to not being moved due to R1's pain. Review of pain assessments on 1/26/22 show 0-zero pain for both 3-11 PM shifts and 11-7 night shifts and R1 was not provided any additional PRN pain medications as ordered or other interventions to alleviate R1's pain.	S9999		

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A statement from V7 (CNA) taken by facility read in part, "1/28/22-AM shift. After lunch, transferred resident to bed via (mechanical lift). Resident usually screams when transferring (R1) and that's usual for (R1) when moving (R1). I also noticed that (R1) was still holding (R1's) right arm/elbow."

Review of pain assessments on 1/28/22 show 0-zero listed pain during both morning shift when R1 screaming and holding R1's right arm and elbow. The afternoon shift was also recorded as 0-zero for no pain. The night shift recording pain of 9 out of 10 for severe pain but had no additional medications provided as ordered or other interventions to alleviate R1's pain.

A review of R1's medication administration records for January 2022 showed on 1/7/22 R1's pain level was at a 7 out of 10; 1/8/22 pain level was 8 out of 10; 1/10/22 pain level was 8 out of 10; 1/24/22 pain level was at a 9 out of 10; and 1/28/22 pain level of 9 out of 10. Of these days, no PRN (as needed) pain medication was provided to R1; yet on 1/27/22 pain level was recorded at 5 out of 10 and PRN pain medication was given; 1/29/22 pain level was 8 out of 10-PRN pain medication given. 1/30/22 pain level 7 out of 10--PRN pain medication given.

Hospital records dated 1/31/22 show R1 was admitted to the hospital with right elbow fracture (Proximal ulnar acute fracture).

Facility records show on 2/2/22, R1 was readmitted back to the facility.

On 2/2/22 at 7:46 PM, V6 (RN) readmitted R1 back to the facility and wrote in part, "Transported by ambulance via stretcher. AOX2 and verbal.

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S9999	Continued From page 11 Patient has right arm sling on for right elbow fracture and to be worn at all times. Right elbow bruise is yellow in color and the swelling has decreased. patient still complaining of pain of both arms and hurts more on the right elbow fracture. Hospice will be here tomorrow to re-admit patient back on hospice as per son and hospital report." Efforts to contact V17 (physician) on 2/3/22 and 2/4/22 were left unanswered. On 2/3/2022 at 3:03 PM, V17 (physician) wrote in R1's progress note that read in part, "Physician Progress Note: History & Physical: 84 year old female with Primary history of Parkinson's, depression, anxiety, hypothyroidism, coronary artery disease without history of stroke, recurrent UTIs, dementia. Alert and oriented x 2 at baseline who presented to nursing home for evaluation of right elbow fracture. As per nursing home staff, patient was getting changed and rolled to (R1's) side and accidentally rolled into the wall as (R1's) bed is against the wall. X-ray done at the nursing home showed right elbow fracture and patient was transferred to ER for further evaluation." On 2/4/22 at 10:45 AM surveyor visited R1's room to interview the resident. R1 was in bed that was parallel to the wall. A light green mattress was placed upright on it's side and was wedged in between R1's bed and wall. R1 appeared uncomfortable and was audibly moaning. Surveyor asked how R1 was doing. R1 stated, "I'm still in pain. I was shoved up against that wall. That thing is new (motioning with R1's head about the greenish mattress). Surveyor asked whether the nurse gave R1 pain medications. R1 stated,	S9999		

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S9999	Continued From page 12 "Yes but it still hurts." Surveyor asked if R1 knew who pushed R1 against the wall. R1 stated, "I don't know, I know she's white and she has black hair." Surveyor asked when this happened, R1 stated, "I don't know but I've been complaining of pain and they didn't do anything. Finally, I went to the hospital I remember telling them at the hospital too." Surveyor asked how long R1 has been complaining of pain. R1 stated, "I don't know, days, hours, a long time." Surveyor asked if R1 was given pain medications when R1 complains of pain. R1 stated, "Sometimes but they don't work enough. They keep telling me I'm fine." On 2/4/22 at 10:50 AM, V8 (CNA) was asked about R1. V8 stated, "Yes she is my patient today. I saw her earlier and she complain of pain, but the hospice CNA was here earlier, so I didn't tell anyone because I thought the hospice CNA already told the nurse." Surveyor asked what she's done with the resident so far this morning, V8 stated, "She was still in bed when I got here. I think the hospice CNA already took care of (R1), so I didn't have to do anything, so I took care of my other residents." On 2/4/22 at 10:55 AM, V5 (Licensed Practical Nurse/LPN) was asked whether she saw R1 for R1's pain this morning. V5 stated, "I saw (R1) earlier but (R1) got pain medications from the night shift nurse. Why is (R1) complaining of pain again? " Surveyor informed V5 to assess the resident directly. V5 stated, "Yes I will do that." Surveyor asked whether there was any conversation with the hospice physician to reevaluate R1's pain regimen and medications, V5 stated, "I have not seen them for a while, but I will find out."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003511	A. BUILDING: _____ B. WING _____	C 02/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

