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
	IL6003214	A. BUILDING: ______ B. WING ______	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NORTH BRANCH	6840 WEST TOUHY AVENUE NILES, IL 60714

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S 000	Initial Comments Complaint investigations: 2395001/IL161038 2395274/IL161363 2395619/IL161790 2393104/IL158711 2395954/IL162193 2395317/IL161416 2395434/IL161572 2393225/IL158851 2393253/IL158895 2393778/IL159555 Facility Reported Incident of 4/20/23/IL159617	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 11): 300.610a) 300.1210b) 300.1210c) 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

These requirements were not met as evidenced by:

Based on interviews and record reviews, this facility failed to provide continuous CPR and chest compression until emergency services arrived after R4 was found to be unresponsive and code blue called and prior to EMS team arriving. This affected one of three residents (R4) reviewed for CPR and unresponsive residents. This failure resulted in R4 not receiving CPR until the EMS team arrived and R4 being transported to the local hospital where R4 required treatment for diffuse anoxic brain injury (Complete lack of oxygen) by mechanical ventilation and subsequently expiring.

Findings include:

On 7/28/23, R4's family member stated R4 had video monitoring device positioned facing R4.

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R4's family member stated on 1/4/23 she was watching R4 via the video monitoring device until 10:15 am when she had to start work. R4's family member stated she checked back at 10:45am and observed the device had been turned so she could not visualize R4. R4's family member stated she called this facility at 11:30 am and spoke with V97 DON (former director of nursing) and was informed V2 would go to R4's room and check the video monitoring device and instruct staff not to touch it again. R4's family member stated the next thing she knew she was being notified R4 was unresponsive. R4's family member stated at 10:15 am, R4 was okay and in no distress.

On 7/27/23 at 12:30pm, V30 RN (registered nurse) stated V30 was working on R4's nursing unit on 1/4/23 but was not assigned to provide care for R4. V30 stated V52 CNA (certified nurse aide) was shouting for help. V30 and V32 LPN (licensed practical nurse) walked in to R4's room, Respiratory therapist came in also, R4 was observed in reclining chair. V30 stated R4's vital signs, oxygen saturation level, and ventilator settings were checked. V30 stated V30 did not hear any alarms sounding from R4's ventilator. V30 stated R4 was transferred from chair to bed. V30 stated V30 believes CPR was performed after R4 was transferred to bed but is unsure. V30 stated V30 did not perform chest compressions or rescue breathing with the bag valve mask (Ambu bag). V30 stated a code blue was announced overhead. V30 does not recall if V30 or another nurse called EMS 911. V30 stated V30 does not recall if AED was used. V30 stated nursing is supposed to document on a code blue sheet. V30 stated the resident's nurse documents a summary of events in the resident's progress notes.

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On 7/27/23 at 3:40pm, V32 LPN (licensed practical nurse) stated V32 was assigned to provide care to R4 on 1/4/23. V32 stated V32 received a telephone call from V1 (administrator) stating R4's electronic surveillance monitoring device was disconnected or turned away from R4. V32 stated V32 went to check R4 and found R4 unresponsive sitting in a reclining chair. V32 stated the reclining chair does not recline flat. V32 stated V32 called out for the respiratory therapist and called a code blue. V32 stated more nurses arrived. V32 stated V32 left R4's room to call EMS 911. V32 stated R4 was transferred from chair to bed by staff in R4's room at some point. V32 stated V15 RT (respiratory therapy manager) was performing chest compressions and not managing R4's airway.

7/28/23 at 11:03am, V15 RT (respiratory therapy manager) stated the nurse, V32, assigned to R4 was performing CPR on 1/4/23. V15 stated V15 was maintaining the airway and using the bag valve mask on R4. V15 stated CPR was performed in the reclining chair with backboard under R4. When asked to clarify location of R4 during this event, V15 stated R4 was in chair during event. V15 then stated R4 was found in reclining chair, CPR was started in chair and thinks R4 was moved to bed to continue CPR. V15 stated V15 does not recall if AED was used.

On 7/28/23 at 2:00pm, V34 (nurse) stated V34 recalls R4 but does not recall event on 1/4/23. V34 reviewed R4's code blue sheet and stated the code blue sheet notes V34 initiated CPR (cardiopulmonary resuscitation) at 12:06pm. V34 is unable to state who was performing chest compressions or rescue breathing for R4. V34 stated the AED was applied at 12:10 pm and a

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shock delivered at 12:11pm.

On 7/27/23 at 4:30pm, V51 (EMS paramedic) stated the fire engine crew arrived first because the ambulance was finishing another call and then responded to this facility. V51 stated V51 does not recall this event but stated the EMS run sheet provides an accurate description of the event.

On 8/3/23 at 10:50am, the local fire engine report, dated 1/4/23, was reviewed with V50 (fire department personnel). V50 stated fire engine 3 arrived at the facility first because the ambulance was coming from the hospital. V50 stated EMS personnel from the engine and ambulance provided resuscitative care for R4 prior to transporting R4 to the hospital.

The EMS 911 run sheet, dated 1/4/23, notes crew notified at 12:09 pm for resident in cardiac arrest. Ambulance crew arrived at R4's bedside at 12:18 pm. Upon arrival found R4 lying in bed in cardiac arrest with fire engine crew performing CPR. Fire fighter stated nurse shocked once with no change and R4 was in asystole (without pulse) on the monitor upon the arrival of the fire engine crew. Baseline manual vital signs were obtained, and compressions were done by EMS' portable chest compression system. AED pads were placed on R4. Paramedics administered two doses of epinephrine (intravenous medication increases heart and brain blood flow during CPR). Return of spontaneous circulation was established. R4 was monitored in route and re-arrested in the ambulance bay at the hospital. Additional dose of epinephrine was given with positive change. This report notes CPR prior to the arrival of EMS crew was not attempted. EMS initiated CPR and

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performed chest compressions; ventilations were attempted.

Fire engine 3's report, dated 1/4/23, notes crew was notified at 12:09 pm for resident in cardiac arrest. Fire engine 3 arrived at the facility at 12:12pm. Primary action taken was ALS (advanced life support) care prior to the ambulance crew's arrival. Fire engine 3 and ambulance personnel provided ALS care and then R4 was transported to the hospital.

R4's hospital record, dated 1/4/23, notes on arrival R4 once again arrested, CPR in progress on arrival. A pulse check, R4 did have palpable carotid pulses. R4 with no spontaneous extremity movements, skin cool and dry, neurologic assessment noted R4 unresponsive, pupils sluggishly reactive to light. R4's neurologic baseline previously was more interactive, responsive, able to move extremities, and mouth words. MRI (magnetic resonance imaging) noted diffuse anoxic brain injury (complete lack of oxygen to the brain resulting in the death of brain cells). Pulse oximetry (measurement of oxygen saturation level) was ordered and reviewed: 92% on bag valve mask indicating inadequate oxygenation. R4's condition did not improve with aggressive treatment. R4 expired in hospital on 1/20/23.

Review of R4's code blue sheet, dated 1/4/23, notes R4 was found at 12:05 pm unresponsive and without pulse. It notes CPR initiated at 12:06 pm but does not note if chest compressions and/or bag-valve-mask resuscitation occurred. It only notes cardiac board placed under back, oxygen/bag-valve-mask assembled, suction set-up in place, and AED applied at 12:10 pm and shock received at 12:11pm. It also does not note

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S9999	Continued From page 6 when R4 was moved from reclining chair to bed. Review of R4's medical record, dated 1/4/23, V32 noted at 12:05 pm while making rounds to assess R4 for dialysis, R4 noted unresponsive in dialysis chair by V32. Code blue immediately called, EMS 911 contacted, and CPR initiated by staff and RT. AED applied. Vital signs unappreciated, blood sugar 153. EMS 911 in the facility at 12:14 pm and took over CPR. This facility's CPR policy, revised 3/22/22, notes the facility will provide basic life support, including CPR, when a resident requires such emergency care, prior to the arrival of EMS. On 7/28/23 at 9:37am V38 (attending physician) stated this facility's medical director should write or oversee the AED (automated external defibrillator) protocol. V38 stated if the resident is found unresponsive, staff must call EMS (emergency medical services) 911 immediately and start chest compressions. V38 stated while the chest compressions are being done someone should run and go get the AED. V38 stated the chest compressions should continue while the AED leads are being attached to the resident. V38 stated if the facility is going to have AEDs, then all nursing staff should be trained on how to use it. V38 stated the AED should be kept on the code blue cart. V38 stated the AED should be applied to the resident right away, after CPR initiated, to determine if a shock is needed. On 8/11/23 at 4:15pm, V38 (attending physician) stated all ventilators have alarms to alert staff to check resident and determine what is going on with resident. V38 stated if the ventilator tubing becomes disconnected from the resident's tracheostomy tube, the ventilator's alarm will	S9999		

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sound to indicate disconnection has occurred. V38 stated if a resident is having decrease in breathing on the ventilator, the ventilator's apnea alarm should sound. V38 stated having the ventilator's apnea alarm on should be the standard of practice.
(No Violation)

Statement of Licensure Violations (2 of 11):

300.610a)
300.1210b)5)
300.1210d)6)

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.

