STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001176	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON CARE AND REHABILITATION	4538 NORTH BEACON CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation: 2381901/IL157212	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1 300.1210d)2 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide ice for a resident's orthopedic cold therapy ice machine used for pain and swelling and failed to timely provide and administer a controlled substance seizure medication to a resident which affected one resident (R1) of four residents (R1, R2, R3, and R4) reviewed for improper nursing care and resident rights. This failure resulted in R1 experiencing a seizure and emergently being sent to the hospital. Findings include: R1's Admission Record, documents, in part, that R1's diagnoses include encounter for other orthopedic aftercare, epilepsy, lack of coordination, difficulty in walking and unspecified fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing.	S9999		

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S9999	Continued From page 2 R1's Minimum Data Set (MDS), dated 2/9/23, documents, in part, that R1's Brief Interview for Mental Status (BIMS) score is a 13 which indicates that R1 is cognitively intact. R1's Functional Status for Functional Limitation in Range of Motion for upper extremity is coded as "1" which indicates "impairment on one side." R1's Order Summary Report documents, in part, orders as followed: "Apply cold therapy machine to right arm to reduce swelling as needed (start date 2/3/23)" and "Apply cold therapy machine to right to reduce swelling and pa (pain) as needed (start date 2/5/23)." R1's Care Plan, with admission date 2/3/23, documents, in part, a focus of "(R1) has an alteration in musculoskeletal status r/t (related to) right arm fracture" with an intervention of "heat/cold applications as ordered and as tolerated." On 3/14/23 at 10:18 am, V6 (Nurse Practitioner, NP) stated, V6 is the "in-house" NP who rounded and visited R1 on multiple occasions during R1's one month stay at the facility. V6 stated, R1 was admitted from the hospital after R1 had surgery to repair a shoulder fracture from a fall in the community. V6 stated, R1 came from the hospital with 2 cold therapy ice machines that were to be filled with ice and water. V6 stated, the cold therapy ice machine was a "great help for (R1)." V6 stated, "Ice machine was lifeline for (R1's) pain." V6 asked if at any time was there was an incident when no ice was in R1's cold therapy ice machine. V6 stated, "Yes. I (V6) was making rounds. (There was) no ice in (R1's). (V6) and (V9, Assistant Director of Nursing, ADON) dealt with it. Ice had not been delivered yet that morning." V6 stated, R1 "would have pain with ice	S9999		

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S9999	Continued From page 3	S9999		

machine off most of the time." V6 stated, V14 (Wound Care Nurse) informed V6, "It's magical" when talking about the cold therapy ice machine.

In R1's Physician's Progress Notes, V6 (NP) documented, in part, the following notes:
1) On 2/8/23 at 9:30 am: " ... (R1) c/o (complained of) pain in R (Right) shoulder surgical site, noted ice pump was off last night. Back up pump is at bedside, refilled with water and ice, and re-initiated at bedside with (V6) and (V9, ADON)."
2) On 2/20/23 at 12:30 pm: " ... (R1) also c/o surgical site pain, noted ice pump is not on. (V6) reinforced nursing importance of having ice pump on for pain management."
3) On 3/2/23 at 10:05 am: " ... Ice machine in not on due to no ice at night sift, ensure ice machine in on, reconnected this morning with good (pain) relief."

On 3/15/23 at 12:23 pm, V14 (Wound Care Nurse) stated, V14 was seeing R1 for R1's right shoulder surgical incision care. V14 stated, the cold therapy ice machine had a double lumen tubing that came out of the ice bucket where ice cold water would flow from the ice bucket through one lumen, up the to pad that was secured on R1's right shoulder and then the ice cold water would return back down through the other lumen to the ice bucket. V14 stated on one occasion, V14 did fill up R1's ice bucket due to R1 stating that the cold therapy ice machine was not cold and that V14 had observed mostly water in the ice bucket.

On 3/14/23 at 12:24 pm, V9 (ADON) stated, R1 was using the cold therapy ice machine to help with both pain and swelling of R1's surgical site. V9 stated, staff puts ice in the ice bucket which is

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connected to a wrap that "looks like a blood pressure cuff" that goes over R1's right shoulder. V9 stated, one morning, V9 did assist R1 with filling ice in the cold therapy ice machine due to staff "had not gotten to her yet," and the ice machine bucket was "mostly water in the bucket."