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S9999	Continued From page 13 On 2/4/22 at 10:58 AM, V2 (Director of Nurses) wrote in R1's progress notes, "Follow up call to Hospice to inquire why nurse has not arrived yet. Spoke hospice Director of Nursing who stated RN will be coming and this nurse (V2) requested immediate response." On 2/4/22 at 11:05 AM, surveyor asked about R1's hospice, V2 (Director of Nursing) stated, "I know that I have been having issues with them coming here and I'm aware of this and I've already put a call out to them. I know they should be here weekly or at least the hospice c.n.a should be." Hospice contract presented to surveyor on 2/4/22 reads in part, "Services provided to me (R1) will be as follows: Routine home care: expected frequency and duration: Daily. Respite care: as needed; General inpatient care: As needed; Continuous care: As needed." On 2/4/22 at 11:47 AM, V1 (Administrator) wrote in the nursing progress notes that read in part, "Notified by (V5) LPN of resident complaints of pain 9 of 10 in both shoulders in spite of 5 mg morphine given at 11:08 PRN (as needed) and 6:45 Norco PRN for 10/10 both arms, shoulders, and buttocks. V5 notified NP and ordered for hospice to give baseline orders. I assessed the resident and (R1) was resting calmly in bed with left arm over right arm, no shortness of breath, no brow furrowing, no agitation, does not appear in pain. Hospice was called by V2 (Director of Nursing)." Interview with V6 (RN) on 2/4/22 at 12:30 PM stated, "I was told by the CNA (V4) that the resident was complaining of pain earlier during the start of my shift (3-11 Friday 1/28/22). I	S9999		

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S9999	Continued From page 14	S9999		

assessed R1's arm because (R1) pointed to it that (R1) was in extreme pain. (R1's) arm was very bruised, purple colored and it was swollen." I notified the hospice agency, the doctor and son to let them know. V14 (physician assistant) ordered to get x-ray of the resident and so I called the x-ray company and they said they'd come out that same night. I left for my shift at 11 PM and I found out the next day because I worked again (3-11 shift) that the x-ray company never came. The x-ray company kept telling us they would come but they still didn't, so we informed the son, hospice and the doctor know again, and we just waited. The next day Sunday (1/30/22), I worked again the 3-11 shift and the resident still had not gotten an x-ray to find out where the pain and swelling was, so I contacted the hospice nurse (V16) who called her supervisor. I pleaded with them that we need to send the resident to the hospital to get x-rays, but they said she couldn't go out because (R1) was hospice. I told them this was about patient comfort and that (R1) had been complaining for days about pain, so they finally were able to send an ambulance to go to the hospital for treatment and x-rays. Before I could send (R1) out, the x-ray people finally came to the building and took the x-ray and so we waited again for the results which showed (R1) got a fracture, so then I was finally able to send (R1) out to the hospital." Surveyor asked why it took several days for R1 to get x-rays and if anyone else from the facility followed up with the x-ray company. V6 stated, "I'm not sure why. I just know that when I left for my shift, I thought the other nurse would follow up." Surveyor asked if a doctor gives orders when these orders need to be carried out. V6 stated, "They should be carried out right away when you get the order and there should be a follow up to make sure it was carried out." Surveyor asked if she knew how R1 could

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S9999	Continued From page 15	S9999		

have been injured. V6 stated, "I don't know. (R1) always is in chronic pain and especially when (R1) is moved by the CNAs to get cleaned up or whenever." Surveyor asked how R1 is generally handled with transfers, toileting, and other ADLs. V6 stated, "(R1) is hospice so mostly when they are not here, the CNAs will clean (R1) up and put (R1) in (R1's) chair (geriatric recliner) and then put (R1) back to bed." Surveyor asked what type of assistance R1 required in performing all of these ADLs. V6 stated, "(R1) is extensive assist so there should be two people to move (R1) to (R1's) chair but the staff are supposed to use the (mechanical lift)." Surveyor asked when R1 is "cleaned up" as she mentioned. V6 stated "I know that the CNAs will change (R1) in (R1's) bed but there's also just one hospice CNA that does this by herself too when she is here. I don't think it needs two people."

On 2/4/22 at 1:00 PM, V3 (ADON) provided surveyor contact information for hospice agency. Calls to the hospice agency were met with no return calls.

On 2/4/22 4:00 PM R1 was provided new orders for increased pain medications. V5 (LPN) wrote in progress notes that read in part, "Communication with Physician. Spoke with hospice nurse/ hospice doctor to clarify medication for resident due to resident in pain. New order received and noted: Discontinue Norco 5/325 mg and Norco 10/325 mg PO PRN, start Norco 10/325 mg PO TID (6AM, 2PM, 10 PM) for moderate to severe pain; start Clonazepam 1 mg PO at bedtime for agitation and restlessness."

"A"