Section 300.1210 General Requirements for Nursing and Personal Care

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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.

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:

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.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to implement effective fall interventions to include monitoring/supervision, and safe outpatient transport. This affected three of three residents (R1, R17, and R18) reviewed for fall prevention. This failure resulted in R1 getting out of bed at approximately 3:30am falling to the floor sustaining a right femoral neck fracture.

Findings include:

R1

R1 admitted to the facility on 1/7/22 with a diagnosis of type II diabetes, kidney disease, encephalopathy, and history of falling.

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R1's fall risk dated 2/27/23 documents: R1 is at high risk for falling. Under gait: impaired gait (difficulty rising from the chair, uses chair arms to get up, bounces to rise, keeps head down when walking, watched the ground, grasps furniture, person or aid when ambulating, cannot walk unassisted). Under mental status: overestimates or forgets limits.

R1's fall care plan dated 1/8/22 documents: R1 is at high risk for falls due to impaired balance, gait and mobility, needs assistance with surface-to-surface transfer related to weakness and impaired cognition with confusion secondary to dementia, diabetes, unsteadiness on feet, lack of coordination and history of falling and recent fall on 4/20/23. Interventions in place prior to fall on 4/20/23: Keep furniture in locked position. Date Initiated: 01/08/2022; Maintain a clear pathway, free of obstacles. Avoid repositioning furniture. Date Initiated: 01/08/2022; Keep needed items, water, etc. in reach. Date Initiated: 01/08/2022; Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: 01/08/2022; Be sure call light is within reach and encourage resident to use it for assistance as needed Date Initiated: 01/08/2022 Revision on: 02/20/2022; Ensure that resident is wearing appropriate footwear (nonskid socks/rubber soled shoes) when ambulating or mobilizing in wheelchair. Date Initiated: 01/08/2022

On 7/26/23 at 3:29PM, V19 (Nurse) said R1 was fall risk and would try to get up form bed. V19 would be looking for coffee at times. At time of fall, R1 observed coming out of room by V83 (CNA). V83 attempted to get to R1, but he fell on

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his right side by door of his room.

On 8/10/23 946AM, V83 (CNA) said R1 was a fall risk and would try to get up and walk from his wheelchair.

On 8/4/23 10:30Am, V5 (social service) said R1 had behavior of being restless and attempting to get up unassisted. Interventions in place were to move closer to nursing station, frequent rounding at least every 2 hours and R1 needed to be supervised.

On 8/1/23 at 12:44am, V41 (CNA) said R1 had behaviors of trying to get up unassisted and tries to get coffee.

R1 hospital record dated 4/20/23 documents: x-ray of right hip: transverse, displaced and overlapped subcapital fracture of the right femoral neck.

R17

R17 admitted to the facility on 2/21/22 with a diagnosis of major depressive disorder, cyst of pancreas, cauda equina syndrome, hyperlipidemia, vascular disease, and hypertension.

R17 progress notes dated 5/17/23 documents R17 informed writer that she fell on her right side with wheelchair yesterday on her way to V88 (MD) appointment. R17 said she informed the doctor and x-rays were done aside from scheduled back x-rays and no injury noted. Body assessment done, no bruise, no swelling.

On 7/25/23 at 2:05PM, R17 who was alert and

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oriented x 3 said on May 16 she was going to doctor appointment and she fell in the facility van while she was in her wheelchair. R17 said the driver did not strap her wheelchair in correctly and when the facility van turned right the wheelchair tipped over causing the resident to fall while in the wheelchair to her right side.

On 7/27/23 at 1:36PM, V90 (transportation company) said R17 did sustain a fall on the transportation trip on 5/16/23. V90 was unable to provide any further information.

On 8/10/23 at 11:20AM, V1(Administrator) said transportation called to inform the facility of the incident but unsure of the date or who spoke to the company. V1 said they have no control over the transportation company and if a resident is a fall risk, they will provide an escort.

R18
R18 was admitted to the facility on 4/4/23 with a diagnosis of encephalopathy, traumatic subdural hemorrhage without loss of conscious, aphasia, repeated falls, hemiplegia, and hemiparesis affecting right side, epilepsy, acute respiratory failure with hypoxia, pulmonary nodule, heart failure, hyperlipidemia, atherosclerotic heart disease and dementia.

R18 fall report dated 4/28/23 documents resident was observed sitting on the floor beside wheelchair. Under location: dining room. No injuries observed.

On 8/2/23 at 12:58PM, V47(CNA) said she was assigned to monitor dining room on 4/28/23. V47 said she was talking to another resident in the room when she heard a resident screaming. V47 said she turned around and observed R18 on the

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floor by his wheelchair.

On 8/9/23 at 11:59AM, V2 (DON) said staff are to be always monitoring the dining room when there are residents in the room. Staff should be able to see all residents to ensure they are supervised and overseeing their safety.
(A)

Statement of Licensure Violations (3 of 11):

300.610a)
300.1210b)2)3)
300.1210c)
300.3240a)

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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.

Restorative measures shall include, at a minimum, the following procedures:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee

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or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess, monitor, prevent urinary tract infections and secure indwelling catheters. This affected four of four (R6, R7, R27, R39) residents reviewed for indwelling catheter and catheter care. This failure resulted in R6 sustaining labia wound consistent with the width of the indwelling catheter, R7 being diagnosis with sepsis due to polymicrobial infection, R27 having a partially obstructed urine output with feces caked on the catheter and R39 who had a history of urinary retention complaining of abdominal pain which result in a urinary tract infection.

Findings includes:

(R6)

R6 had the diagnosis of Neuromuscular Dysfunction of Bladder. Minimal data set dated 4/10/23 section H documents: indwelling catheter

On 7/28/23 at 9:37am, V38 (medical doctor) said, R6 did not received Foley catheter care using any aseptic techniques. R6's Foley insertion site was not cleaned properly. The facility was not practicing infection control protocols. There is no way that many bacteria are jumping into a Foley without facility staff spreading contaminates.

Emergency Department (ED) note dated 4/8/23 documents: Foley catheter is out and is draining

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white pus material. ED diagnosis documents: Urinary tract infection associated with indwelling urethral catheter. R6's old catheter from nursing home was not stabilized with a stat lock or tape to the leg and only was being held by R6's diaper. While changing out the Foley a wound was found to the labia with the same width of the Foley catheter. Urine Culture collected date 4/8/23 at 2014 (8:14 pm) documents: Three or more organisms present (polymicrobial sepsis): gram positive cocci in chains, staphylococcus and yeast, etiology was unclear. R6 was admitted with UTI possible urosepsis.

(R7)

R7 had the diagnosis of Neuromuscular Dysfunction of Bladder. Minimal data set dated 5/2/23 section H documents: indwelling catheter

On 8/4/23 at 9:19am, V59 (nurse practitioner) said, R7's Foley infection was related to poor care.

Hospital paperwork dated 4/14/23 documents: R7 was admitted to the floor at this time. Urine culture positive for proteus mirabilis and Providencia stuartii. UA dated 4/14 with moderate leukocytes and many bacteria. Nursing admission report undated documents: Sepsis secondary to UTI.

(R27)

R27 was diagnosis with Anoxic Brain Damage, Acute Respiratory Failure with Hypoxia, encounter for attention to Tracheostomy, dependence on respirator (ventilator), End Stage Renal Disease Dependence on Renal Dialysis and Pressure Ulcer of Sacral (Stage 4). Minimal

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data set section H (bladder and bowel) dated 6/7/23 documents: Indwelling catheter

On 7/28/23 at 9:37am, V38 (medical doctor) said, R27's Foley catheter was infected. The cultures showed multiple drug resistance organisms. R27's catheter was not changed appropriated if at all. The insertion site was not cleaned properly. The facility was not practicing infection control. There is no way that many bacteria are jumping into a Foley.

On 7/28/23 at 3:11pm, V43 (wound tech/CNA) said, R27 had a Foley. V43 said when R27 had a bowel movement, the fecal matter would come up in between R27's legs and cover the Foley. After a bowel movement, R27's Foley tube would need to be clean from the insertion site down. V43 said V43 did not provide any care for R27. R27 was discharged to the hospital.