R1's Medication Administration Record (MAR) for February 2023 documented, in part, that for R1's order to apply cold machine to right arm to reduce swelling and pain as needed, only one administration entry (2/17/23) was noted documented by nursing staff.

On 3/14/23 at 12:57 pm, V11 (LPN) stated that R1's cold therapy ice machine had a bucket that had a line at the bottom of the ice box where staff would fill small amount of water and then fill the remaining box full of ice. V11 stated, V11 taught the CNAs about R1's cold therapy ice machine and how to refill the majority of the ice box with ice. V11 stated, R1 "wanted it on all the time" and used to reduce swelling and to help with pain.

On 3/15/23 at 1:43 pm, V2 (Director of Nursing, DON) stated that non-pharmacological interventions for pain include ice (cold therapy). V2 stated, for the nursing staff must go to the kitchen to retrieve ice from the ice machine and brings it back upstairs to the floor. V2 stated, if nursing staff need to get ice during the night shift, the staff member will retrieve a key from the receptionist desk and go downstairs to unlock the kitchen to access the ice machine. V2 stated, V2 did recall a complaint from R1 about not having ice, and when V2 followed up with staff, V2 stated, a CNA was "given a hard time" about trying to get ice in the kitchen. V2 stated, V2 then "got the message out" to kitchen staff to allow nursing staff to retrieve ice from the kitchen. V2

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S9999	Continued From page 5 stated, R1's cold therapy ice machine was used to help with R1's swelling and pain. R1's Order Summary Report documents, in part, the Clonazepam orders as follows: "Clonazepam Oral tablet 1 mg (milligram). Give 3 tablet by mouth two times a day for anticonvulsants (order date of 2/3/23)" and "Clonazepam tablet 2 mg. Give 1 tablet by mouth two times a day for anticonvulsants. Add with 1 mg = (equal to) 3 mg (order date of 2/5/23)." R1's Medication Administration Record (MAR) for February 2023 documents, in part, that for the scheduled "Clonazepam tablet 2 mg. Give 1 tablet by mouth two times a day for anticonvulsants. Add with 1 mg = 3 mg" on 2/5/23 at 9:00 pm, V15 documented a chart code of "9" which indicates "Other/See Progress Notes." In R1's Orders - Administration note (EMAR, electronic MAR note), on 2/5/23 at 9:04 pm, V15 (LPN) authors, "Clonazepam tablet 2 mg. Give 1 tablet by mouth two times a day for anticonvulsants. Add with 1 mg = 3 mg. On order MD (Doctor) aware." On 3/15/23 at 12:03 pm, V15 (LPN) stated, on 2/5/23, R1 stated that R1 was "allergic to anything blue." V15 stated, when V15 went to administer the Clonazepam 1 mg tablets (blue in color), R1 stated that R1 didn't want to take the blue colored Clonazepam (1 mg dose) due to R1's allergy to the blue dye. V15 stated, "I (V15) documented it. To call (R1's) doctor or pharmacy to change the medication (Clonazepam dose)." When this surveyor asked if V15 called R1's doctor on 2/5/23, V15 stated, "No. I (V15) endorse to the morning nurse (V11, LPN). At night, I (V15) don't want to wake the doctor up."	S9999		

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In R1's Orders - Administration noted, on 2/5/23 at 9:41 pm, V15 (LPN) authored, "Clonazepam oral tablet 1 mg. Give 3 tablet by mouth two times a day for anticonvulsants. The medication comes in a blue color, and (R1) 'state I (R1) can't take anything with blue dye.' MD aware."

On 3/15/23 at 3:59 pm, when this surveyor asked V11 (LPN) about V11's authored EMAR note (2/6/23 at 11:45 am) which documented, in part, "Physician needs to change order," V11 stated, on 2/6/23, V11 punched out one of R1's Clonazepam 1 mg tablets from the controlled substance medication dispensing card and showed the blue table to R1. V11 stated, R1 was allergic to the blue dye in the medication. V11 stated, V11 then called the pharmacist and was informed that the 2 mg tablets were white in color; therefore, R1 would be able to take one 2 mg tablet and a half of another 2 mg table of Clonazepam to equal the ordered 3 mg dose. V11 stated, V11 then phoned V18 (Nurse Practitioner) on 2/6/23 for the new order of Clonazepam 2 mg tablets to get the 3 mg dose. V11 stated, "At first, I (V11) thought I (V11) didn't need a new order for the different color. I (V11) called for a stat order." This surveyor then asked V11 if V11 had R1's new Clonazepam 2 mg tablets order (total dose of 3 mg) prescription signed by V18, and V11 stated, "For the change in color (of Clonazepam), it ended up that I (V11) needed a new script. I (V11) got it signed right then and there. I (V11) put the new order in and asked for it stat. (V6, NP) was here. I (V11) said (to V6), 'Can you please write the script?'" V11 stated that R1's Clonazepam 2 mg tablets (white in color) were delivered to the facility on the same day when V11 changed the Clonazepam order which was the same day that R1 was sent to the

