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
	IL6010052	A. BUILDING: ____ B. WING ____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE OF LAKE COUNTY	850 E US HIGHWAY 45 MUNDELEIN, IL 60060

(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
S 000	Initial Comments Complaint Survey 2314465/IL160394	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to treat and manage a resident's pain after a resident sustained a fall resulting in injury for 1 of 3 residents (R1) reviewed for pain in the sample of 7. This failure resulted in R1 suffering excruciating pain with movement during cares and therapy. R1's fall resulted in a fractured pelvis and subdural hematoma. The finding include: R1's fall investigation report dated May 18, 2023, showed, on May 17, 2023, at 11:45 PM, R1 was found on the floor in the bathroom of her room. A laceration was noted above R1's right eye. The report showed R1 was assessed by staff immediately after the fall. R1's was found to have no "significant" pain to R1's extremities during range of motion exercises, and steri-strips were applied to R1's head laceration. R1's physician (V18) and V4 (Power of Attorney/Family of R1) were immediately notified of R1's fall. The report showed V4 (Family of R1) refused to have R1 sent to the hospital at that time. The report showed R1 began to complain of increased pain during the morning of May 18, 2023. V4 was	S9999		

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S9999	Continued From page 2 notified of R1's increased pain. V4 agreed, at that time, to have R1 sent to the hospital for an evaluation. At the hospital, R1 was evaluated and diagnosed with a pelvic fracture and subdural hematoma (brain bleed), as a result of her fall. R1 was hospitalized until May 22, 2023, and then transferred back to the facility. The report showed R1 was severely cognitively impaired, related to her diagnoses of dementia and Alzheimer's disease, prior to her fall. On June 5, 2023, at 12:40 PM, V4 (Family of R1) stated, "When (V5 Registered Nurse/RN) called me after (R1) fell (on May 17, 2023), he said he was going to give her some medication for pain because she had begun complaining of general pain. I am not sure if he ever gave it to her....When (R1) returned to the facility, from the hospital on May 22,2023, (V7 Physical Therapist) came in to do an assessment on (R1), around lunch time. During the assessment, (R1) was in terrible pain, yelling out every time (V7) tried to move her. I finally asked (V7) to stop doing the assessment." R1's May 2023 Medication Administration Record showed two physician order's for Tylenol. One order showed Tylenol 325 mg (milligrams), give 2 tablets by mouth every 4 hours as needed for pain. The second order showed Tylenol 325 mg, give 2 tablets once a day, at 9:00 AM. The record showed R1 received no Tylenol for pain, after her fall on May 17, 2023 at 11:45 PM, until 9:00 AM on May 18, 2023. On June 6, 2023, V5 RN stated, "I was called to (R1's) room by (V6 CNA) when he found her on her bathroom floor. She had a small laceration above her left eye. Aside from her head wound, she had no obvious other injuries or deformities.	S9999		

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She moved all of her extremities without complaints of pain. I called her physician and notified her of (R1s) fall. The physician wanted to send her to the hospital at that time but when I called (V4 Family of R1) to inform her of the fall, (V4) refused to have (R1) sent to the hospital at that time. (R1) began complaining of increased pain to her hips, later on in my shift. I again called the doctor and got an order to do an X-ray of (R1's) hips. I called (V4) a second time, to let her know (R1) was having increased pain..." When V5 RN was asked if he medicated R1 for pain, at any time after her fall, V5 stated, "I thought I gave her Tylenol that night."

R1's Admission Summary note dated May 22, 2023, at 10:55 AM, showed R1 was readmitted to the facility, from the hospital. The note showed R1 was complaining of pain upon readmission.

R1's May 2023 Medication Administration Record showed R1 had a physician order for Norco 5/325 mg (narcotic pain medication), one tablet every 6 hours as needed for pain, at 1:01 PM on May 22, 2023. The record showed R1 did not receive a dose of Norco until 4:34 PM, on May 22, 2023.

On June 6, 2023, at 10:05 AM, V7 Physical Therapist stated, "For therapy, we coordinate with nursing to make sure pain medications are given at least one hour before a resident's therapy session. I saw (R1) on May 22, 2023, shortly after she was readmitted to the facility. There was a physician order for her to have a physical therapy assessment completed upon readmission to the facility. When I entered her room, (R1) was in bed with her eyes closed. She would respond to verbal commands. Every time I moved her, she was in pain. She would try to pull away. She would moan. I tried to sit her up and

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S9999	Continued From page 4 get her to stand. I know she was on a pain pill. I am not sure when she got it... If a resident is in a lot of pain, we normally stop the therapy assessment. We talk with the nurse about pain control. If a resident's pain isn't under control, therapy is useless. It's like torturing patients at that point..." When (V7) was asked why she did not stop R1's therapy session when R1 began complaining of pain, V7 stated, "I thought (R1) had already received pain medication but I was not 100% sure." V7 also stated she never reported R1's complaints of pain to R1's nurse. V7 stated she never spoke with R1's nurse to ensure R1 received any pain medications prior to her therapy assessment. On June 6, 2023, at 11:54 AM, V2 Director of Nursing stated, "The goal with pain management is maintain a resident's pain at a manageable level." R1's May 2023 Medication Administration Record with reviewed with V2. V2 stated, "If (R1) began complaining of pain, after her fall, she should have gotten something for pain. Even if she just got Tylenol. I see there is no documentation that (R1) got any Tylenol after her fall on May 17, 2023, until 9:00 AM on May 18, 2023....If a resident is still having breakthrough pain while already on pain medications, staff should notify the physician of the pain... When (R1) was readmitted to us, she was in quite a bit of pain, anytime we tried to move her... Pain medication should have been given to (R1) prior to any cares due to her pain with movement..." On June 6, 2023 at 1:10PM, V18 (R1's Physician) stated, "I expected her (R1) to have pain due to her injuries that is why I prescribed the Norco every 6 hours." The pain should be reasonable (level) so they can perform cares and therapy.	S9999		

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S9999	Continued From page 5 The facility's Pain Management policy dated May 2023, showed, "It is the policy of this facility to respect and support the resident's right to optimal pain assessment and management... Effective pain management can remove the adverse psychological and physiological effects of unrelieved pain...Strategies for pain management include...Identifying and using specific strategies for preventing or minimizing different levels or sources of pain or pain-related symptoms based on resident-specific assessment, preferences and choices, a pertinent clinical rational, and resident's goals and using medications judiciously to balance resident's desired level of pain relief with avoidance of unacceptable adverse consequences..." (A)	S9999		