On 7/28/23 at 3:52pm, V45 (restorative aide) said, V45 provided ADL care for R27 with V43.

On 8/4/23 at 9:44am, V4 (wound nurse) said V4 didn't see any Foley orders for R27.

R27's physician order sheet dated 7/1/23 - 7/31/23- did not document any Foley order.

Hospital paperwork dated 7/21/23 documents: Foley looks like it was sliding in and out with caked on stool, kinked and foul-smelling. R27's Foley and penis was caked with stool. Foley was knotted through the stat lock partially obstruction output.

(R39)

R39's minimal data set dated 7/18/23 section H

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documents: indwelling catheter

On 8/10/23 at 2:00pm, R39 was observed to have the tubing from indwelling catheter through the stabilization device attached to R39's left upper anterior thigh. This tubing was draped over R39's left lateral thigh, under left thigh, under R39's left hand, and then draped over the bed. R39's indwelling catheter was not visible.

On 8/10/23 at 2:00pm, V30 RN (registered nurse) stated R39's indwelling catheter tubing looked okay. When questioned if the indwelling catheter or the tubing should be inserted through the stabilization device on R39's left thigh, V30 appeared puzzled and did not respond. When asked to see R39's indwelling catheter, V30 again appeared puzzled and did not respond. This surveyor asked V30 to remove the fastener on R39's incontinence brief and pull back brief so catheter could be visualized. R39's catheter was under penis, went down the right side of scrotum, under scrotum, and ended at left groin. When questioned if R39's catheter looked okay, V30 responded "yes". This surveyor asked V30 to reposition R39's indwelling catheter so skin under catheter could be assessed. R39's skin was reddened from the catheter.

Progress noted dated 8/6/23 documents: R39 was sent out for lower abdominal pain, ended up having urinary retention. R39's urine culture results, dated 8/10/23 documents: urine with more than 100,000 colonies/ml candida albicans: candida infection. Progress noted dated 8/13/23 documents: R39 complains of abdomen pain. Visibly upset, anxious and concerned that there is something wrong. Progress noted dated 8/14/23 documents: R39 was transported to the hospital.

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Policy, revised 9/1/2016, notes catheter stabilization shall be used to preserve the integrity and position of the catheter.
(A)

Statement of Licensure Violations (4 of 11):

300.610a)
300.1010h)
300.1210b)
300.1210c)
300.1210d)2)
300.1220b)3)

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.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such

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accident, injury or change in condition at the time of notification.

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:

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

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

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to monitor and implement an effective to plan to prevent an unplanned significant weight loss for residents receiving enteral feedings. This affected two of three residents (R6, R46) reviewed for significant weight loss. This failure resulted in R6 having a 15.8% weight loss in one month (2/2/23 - 3/7/23) and R46 having a 12.9% weight loss in two months.

Findings Include:
(R6)

R6 had the diagnosis of dysphagia and encounter for gastrostomy tube.

On 7/26/23 at 11:08am, V44 (dietitian) said, on March 30th R6 had a weight loss. V44 was going to increased R6 feeding but R6 was sent to the hospital.

On 7/26/23 at 11:26am, V29 (nurse) said, V29 pushed air into R6's g-tube to check for placement and R6 grimaced with pain and R6 had a bulge and redness at the g-tube site.

R6's progress note dated 4/4/23 documents: Writer (V29) noticed bulging on g-tube site. Auscultated and no sound detected. Noted grimacing when flushed with air. R6 was

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discharged to the hospital. R6 returned. Emergency room doctor checked and it was only the balloon.

On 7/27/23 at 12:38pm, V30 (nurse) said, R6 had a problem with her g-tube being flush and grimaced with pain a few days prior to my assessment. I flushed R6's g-tube and noticed a bulged at the g-tube site. R6 was sent to the hospital on 4/8/23 for a dislodged PEG tube.

Progress note dated 4/6/23 documents: (V30) observed resident (R6) grimacing upon air flushing and observed bulging. Feeding stopped.

On 8/16/23 at 4:15pm, V44 said, V44 was looking through the R6's chart. V44 said, R6's weight for February was the same weight recorded in the hospital so V44 cannot vouch for that weight being accurate. V44 said V44 requested a re-weight that was not done for February. R6 had the monthly weight recorded in March. V44 said, the goal was to get R6 to gain weight.

On 7/28/23 at 9:37am, V38 (medical doctor) said, R6 had malabsorption related to stopped feeding.

On 8/15/23 at 1:54PM, V2 (DON) said, if a resident was receiving gastronomy tube feeding, they should not lose weight.

Dietitian note dated 3/30/23 documents: R6 has a significant weight loss. 2/13 (readmit weight per hospital)-136.6#, 2/2-152.1#, 1/19 (adm)-150.6#. Weight loss of -6.3% x 2 weeks, -15.8% x 1 mo.

R6's weight report document: dated
4/4/23 - 124.3 pounds,
3/7/23- 128.0 pounds,
2/13/23 -136.6 pounds

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2/2/23 - 152.1 pounds.

Physician order sheet dated 2/16/23 documents: Glucerna 1.5 Cal @ 50 mL/h VIA PUMP ASSIST x 21 h or until 1050 mL given. May hold TF 1 h q shift for wound care, other ADLs.

Hospital paper dated 4/8/23 documents: R6 presented to the ED with the chief complaint of g-tube dysfunction. Tube has not been functioning for the past four (4) days per emergency medical service (EMS) report. Nursing home stated they were unable to flush anything through or give tube feeding, so they have been infusing an unknown amount of dextrose through an IV they placed. Percutaneous gastrostomy (PEG) tube not appearing to be in correct place/mal positioned. ED diagnosis documents: Gastrostomy tube dysfunction: Dysphagia: severe protein calorie malnutrition with PEG tube. R6's weight was 119 pounds and 0.8 ounces

R46

R46 was admitted to the facility on 3/3/23 with a diagnosis of anoxic brain damage, moderate protein-calorie malnutrition, dysphagia, and encounter for gastrostomy, pressure ulcer stage four, anemia, and persistent vegetative state.

On 8/4/23 at 5:50am, V2 assessed R46 for incontinence. R46 was lying on right side and was turned onto her back. R46's gown was wet. V2 lifted R29's gown and observed a face towel wrapped around R46's gastrostomy tube. V2 stated, V2 was informed that this is a chronic problem for R46 because stoma is large. V2 said the towel should not be wrapped around R46's

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tubing, there should be a gauze dressing/drain sponge at the insertion site. V2 said, R46's stoma is draining a lot. R46's stoma was observed to be oozing brown liquid consistent with the brown enteral feeding being pumped through R46's g-tube site. R46 was oozing from the proximal stoma with every inspired breath. V2 said, R46's feeding should not be oozing out. V2 said the nurse is expected to notify the physician and not just wrap a towel around it. V2 said, if R46's feeding is oozing out it can't be determined how much feeding R46 is actually receiving.

On 8/15/23 at 1:07pm, V44 (dietician) said, V44 was not notified of any additional weight loss for R46 for the month of August by the facility. V44 said, V44 found out about R46's current weight loss through a chart review last week. V44 said, V44 has not made any changes yet to R46's tube feeding due to the facility not having their monthly Nutritional at risk meeting because Illinois Department of Public Health (IDPH) was in the building. V44 said, it was on V44's to-do list. V44 confirmed, R46 sustained a 6.9% weight loss in one month which was significant. R46 had a 12.9% weight loss in three months after review of current August weight. V44 said, V44 increased R46's feedings on 7/30/23 due to weight loss and requested a reweigh of the resident to ensure weight loss. V44 said, V44 never received the re-weigh information and does not see the information in medical record. V44 said, V44 would not expect R46 to lose weight nor was R46 on a weight loss program but there can be other factors contributing to weight loss like malabsorption, diuretic use or wounds.

On 8/15/23 at 1:54pm, V2 said, V2 was just made aware of R46's weight loss. V2 said if a resident was receiving gastronomy tube feeding, they

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should not lose weight. A resident may have weight loss which can vary based on resident's co-morbidities. V2 said, V2 did not see any follow-up for the progress notes 6/4/23 and V2 would expect someone to follow-up with R46's gastronomy tube site leaking because that is not expected. R46's weight loss could be associated with the gastronomy site leaking due to resident not receiving feeding. We do monthly weights to evaluate any trends and put in new interventions. V2 said R46 doesn't not have a reweighs.