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hospital after having a seizure. This surveyor reviewed with V11 from R1's electronic medical record (EMR) where R1 was sent to the hospital after a seizure in the facility on 2/7/23, but that V11 had documented in a Nurses Note on 2/6/23 at 5:23 pm, "D/C (discontinue) Clonazepam 3 mg and start 2 mg w/ (with) half." V11 stated, "On 2/7/23, I (V11) ordered it stat. When the man from the pharmacy came up, (R1) was being sent out to the hospital." When asked about Clonazepam being a controlled substance, V11 stated, "I (V11) can't get (Clonazepam) medication without a script (signed prescription)." This surveyor asked V11 when V11 documented changing R1's Clonazepam order to 2 mg tablets on 2/6/23, why was there a delay with R1's Clonazepam 2 mg tablets getting delivered to the facility on 2/7/23. V11 stated, "(V6) was probably out of the building. I (V11) could not get the script. I (V11) endorse to night nurse. I (V11) knew I (V11) would be here the next day (on 2/7/23) and had to get it taken care of."

R1's Order Summary Report, documents, in part, an order of "Clonazepam Oral Tablet 2 mg. Give 3 mg by mouth two times day for seizures. Give one and half tablet to equal 3 mg (start date of 2/6/23)."
In R1's Nurses Note, dated 2/6/23 at 5:05 pm, V11 documented, "(R1) has allergy to blue dye in which one of (R1's) medications contains it. Writer (V11) called the pharmacist, and she recommended giving (R1) a 2 mg tab and half because its white and it won't affect allergy."

On 3/14/23 at 12:57 pm, V11 (LPN) stated that V11 was R1's primary nurse on 2/7/23 when V11 witnessed R1's seizure in R1's bed from 2:27 pm to 2:33 pm. V11 stated that 911 emergency services were called and that R1 was transferred

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S9999	Continued From page 8 emergently to the hospital on 2/7/23 after R1's seizure. In R1's Nurses Note, dated 2/7/23 at 4:43 pm, V11 documented, in part, that V11 was called to R1's room by a physical therapist where V11 "observed (R1) experiencing a seizure. Seizure started at 2:27 and lasted until 2:33 (pm) ... Once seizure stopped, (R1) was unresponsive with eyes open. 911 called ... Ambulance took (R1) to (local hospital) for eval (evaluation) at 2:45 (pm)." R1's prescription (paper) for "Clonazepam Oral Tablet 2 mg. Give 3 mg by mouth two times day for seizures. Give one and half tablet to equal 3 mg" with an order date of 2/7/23 was signed by V6 (NP) for a 2 week supply. On 3/14/23 at 10:18 am, V6 (Nurse Practitioner, NP) stated that due to R1's allergy to blue dye in medications, V6 did change the Clonazepam from 1 mg tablets which were blue to the 2 mg tablets which were white pills. V6 stated, V6 will sign paper prescriptions when nursing staff needs medications ordered or reordered that require a nurse practitioner or physician's signature. V6 stated, within the EMR, the nurse will hit "print script" button, and the paper prescription will print in the facility where V6 will then sign the medication prescription. V6 stated, "once or twice" there was a problem with the printer in the facility where the prescription wouldn't print for V6 to sign. V6 stated , V6 was asked by V11 to sign R1's prescription for changing the Clonazepam dosage due to R1's allergy. V6 stated, V6 signed the new Clonazepam prescription on the same day that V11 asked for V6 to sign it (2/7/23) and was informed that for 2 days, R1 had not been taking the Clonazepam (due to blue dye allergy). V6 stated, the nursing staff had called the primary	S9999		