R46's weight summary documents on 8/9/23 weight 122.4 pounds 7.5 percent change comparison to weight 6/6/23 140.6, 12.9 percent 18.9 pounds; 5.0 percent change over 30 days comparison weight 7/10/23 131 pounds 6.9 percent nine pounds. 7/10/23 weight 130.6 pounds 5 percent change over thirty days comparison weight 6/6/23 141 pounds which 7.1 percent loss of ten pounds; 6/6/23 weight 140.6; 5/4/23 132 pounds; 4/4/23 133.8 pounds; 3/11/23 132.4 pounds; 3/6/23 135.2 pounds.

R46's progress note dated 6/4/23 documents: Patient has an increased work of breathing (WOB). Upon assessing patient, patient has leakage around the gastrostomy tube site. Nurse notified.

R46's dietary note dated 7/30/23 documents: current tube feeding orders: 1.5 Cal at 45 milliliters/hour x 18 hour via pump assist or until 1080 mL given. Weight 130.6pounds (7/10), BMI 29.3 (overweight, Body mass index BMI not accurate for heights under 60"). Weight history: 6/6-140.6 pounds, 5/4-132 pounds, 4/4-133.8pounds, 3/6 (admission)-135.2pounds. Weight changes of -7.1% x 1 month, -2.4% x 3 months. Previously triggered for significant weight

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gain (in June). Increase feeding rate related to weight loss. Enteral feeding 1.5 Cal at 55 milliliters/hour x 21 hour via pump assist.

Weight Monitoring Policy undated documents: To ensure the client maintains acceptable parameters of nutritional status unless their clinical condition demonstrates that this is not possible.

(B)

Statement of Licensure Violations (5 of 11):

300.610a)
300.1010h)
300.1210b)
300.1210d)2)3)

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.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain

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ELEVATE CARE NORTH BRANCH	6840 WEST TOUHY AVENUE NILES, IL 60714

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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:

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 resident's medical record.

These requirements were not met as evidenced by:

Based on observation, interview and record

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review, the facility failed to follow their gastrostomy tube (g-tube) policy by not monitoring, assessing or inspecting the stoma site for placement, signs of infections, and gastric leaking. This affected three of three residents (R6, R46, R10) reviewed for G-tube policy and procedures. This failure resulted in (R6) being hospitalized with an infected g-tube site which required surgical interventional; R46's g-tube feeding leaking out at the insertion site with each inspiration; and R10 having leaking g-tube site with no dressing.

Findings Include:

R6

On 7/26/23 at 11:26AM, V29 (nurse) said, V29 checked R6's g-tube for residual without any issues then I pushed air into R6's g-tube to check for placement. R6 grimaced with pain. V29 said, V29 saw a bulge/bubble and redness at R6's g-tube stoma. R6 was sent to the hospital and returned. The hospital did not do anything for R6 g-tube.

Progress note dated 4/4/23 documents: Writer (V29) noticed bulging on g-tube site. Auscultated and no sound detected. Noted grimacing when flushed with air. R6 was discharged to the hospital. R6 returned. Emergency room doctor checked and it was only the balloon.

On 7/27/23 at 12:38pm, V30 (nurse) said, V30 flushed R6's g-tube and noticed a bulged at the g-tube site. V30 got an ordered for a stat abdominal x-ray that was not done when ordered. R6 was sent to the hospital on 4/8/23 for a dislodged PEG tube.

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Progress note dated 4/6/23 documents: (V30) observed resident (R6) grimacing upon air flushing and observed bulging. Feeding stopped. STAT KUB. Radiology report dated 4/7/23 documents: Percutaneous gastrostomy tube overlies the left upper abdominal quadrant, for intraluminal confirmation, consider repeat imaging with pre and post air administration. Radiology report dated 4/8/23 documents: Tip of gastrostomy tube is not adequately within the stomach after air insufflation.

On 7/28/23 at 9:37am, V38 (medical doctor) said, R6 was hospitalized with an abscess in the abdominal wall due to poor g-tube care and insufficient/poor dressing changes, if any. R6's g-tube infection was associated with extremely poor gastrostomy care and infection control practices. Infection spread to the abdominal wall. Microorganism deposited air, air leaked into R6's abdominal wall resulting in a very serious but preventable infection that required surgical debridement and drain in place. R6 had a multiple drug resistance polymicrobial infection. This massive infection made it hard to remove R6's old g-tube. R6's blood stream was infected as result of the g-tube infection. R6's blood culture contained yeast. Yeast does not naturally grow in the blood. R6's g-tube was not clean properly. R6 had to be given total parenteral nutrition intravenously.

On 8/4/23 at 8:08am, V2 (DON) said, Y/N -on the medication administration record (MAR) is asking, (Y) means yes it was done or (N) means no it was not completed, it is my expectation to document every task complete, if its blank, that task was not completed or didn't happen.

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Medical Administration records dated 3/1/23 - 3/31/23 document: G-tube care and dressing change every night shift Y/N. On 3/2/23, 3/3/23, 3/5/23, 3/6/23, 3/15/23 and 3/20/23 documents: (N/no) and 3/9/23, 3/14/23, 3/16/23, 3/19/23, 3/23/23 and 3/27/23 was blank/no documentation.

Medical Administration record dated 4/1/23 - 4/8/23 document: G-tube care and dressing change every night shift Y/N. 4/2/23 and 4/6/23 was blank/no documentation.

Hospital paperwork dated 4/8/23 documents: R6 present to the emergency department (ED) with the chief complaint of gastrostomy tube dysfunction. Tube has not been functioning for the past four (4) days per emergency medical service (EMS) report. Nursing home stated, they were unable to flush anything through or give tube feeding, so they have been infusing an unknown amount of dextrose through an intravenous (IV) they placed. G-tube with drainage around the insertion site. Percutaneous gastrostomy (PEG) tube not appearing to be in correct place/malposition. Abdominal x-ray report with G-tube in indeterminate location. R6 presented from the nursing home for G-tube malfunction, buried bumper/entrapped bumper with feeding leaking to G-tube site track. It is not clear how long this buried bumper syndrome has been ineffective. Minimal tenderness noted at the PEG site. Abdominal exam reveals soft, with 2 milliliter mm x 2 mm opening over previous G-tube site 20mL of foul smelling purulent drainage with white specks suspected to be particulate of feed present. Purulence expressed from former G-tube site, recommend ostomy bag to be place over opening. R6 was admitted with fever and leukocytosis. Not a simple G-tube

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replacement. Sever dissecting soft tissue infection deep to the edge abdominal wall extending from the level of the catheter balloon into the lower pelvis and beneath the fascia. JP drain remain in place at prior PEG tube location with purulent output. Decreasing but persistent air-fluid collection along the left ventral abdomen and in the lower abdomen/pelvis with coiled surgical drain with tip terminating in the left upper quadrant cranial to the dominant component of air fluid in the left central abdomen. Active infection and drainage of pus/feeding tube. Localized infection due to poor gastrostomy site care at nursing home.

Gastrostomy Tube-Feeding and care dated 8/3/20 documents: Stoma site care: inspect the surrounding skin for redness, tenderness, swelling, irritation, purulent draining, or gastric leakage.

R46

On 8/4/23 at 5:50am, V2 assessed R46 for incontinence. R46 was lying on right side and was turned onto her back. R46's gown was wet. V2 lifted R29's gown and observed a face towel wrapped around R46's gastrostomy tube. V2 stated, V2 was informed that this is a chronic problem for R46 because stoma is large. V2 said the towel should not be wrapped around R46's tubing, there should be a gauze dressing/drain sponge at the insertion site. V2 said, R46's stoma is draining a lot. R46's stoma was observed to be oozing brown liquid consistent with the brown enteral feeding being pumped through R46's g-tube site. R46 was oozing from the proximal stoma with every inspired breath. V2 said, R46's feeding should not be oozing out. V2 said the nurse is expected to notify the physician and not

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just wrap a towel around it. V2 said, if R46's feeding is oozing out it can't be determined how much feeding R46 is actually receiving.

On 8/11/23 at 2:16pm, V2 (DON) said, V2 asked V56 (nurse) to check R46's g-tube site. V56 applied a drain sponge and the drainage stop. V2 said, V56 called the doctor but V56 did not document it. If it's not documented is not done.

On 8/11/23 at 2:22pm, V56 (nurse) said, V2 texted me to check R46 due to her g-tube draining. When V56 assessed R46, R46 was on her back, head up and G-tube site was not draining. I applied a drain sponge and told the day shift nurse to call the doctor. I did not call the doctor. I would not call the doctor if I did not observe any drainage.

On 8/15/23 at 2:46pm, V96 (diagnostic imaging personnel) said, the R46 g-tube placement cannot be confirmed which is why a non-ionic contrast was suggested. Air inflation in a negative pressure ionic contrast.

Respiratory note dated 6/4/23 documents: patient (R46) has an increased work of breathing (WOB). R46 has leakage around the g-tube site.

Progress note 8/11/23 documents: Reported by CNA residents (R46) g-tube ostomy is leaking. Writer immediately attended and assessed. Resident noted with scant drainage on g-tube site, non-distended, bowel sounds are present in all quadrants. Ordered STAT KUB.

Abdominal 1 view dated 8/12/23 documents: Gastrostomy tube seen in place with tip in left mid abdomen, its position cannot be commented, wound recommend non-ionic contrast injected via

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gastrostomy for tip confirmation.

Gastrostomy Tube-Feeding and care dated 8/3/20 documents: Stoma site care: inspect the surrounding skin for redness, tenderness, swelling, irritation, purulent draining, or gastric leakage.

R10

On 7/27/23 at 9:40am, R10 was observed lying in bed. R10's gown was observed to have a 3 inches x 5 inches area of dried dark red drainage over R10's upper abdominal area.

On 7/27/23 at 10:55am, V33 CNA (certified nurse aide) was observed providing incontinence care for R10. When V33 removed R10's gown, drainage on gown was directly over R10's gastrostomy site. R10 did not have a dressing at gastrostomy tube insertion site.

On 7/27/23 at 12:10pm, V31 LPN (licensed practical nurse) stated the night shift nurse is responsible for changing the gastrostomy tube insertion site dressing. V31 stated he is unsure if R10 currently has a dressing at gastrostomy tube insertion site. V31 stated all gastrostomy tubes should have a dressing unless physician orders no dressing.

On 7/27/23 at 12:30pm, V30 RN (registered nurse) stated all gastrostomy tubes should have a dressing covering insertion site. V30 stated the nurse on night shift is responsible for changing this dressing. V30 stated if a dressing is not present, V30 will place dressing after cleaning site with normal saline.

(A)

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Statement of Licensure Violations (6 of 11):

300.610a)
300.1210b)
300.1210c)
300.1210d)2)3)4)A)

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.

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

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following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow their tracheostomy policy and physician order by not providing suction at least every 4 hours. This affected one of three residents (R7) reviewed for respiratory care, including tracheostomy care. This failure resulted in R7 being hospitalized in acute respiratory distress with a mucous plug.

R7 was diagnosed with tracheostomy dependence on respiratory (ventilation).

On 8/3/23 at 9:19am, V59 (nurse practitioner)

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said, mucus plugs should not happen. They are highly and easily preventable with suctioning every four hours and as needed. V59 said, R7 was not suctioned at the facility. Secretions are present in R7's lungs. Consolidation is mucus build-up. Pneumonia is when bacteria get in the lungs. R7 couldn't spit. The lungs produce secretions to trap bacteria which must be suctioned out, not suctioning properly leads to a mucus.

Facility chest x-ray dated of service 4/14/23 documents: Clinical Information: difficulty breathing. Impression: finding consistent with mild CHF or volume overload in the appropriated setting. Diagnosis includes but not limited to mild bronchitis and interstitial pneumonia in the appropriate clinical setting.

Hospital paperwork dated 4/14/23 documents: R7 was sent in from nursing home yesterday after chest-x-ray found to be abnormal. R7 was diaphoretic and tachycardia in the emergency department. R7 had secretion around trachea. R7 present pneumonia. Pulmonary was consulted for acute on chronic respiratory failure. Rapid response called 4/15/23 for concerns for respiratory distress, patient (R7) vital signs were stable and in acute respiratory distress. Second rapid response was called on 4/15/23 for tachypnea with high peak vent pressures. Pressures improved with suctioning. Bedside 'bronch' by pulmonology noted a tissue mass at the end of the tracheostomy tube preventing advancement of the 'bronch'. Active problem: Acute respiratory failure with hypoxia, Mucous plugging. CT: Debris' within evaluation with mucous plugging and atelectasis in left lower lobe. R7 had tracheomalacia/stenosis.

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Tracheostomy Care dated 12/1/2021 documents: To provide a guideline for maintaining an unobstructed airway and preventing infection in resident with a tracheostomy. It is the policy of this facility that residents with tracheostomies received routine care to maintain a patent airway.
(No violation issued)

Statement of Licensure Violations (7 of 11):

300.610a)
300.1010h)
300.1210b)
300.1220b)3)

Section 300.610 Resident Care Policies

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Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow their pain policy by not developing

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S9999	Continued From page 38 an effective pain management plan for one resident with persistent pain and break through pain after 1 to 2 hours. This affected one of three residents (R17) reviewed for pain management. This failure resulted in R17 experiencing episodes of pain crying to staff, expressing being unhappy with current pain management plan and requesting to go the hospital. R17 required spinal surgery for hardware and pain management. Findings include: R17 admitted to the facility on 2/21/22 with a diagnosis of major depressive disorder, cyst of pancreas, cauda equina syndrome, hyperlipidemia, vascular disease, fusion of spine, wedge compression fractures t7- t10 vertebra and hypertension. R17's brief interview for mental status score dated 4/6/23 documents a score of 15/15 which indicates cognitively intact. R17's minimum data set dated 6/27/23 under section J pain management documents: have you had pain or hurting in last 5 days with a score of 'yes'. On 8/4/23 at 9 :10 AM, R17, who was alert and oriented at time of interview R17, said she was taking pain medication two to three times a day with no relief. R17 said she told everyone about her pain with no changes. R17 said pain medication would relieve her pain for an hour to two hours but then return. R17 said she would get Tylenol in-between for pain but was not helpful. R17's progress note dated 4/15/23 documents: Resident complained of pain despite having Morphine 15 mg q 12 hours. Notified V84 (MD) with order Acetaminophen 325 mg give 2 tabs every 4 hours. Noted and carried out.	S9999		

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R17's progress note dated 4/18/23 documents: R17 informed writer that she is still having unresolved pain from her mid back throughout the day even with scheduled morphine medication. Writer called V88 (neurosurgeon) office and spoke to staff who will give the message to the nurse. A nurse will callback.

R17 encounter note dated 5/16/23 reviewed: patient reports she has had excruciating pain over the past month without an inciting event. Pain is located between her scapula at the top of her construct. No weakness. During encounter patient became tearful and stated if she had to live with the pain any longer, she would kill herself. Orders placed CT of spine, Xray scoliosis and referral to pain clinic. Pain documents as 10/10 worst pain ever.

R17 palliative progress note dated 5/18/23 documents: R17 reports pain 8/10 pulling, stabbing in the back radiating up to bilateral scapulae and around towards the chest with sharp poking pain, pain worse since revision surgery in 11/2022. R17 admits she feels the screws in her back and reports fair relief from her current treatment.

R17 palliative progress notes 6/6/23 documents: R17 reports pain in back radiated to chest, moderate to severe, worse with movement. Patient reports pain with deep breathing, sneezing and cough- reports increase in symptoms in the past week.

R17's progress note dated 6/25/23: patient seen in follow up for back pain. Not happy with current pain management. Discussed with daughter in detail neuro surgery referral ordered.

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R17's progress note dated 6/27/23 documents: Daughter and resident requesting to send resident out to the Emergency room to be evaluated for her back pain. R17 reported pain is eight out of ten.

R17 hospital records dated 6/28/23 documents under history: R17 with pertinent thoracic and lumbar fusion as well as recent traumatic burst fracture of lumbar region with compression fracture T7 through T10 presents now for evaluation of severe back pain. Patient reports the pain has become progressively worse in the last couple of weeks now not responding to medications in her current skilled nursing facility. She (R17) reports back in May that in the process of returning for a follow-up visit she was inappropriately strapped in to wheelchair on what a tipping over resulting in an acute injury. Patient reports that the pain is most severe in the mid part of her upper back right between her shoulder blades and she is reporting shooting pain down her right arm and wrapping around the right side of her chest. The right side of her chest discomfort is worse with deep inspiration. Nursing home records reviewed but no discrete indication for the transfer was contained. She did however have prior plain films done at the nursing facility which revealed what they described as burst compression fractures in both the thoracic and lumbar regions. Recent imaging reflects: Impression 1. Noncontract cervical and thoracic spine CT examinations shows new findings at the cranial termination of multilevel posterior instrumentation/fusion of the thoracic segments as detailed. 2. Findings are consistent with fusion failure and possibly discitis/osteomyelitis at T3/T4 level. 3. The cervical segments show multilevel deformities of disc related spondylosis in the

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upper and mid cervical segments as noted. Under chief complaint and reason for admission documents T5 vertebra fracture and hardware failure. Hospital note dated 6/28/23 documents: The patient is a 61-year-old female, known to the Neurosurgery Service. The patient has had a previous T10 to pelvis, which required extension of hardware all the way up to the level of T5, which she had proximal junctional kyphosis. At that time, the surgery was done and it went very well. This was done back in September of 2022. She recovered very nicely. However, over a period, she developed increased stress along the level of T4, the un-instrumented level resulting in proximal junctional kyphosis to the point at which the vertebral body collapsed. Once the vertebral body collapsed, she developed some significant amount of back pain and numbness and tingling in the thoracic dermatomal distribution. She came in for evaluation and a scoliosis film was performed and it was evident that she had a positive sagittal balance, which required correction of the kyphotic deformity. She was a surgical candidate and was taken to the OR for correction.