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S9999	Continued From page 9 NP (V18) to get the new Clonazepam prescription signed, but that it was not signed yet. V6 stated, "I (V6) wasn't aware. They (nurses) were telling me (V6) that they were trying to contact primary. I (V6) don't know to ask. I (V6) was not notified that (R1) wasn't getting the medication (Clonazepam). They (nurses) asked me 'Can you sign this' for (R1's) seizure medication (Clonazepam)." When asked if R1 is not receiving a seizure medication, could this cause R1 to have a seizure, "Yes. It could cause (R1) in having a seizure, when (R1's) missing medication." Upon this surveyor reviewing R1's MAR from February 2023, no documentation of nurses administering R1's Clonazepam 3 mg orally twice a day for seizures is noted from R1's re-admission to the facility on 2/5/23 to R1's hospitalization on 2/7/23 for a seizure in the facility. R1's Care Plan, with admission date 2/3/23, documents, in part, a focus of "(R1) has a seizure disorder" with an intervention of "give seizure medications as ordered by doctor." On 3/15/23 at 3:38 pm, V18 (Primary NP) stated that V18 saw R1 twice in the facility. This surveyor informed V18 that R1 was ordered for Clonazepam from the hospital with an original dose in 1 mg tablets that were blue in color. When asked if nursing staff notified V18 of this, V18 stated, "I (V18) don't recall that. When residents come from the hospital each time, I (V18) tell the nurses to follow on discontinued hospital medications." When asked since R1 was ordered for Clonazepam and the dose needed to be changed due to R1's blue dye allergy (to change Clonazepam from blue to white color tablets), did V18 write or sign a prescription for	S9999		

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S9999	Continued From page 10 R1's new Clonazepam order, and V18 stated, "No, I (V18) didn't write the script. I (V18) confirm the orders over the phone with the nurse. I (V18) don't have a fax at home. And I'm (V18) in the clinic once a month. I (V18) don't have the access to send to a script to pharmacy for controlled substances." This surveyor informed V18 that R1 was ordered for Clonazepam for seizures. V18 stated, "I (V18) am not aware of that. That (R1) was on Clonazepam for seizures. I (V18) tell the nurses for anything medical, follow everything with the hospital. If it's a medication for psych, then call the psych doctor for clarification." On 3/15/23 at 1:43 pm, V2 (Director of Nursing, DON) stated that Clonazepam is a controlled substance and that the nurse must have the paper prescription signed to be faxed to the facility's pharmacy. V2 stated that during the day shift, the in-house NP can sign any prescription for controlled substances. V2 stated nurses can remove emergency medication from the facility's emergency medication dispensing machine if needed. V2 stated, the process for administering meds is for the nurse to verify the dosage and medication name; use aseptic technique; determine proper way to administer (crushed or whole); and then document in EMAR that medication is given. V2 stated, a "check mark" will appear on the EMAR when the nurse administers the medication, or the nurse will document a "chart code" if nurse is not able to give medication for whatever reason. On 3/15/23, V2 provided this surveyor a list of the emergency medications housed in the emergency dispensing machine in the facility, and Clonazepam is not on the emergency medication list.	S9999		

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Facility policy, titled "Pain Assessment and Management" and dated 1/2/22, documents, in part, "Purpose: The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain ... Implementing Pain Management Strategies: 1. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: ... b. Physical - ice packs, cool or warm compresses."

Facility policy, titled "Documentation of Medication Administration" and dated 3/1/22, documents, in part, "Policy heading: The facility shall maintain a medication administration record to document all medications administered. Policy Interpretation and Implementation: 1. A nurse ... shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given."

Facility policy, titled "Medication Orders" and dated 6/2/22, documents, in part, "Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders ... Recording Orders: 1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered."

Facility policy, titled "Controlled Substance" and dated 3/1/22, documents, in part, "Controlled Substances. Policy Statement: The facility complies with all laws, regulations, and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001176	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON CARE AND REHABILITATION	4538 NORTH BEACON CHICAGO, IL 60640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 requirements related to handling , storage, disposal and documentation of controlled medications. Policy Interpretation and Implementation: ... 9. ... c. An individual resident controlled substance record is made for each resident who is receiving a controlled substance." Facility policy, titled "Resident Rights" and dated 2/1/23, documents, in part, "Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... jj. equal access to quality care." Facility job description titled "Licensed Practical Nurse, (LPN)" and dated 4/1/17, documents, in part, "Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Supplies: ... Prepare & administer medications as ordered by the physician. If a medication is unavailable, the physician is to be notified for further instruction and potential follow up orders ... Monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies." (B)	S9999		