On 8/10/23 at 10:10AM, V49 (Nurse) said R17 would complain of back pain most days she took of her. R17 would usually rate her pain 8/10. R17 had scheduled pain medication twice a day and she would usually ask for additional mediation in the afternoon. R17 had a Tylenol as needed order. V49 said she did not think Tylenol was working anymore for R17, but she was being seen by palliative and neurosurgeon. V49 does not recall contacting V88 (neurosurgeon) about pain except once because R17 was requesting an appointment sooner because of her pain but was unable to get a sooner appointment.

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On 8/10/23 at 11:20AM, V9 (ADON) said R17 was always in pain and was referred to palliative on 5/18/23. R17 was having more pain after the fall on 5/16/23. Nurses are expected to call the doctors when there is a change and if pain worsens, then resident should be sent out to the hospital.

On 8/9/23 at 10:07AM, V93 (palliative nurse) said she was referred to see R17 in May for more psychosocial support. V93 said R17's pain was being managed by pain clinic at hospital and they would the primary source for prescribing or changing pain medication.

On 8/9/23 at 11:26am V84 (MD) said R17 was having pain from surgery in her back. R17 pain was being treated with morphine, Norco and Lidoderm patch. CT scans performed on 6/16/23 were ordered by V88 (neurosurgeon) and not aware of results or findings. Xray was done on 6/25/23 and referred to V88. R17 was receiving a high dose of controlled pain medications and did not feel comfortable with patient being on additional medications due to her small size. Patient was being followed by palliative and rehab for pain management

On 8/10/23 at 3:03PM, V91 (pharmacy) said 15 mg is the lowest dose of morphine and is not weight based. Recommended to start with lowest dose for short period of time and monitor for effectiveness. V91 said, 15 mg can be given every 8 hours but would be based on doctor preference and patent tolerance.

On 8/10/23 at 2:52PM, V92 (CNA) said R17 was in pain all the time. She was crying form the pain and would ask me to get the nurse for pain pills.

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On 8/1/23 at 12:55, V25 (therapy) said R17 was referred to therapy on 5/26/23 but refused evaluation due to pain.

Pain management program revised 1/29/18 documents: to establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrevealed pain and to develop an optimal pain management plan to enhance healing and promote wellness.
(A)

Statement of Licensure Violations (8 of 11):

300.1210b)
300.1210d)2)

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.

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:

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

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These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure the contracted radiology contractor conducted a stat x-ray instead of a routine/standard x-ray. This affected one of three residents (R1) reviewed for radiology testing per order. This failure resulted in R1 having to wait 7 hours for an x-ray and treatmentof a which revealed right femoral neck fracture.

Finding include:

R1 admitted to the facility on 1/7/22 with a diagnosis of type II diabetes, kidney disease, encephalopathy, and history of falling.

R1's progress note dated 4/20/23 at 7:30AM documents: Endorsed by night nurse that (R1) resident was seen by CNA from the nursing station walking out of his room, (R1's) knees buckled and CNA ran to steady R1 but was not able to hold him on time and R1 fell on his right side. Head to assessment done and noted facial grimacing upon movement on right leg. Resident (R1) verbalized pain on his right knee. No swelling/redness/bruising noted. No shortening of the extremity. Doctor aware and received order STAT x-ray of right knee/right hip.

R1's physician order sheet dated 4/20/23 at 8:00AM, x-ray of right hip and right knee stat.

On 7/26/23 at 1:51PM, V26 (x-ray representative) said R1's x-ray was called in as a stat x-ray on 4/20/23 at 8:03AM, informed nurse that it would not be able to do it stat. Technician arrived at 2:02PM, results faxed to the facility 2:12PM. Facility was called at 3:20PM to report results.

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On 8/9/23 at 11:59AM, V2 (DON) said stat x-ray should be performed within 4 hours. If they are unable to provide service within time frame then the doctor should be notified and possibly send resident to Emergency room.

R1's medical record did not document any documentation to the doctor after x-ray order to inform of delay in x-ray.

R1's right hip x-ray dated 4/20/23 documents: There is a contour deformity of the right femoral neck, with questionable lateral lucency. Findings suspicious for femoral neck fracture. Recommended CT for further evaluation.

R1 progress note dated 4/20/23 at 2:56PM documents: ambulance called and gave an estimated time of arrival of one hour to one- and one-half hours.

R1 progress note dated 4/20/23 at 4:11PM documents: resident transported to local hospital.
(B)

Statement of Licensure Violations (9 of 11):

300.650c)

SECTION 300.650 PERSONNEL POLICIES c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.

This requirement was NOT MET as evidenced by:

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Based on observation, interview and record review, the facility failed to have a licensed respiratory therapist, who was observed performing respiratory care on three of three residents (R35, R37 and R47). This failure has the potential to affect all ten ventilator dependent and five tracheostomy residents at the facility.

Findings include:

On 8/4/23 at 4:02am, V58 (respiratory therapist) was observed wearing an ID with his typed name and the word "student" underneath. V58 said, I passed my boards. I am not a student. This is my first night working. V58 provided suctioning for R47. V58 was the only respiratory therapist working unit 1A. At 5:00Am, V58 (RT) was observed providing tracheostomy suctioning for R37. At 5:30, V58 (RT) was observed performed suctioning R35.

R35's respiratory administration record for August documents V58 (respiratory therapist) signed off on the following care: tracheostomy care, oral care, and suction tracheostomy.

R37's respiratory administration record for August documents V58 (respiratory therapist) signed off on the following care: tracheostomy care, oral care, atropine drops, ipratropium bromide treatment and suction tracheostomy.

R47's respiratory administration record for August documents V58 (respiratory therapist) signed off on the following care: changing inner cannula, tracheostomy care, oral care and suction tracheostomy.

On 8/10/23 at 3:34PM, V89 (HR) said V58 was a

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respiratory therapy student at another elevate care and not a full-time employee at facility. V58 has not presented any information from state about passing or receiving his license. V58 was under a preceptor until he passed his exam.

On 8/10/23 at 3:57PM, V58(RT) said he graduated in May and is waiting for state. V58 said he called Illinois department of financial and professional regulation, IDFPR and they said it can take up to 8 weeks. V58 said the facility said they checked with their legal department who said it was ok for him to work by himself after he passed his exam. V58 said he usually works with another respiratory therapist, and this was the first time working alone.

On 8/10/23 at 4:30PM, V15 (RT manager) said he was on vacation when V58 worked at the facility. V15 said he would need to confirm with Human resources if V58 could work on the unit without a license.

On 8/10/23 at 4:20pm, V94 (Illinois department of financial and professional regulation) said there is no active license on file for V58 (RT).

On 8/9/23 at 1:14pm, V37 (Director Human Resources) said, V58 (respiratory therapist) was hired as needed (prn). V58 started on 8/3/23. V58 works full time at a sister facility.

Timecard/Edit/ Missed punch authorization form dated 8/3/23 documents: Time in 6:50pm - Time out 7:15am. Please check one option for timecard edit: new hire orientation.

Email date 8/4/23 documents: This letter was sent to verify that the individual (V58) listed has successfully completed the respective National

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Board for Respiratory examination(s) and hold the corresponding credential(s) issued by this board. Credential (CRT), Exam Date (6/16/23) Valid Thru (6/30/28).

Job description dated 6/23/23 and signed by V58 documents: position title: respiratory therapist (RT)- qualification: Respiratory Therapist with current unencumbered state licensure.

On 8/4/23, 8/9/23 and 8/10/23 V58 name was searched on the Illinois department of financial and professional regulation license look up website with no findings.

Illinois Respiratory Care Practice Act documents under section 10 documents: "Basic respiratory care activities" means and includes all of the following activities:(1) Cleaning, disinfecting, and sterilizing equipment used in the practice of respiratory care as delegated by a licensed health care professional or other authorized licensed personnel.(2) Assembling equipment used in the practice of respiratory care as delegated by a licensed health care professional or other authorized licensed personnel.(3) Collecting and reviewing patient data through non-invasive means, provided that the collection and review does not include the individual's interpretation of the clinical significance of the data. Collecting and reviewing patient data includes the performance of pulse oximetry and non-invasive monitoring procedures in order to obtain vital signs and notification to licensed health care professionals and other authorized licensed personnel in a timely manner.(4) Maintaining a nasal cannula or face mask for oxygen therapy in the proper position on the patient's face.(5) Assembling a nasal cannula or face mask for oxygen therapy at patient bedside in preparation for use.(6)

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S9999	Continued From page 49 Maintaining a patient's natural airway by physically manipulating the jaw and neck, suctioning the oral cavity, or suctioning the mouth or nose with a bulb syringe.(7) Performing assisted ventilation during emergency resuscitation using a manual resuscitator.(8) Using a manual resuscitator at the direction of a licensed health care professional or other authorized licensed personnel who is present and performing routine airway suctioning. These activities do not include care of a patient's artificial airway or the adjustment of mechanical ventilator settings while a patient is connected to the ventilator. "Basic respiratory care activities" does not mean activities that involve any of the following:(1) Specialized knowledge that results from a course of education or training in respiratory care.(2) An unreasonable risk of a negative outcome for the patient.(3) The assessment or making of a decision concerning patient care.(4) The administration of aerosol medication or medical gas.(5) The insertion and maintenance of an artificial airway.(6) Mechanical ventilatory support.(7) Patient assessment.(8) Patient education.(9) The transferring of oxygen devices, for purposes of patient transport, with a liter flow greater than 6 liters per minute, and the transferring of oxygen devices at any liter flow being delivered to patients less than 12 years of age. Under section 50c documents: A person may practice as a respiratory care practitioner if he or she has applied in writing to the Department in form and substance satisfactory to the Department for a license as a licensed respiratory care practitioner and has complied with all the provisions under this Section except for the passing of an examination to be eligible to receive such license, until the Department has made the decision that the applicant has failed to pass the next available examination authorized by	S9999		

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the Department or has failed, without an approved excuse, to take the next available examination authorized by the Department or until the withdrawal of the application, but not to exceed 6 months. An applicant practicing professional registered respiratory care under this subsection (c) who passes the examination, however, may continue to practice under this subsection (c) until such time as he or she receives his or her license to practice or until the Department notifies him or her that the license has been denied. No applicant for licensure practicing under the provisions of this subsection (c) shall practice professional respiratory care except under the direct supervision of a licensed health care professional or authorized licensed personnel.

Facility census dated 8/4/23 verified by V15(RT manger) documents: ten ventilators dependent and five tracheostomy residents at the facility.
(C)

Statement of Licensure Violations (10 of 11):

300.1210d)1)2)3)

SECTION 300.1210 GENERAL REQUIREMENTS FOR NURSING AND PERSONAL CARE

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.

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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 resident's medical record.

This requirement was NOT MET as evidenced by:

Based on observations, interviews, and record reviews, this facility failed to ensure licensed nursing staff were able to demonstrate the knowledge and skills to monitor midline and PICC (peripherally inserted central catheter) intravenous sites for complications, including infection and blood clots, administer intravenous medications, and perform central line intravenous catheter dressing changes for six residents (R17, R26, R27, R30, R37, R39) out of six residents reviewed for care and management of midline and peripherally inserted central intravenous catheters in a sample of 48.

Findings include:

On 8/1/23 at 1:50pm, V2 DON (director of nursing) stated an LPN (licensed practical nurse) can administer an intravenous (IV) antibiotic into a peripheral intravenous continuous infusion. V2 stated the nurses are expected to be monitoring peripheral, midline, and PICC (peripherally inserted central catheters) intravenous sites for swelling, leaking, not flushable, and no blood return. V2 stated if nurse observes any of these

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signs, the nurse is expected to stop the infusion and contact the physician for orders. V2 stated at this facility all intravenous catheters are discontinued by an RN (registered nurse). V2 stated the nurse is expected to document the resident's name, drug name, and date and time administered on the intravenous medication. V2 stated the nurse is expected to document the date and time and the nurse's initials on the intravenous tubing and site. V2 stated the nurse is expected to document in the resident's progress notes intravenous catheter insertion, date and time, number of attempts, size of catheter inserted, and resident tolerance of procedure. V2 stated this facility has standing orders when intravenous site is established for intravenous flushes, site care, and dressing changes. V2 stated intravenous medications administered via a midline catheter or PICC line should be infused via an IV pump.

On 8/4/23 at 10:45am, V60 LPN stated V60 is unsure if an infusion pump is needed when infusing into a midline or PICC line. V60 stated there isn't an infusion pump in R17's room. V60 stated R17 has two ports on PICC line but only one port is functioning. V60 stated she does not know how long port has not been functioning or if the physician was notified.

On 8/16/23 at 11:30am, R39's medical record was reviewed with V2 DON.

R17:
On 8/4/23 at 10:30am, R17 stated the nurse lost the cap to one of the two ports of R17's PICC line. R17 stated the nurse informed R17 she would get a new cap but never did. R17 stated the nurses do not infuse her antibiotics through an infusion pump. R17 stated no staff have

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measured her arm circumference prior to V9's ADON (assistant director of nursing) attempt today. R17 stated V9 brought in a tape measure to measure R17's arm but it was too small and V9 has not come back with a longer measuring tape. R17 stated a few days ago the nurse infused the antibiotic medication and afterwards the port stopped working. R17 stated now she only has the one port available for use.

Review of R17's MAR, dated August 2023, notes V49 LPN changed R17's PICC line dressing on 8/8/23. Heparin lock flush 100units/ml, 5mls were administered by V75 LPN on 8/3 at 10:00pm; by V73 LPN on 8/5 at 10:00am and 10:00pm; by V61 LPN on 8/13 at 10:00am; and V68 LPN on 8/13 at 10:00pm. There is no documentation found noting R17's PICC line was flushed with heparin on 8/2 at 10:00pm, 8/11 at 10:00am, 8/11 at 10:00pm, or 8/14 at 10:00pm. On 8/1 at 9:00am, V49 LPN administered vancomycin 1 gram intravenously into R17's PICC line. There is no documentation found noting R17 received vancomycin on 8/5 at 9:00pm.

There is no documentation found in R17's medical record noting R17's arm circumference or external length of catheter were measured or R17's PICC line was flushed with 10ml of normal saline in July or August 2023.

R26:
On 7/27/23 at 10:20am, this surveyor observed tigecycline 100mg (milligrams) infusing directly into R26's right arm midline catheter, not via piggyback into a continuous infusion. V31 LPN was observed flushing R26's midline catheter after antibiotic infusion completed.

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Review of R26's medical record, dated 7/21/23, notes R26 had a midline catheter inserted to R26's right arm while in hospital.

R26's MAR, dated July 2023, notes R26's midline IV (intravenous) catheter was flushed with 10ml (milliliters) of normal saline before and after medication administration by V14 LPN, V31 LPN, and V61 LPN. It also notes V14 LPN, V31 LPN, and V61 LPN administered tigecycline 100mg intravenously directly into R26's midline catheter, not via piggyback into a continuous infusion.

R27:
Review of R27's medical record, dated 6/19/23, notes R27 had a PICC line inserted to R27's left arm.

Review of R27's POS (physician order sheet), dated 6/19/23, notes an order for vancomycin 1.25 grams intravenous every Monday, Wednesday, and Friday. Flush PICC line with 10mls normal saline every 12 hours. Cefepime 1 gram intravenous every 24 hours.

Review of R27's MAR, dated June 2023, notes V63 LPN, V66 LPN, V73, and V103 LPN administered vancomycin 1.25 grams intravenously directly into R27's PICC line catheter at insertion site, not via piggyback into a continuous infusion. V40 LPN, V61 LPN, V62 LPN, V63 LPN, V64 LPN, V66 LPN, and V103 LPN flushed R27's PICC line with 10mls normal saline. V61 LPN and V63 LPN administered cefepime 2 grams intravenously directly into R27's PICC line catheter at insertion site, not via piggyback into a continuous infusion.

R27's MAR, dated July 2023, notes V64 LPN, V66 LPN, V73 LPN, V77 LPN, and V95 LPN

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administered vancomycin 1.25 grams intravenously directly into R27's PICC line catheter at insertion site, not via piggyback into a continuous infusion. It also notes V49 LPN and V63 LPN administered cefepime 2 grams intravenously directly into R27's midline catheter at insertion site, not via piggyback into a continuous infusion. V31 LPN, V49 LPN, V63 LPN, V64 LPN, V66 LPN, V69 LPN, V73 LPN, V77 LPN, V78 LPN, and V95 LPN flushed R27's PICC line with 10mls normal saline.

There is no documentation found noting R27's PICC line dressing, needleless connector, arm circumference or external length of catheter was measured at any time in June or July 2023. There is also no documentation noting nurses monitored R27's PICC line site was observed before and after administration of intermittent medications, during dressing changes, routinely for signs/symptoms of infiltration/extravasation, or documented in R27's notes at least every shift considering prescribed therapy and R27's condition.

R30:
R30 was admitted to this facility on 7/27/23. R30's hospital record, dated 7/27/23, notes R30 had a PICC line inserted to R30's right upper arm.

Review of R30's POS (physician order sheet), dated 7/27/23, notes orders to change PICC line dressing, needleless connector, and measure the external catheter length from insertion site to base of the hub and record in centimeters every night shift every seven days and as needed. Cefazolin sodium 3 grams intravenous every 8 hours. Flush PICC line catheter using SAS (saline-antibiotic-saline) method with 10mls

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normal saline before and after medication.

Review of R30's MAR (medication administration record), dated July 2023, notes V79 LPN changed R30's PICC line dressing and needleless connector on 7/27/23. There is no documentation found noting R30's arm circumference or external length of catheter was measured between 7/27/23 and 7/31/23. It also notes V32 LPN, V49 LPN, V61 LPN, V66 LPN, and V79 LPN infused cefazolin sodium 3 grams intravenously to R30's PICC line. V32 LPN, V49 LPN, V61 LPN, V66 LPN, and V79 LPN also flushed R30's PICC line with normal saline 0.9% 10mls before and after intravenous medication administered.

Review of R30's MAR, dated August 2023, notes V79 LPN changed R30's PICC line dressing and needleless connectors on 8/1 and 8/3. V40 LPN, V66 LPN, V72 LPN, V79 LPN, and V80 LPN infused cefazolin sodium 3 grams intravenously to R30's PICC line. V40 LPN, V66 LPN, V72 LPN, V79 LPN, and V80 LPN also flushed R30's PICC line with normal saline 0.9% 10mls before and after intravenous medication administered.

There is no documentation noted in R30's medical record noting R30's arm circumference or external length of catheter was measured 8/1-8/16.

R37:
R37's MAR (medication administration record), dated July 2023, notes V14 LPN, V31 LPN administered cefepime (antibiotic) 1 gram intravenously directly into R37's midline catheter, not via piggyback into a continuous infusion. It also notes V31 LPN administered vancomycin

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(antibiotic) 1 gram directly into R37's midline catheter at insertion site.

R37's MAR, dated July 2023, notes R37's midline IV catheter was flushed with 10ml (milliliters) of normal saline before and after medication administration by V14 LPN, V27 LPN, V31 LPN, V32 LPN, V49 LPN, V61 LPN, V62 LPN, V63 LPN, V64 LPN, V65 LPN, V66 LPN, V67 LPN, and V95 LPN.

R37's MAR, dated July 2023, notes V14 LPN changed R37's midline catheter dressing on 7/14, 7/21, and 7/28. It also notes V27 LPN changed R37's midline catheter dressing on 7/7.

R39:
On 8/4/23 at 4:30am, this surveyor observed R39 lying supine in bed. R39's PICC line dressing was observed to have the upper left corner and the right lower corner of the clear dressing not adhered to skin. R39's PICC line insertion site was observed to be exposed to air.

On 8/10/23 at 2:00pm, this surveyor observed the skin under R39's PICC line clear dressing to have red streaks extending from the site towards right axilla.

On 8/10/23 at 2:00pm, V30 stated R39's PICC line dressing looked okay and the redness was on the outside of the clear dressing.

On 8/4/23 at 5:45am, V2 DON stated R39's PICC line dressing is non-occlusive and should be changed.

There is no documentation found noting the nurse changed the dressing to R39's PICC line insertion site was changed prior to scheduled

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dressing change on 8/8.

On 8/16/23 at 11:30am, R39's medical record was reviewed with V2 DON. When asked for clarification on R39's intravenous catheter, V2 stated on 7/7 a PICC line was inserted into R39's right upper arm while in hospital. V2 stated V2 contacted the outside IV company to see if a midline catheter was placed for R39 at any time. V2 stated V2 was informed this company never received an order or placed a midline catheter for R39. V2 stated the midline catheter orders placed on 8/1/23 are wrong. V2 stated orders regarding R39's PICC line should have been entered into R39's electronic medical record on 7/7/23 when R39 was re-admitted from the hospital.

R39 was admitted to this facility on 6/30/23. On 7/7/23, R39 had a PICC line single lumen placed in right upper arm while in hospital.

Review of R39's POS, dated 7/7/23, notes orders for cefazolin sodium 3000mg intravenously every 8 hours and normal saline 0.9% 10mls intravenously every 8 hours for flush.

Review of R39's MAR, dated July 2023, notes V32 LPN, V40 LPN, V49 LPN, V62 LPN, V63 LPN, V66 LPN, V69 LPN, V73 LPN, and V95 LPN administered cefazolin sodium 3000mg intravenously and normal saline 0.9% 10mls intravenous flush directly into R39's PICC line.

There is no documentation found noting R39's PICC line dressing, needleless connector, arm circumference or external length of catheter was measured at any time in July 2023. There is also no documentation noting nurses monitored R39's PICC line site was observed before and after

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S9999	Continued From page 59 administration of intermittent medications, during dressing changes, routinely for signs/symptoms of infiltration/extravasation, or documented in R39's notes at least every shift considering prescribed therapy and R39's condition. Review of R39's POS, dated 8/1/23, notes orders for midline IV catheter-change catheter site dressing every night shift every 7 days, midline IV catheter-when not in use flush each lumen with 10mls normal saline every night shift every 7 days, and change needleless connectors every night shift every 7 days. Review of R39's POS, dated 8/11/23, notes orders for fluconazole 200mg intravenously one time a day. Review of R39's MAR, dated August 2023, notes V95 LPN administered fluconazole 200mg intravenously directly into R39's PICC line, not via piggyback into a continuous infusion. V31 LPN, V40 LPN, V61 LPN, V64 LPN, V65 LPN, V66 LPN, V76 LPN, and V95 LPN administered cefazolin sodium 3 grams intravenously directly into R39's PICC line, not via piggyback into a continuous infusion. There is no documentation noting R39 received cefazolin sodium 3 grams intravenous on 8/4 at 2:00pm or 8/9 at 2:00pm. There is no documentation noting R39's PICC line was flushed with 10mls normal saline on 8/4 at 2:00pm, 8/9 at 2:00pm, or 8/13 at 10:00pm. The Illinois Department of Financial and Professional Regulation notes the LPN who possesses the proper education, training, and experience may administer antibiotic medications through a peripheral IV line via piggyback for a	S9999		

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continuous infusion of fluids through an IV access device. A peripheral line is defined as a short catheter inserted through the skin into a peripheral vein. Antibiotics may also be administered through peripheral access for intermittent infusions. Administration of medications via intravenous push and adding heparin in heparin locks is not allowed.
(B)

Statement of Licensure Violations (11 of 11):

300.2940g)1)2)

SECTION 300.2940 ELECTRICAL SYSTEMS

g) Nurses' Calling System

1) Each resident room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. A nurse call shall register at the nurses' station and shall activate a visible signal in the corridor at the resident's door, and in the nurse's station. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, identifying lights shall be provided at the nurses' station.

2) A nurses' call station shall be provided for residents' use at each resident's toilet, bath, and shower location. The cord shall extend to within six inches of the floor.

This requirement was NOT MET as evidenced by:

Based on observations and interviews, the facility

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failed to ensure residents had a functioning call light system at the bedside. This failure affected one resident (R31) out of three residents reviewed for call lights.

Findings include:

On 8/4/23 at 4:30am, R35's bedside call light system was observed to have a plug in the wall and the call light cord removed from the plug.

On 8/4/23 at 5:30am, V2 DON (director of nursing) stated every resident should have a call light cord kept within reach while in bed. V2 stated R35's call light system is nonfunctional and there is no way for call light to be activated to alert staff that R35 needs assistance. V2 stated R35's call light needs to be replaced immediately.

On 8/16/23 at 11:30am, V2 DON stated this facility does not have a policy related essential equipment being maintained and operational.
(C)