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	IL6012967	A. BUILDING: _____ B. WING _____	C 05/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CHICAGO RIDGE	10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

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S 000	Initial Comments 2393771/IL159470 2393683/IL159455 Investigation of Facility Reported Incident of 04-29-2023/IL159536	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. 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 Regulations are not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview and record review, the facility failed to immediately assess and obtain medical treatment following a fall with injury for one of three residents (R2) reviewed for falls with injuries in the sample of four. These failures resulted in (R2) lying in bed with a fractured right leg (tibia) without medical treatment for over 24 hours. Findings include: R2's Admission Record documents R2 was admitted to the facility on 10-31-21 and discharged from the facility on 4-29-23. This same Record documents R2 had the diagnoses of Chronic Kidney Disease Stage Four, Hypotension, Chronic Pain Syndrome, Hallucinations, Peripheral Vascular Disease, Psychosis, Renal Dialysis, Bipolar Disorder, Anxiety Disorder, history of Falling, Ileostomy, Dementia, and Anemia. R2's MDS (Minimum Data Set) Assessment dated 3-17-23 documents R2 was moderately cognitively impaired and required extensive assistance of one staff for transfers and toileting. R2's Progress Notes dated 4-29-23 at 2:59 PM and signed by V6 (RN/Registered Nurse) documents, "R2 has right knee and leg swelling with bruising. Call to nurse practitioner on call who states to ice, elevate, Tramadol, Tylenol, and x-ray of right knee." R2's Progress Notes dated 4-29-23 at 9:05 PM document, "R2's right leg is swollen and bruised. R2 complained of pain 20 out of 10 (1-10 scale). Started on 4-29-23 and has gotten worse. Ambulance notified for transfer. R2 transferred	S9999		

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S9999	Continued From page 3 out of facility via stretcher accompanied by two EMTs (Emergency Medical Technicians)." R2's Progress Notes dated 4-30-23 at 2:04 AM document, "(Hospital) called for status of (R2) to be admitted. Diagnosis: Right leg pain/closed fracture of proximal right tibia." R2's Hospital History and Physical dated 4-30-23 documents, "Date/Time of Admission: 4-29-23 at 10:15 PM. Admitting Diagnoses: Closed fracture of the proximal end of right tibia. Subjective: R2 was sent in for evaluation of her right leg and knee pain. R2 had a fall on Thursday (4-28-23). R2 states has swelling and pain with pain increasing on movement and patient has not been able to stand and weight bear on the right leg since the injury. CT (Computerized Tomography) scan of the right knee and leg showing marked diffuse Osteopenia and Comminuted (broken in two or more places) Fracture Proximal Tibial (leg bone) and Prominent Oblique Fracture component from the Mid-Tibial spine extending obliquely to include the Lateral Cortex of the Proximal Metaphysis (area of bone above the growth plate) with marked soft tissue swelling and edema surrounding the knee. Ecchymosis (discoloration under the skin due to bleeding) right leg." R2's Electronic Health Record dated 4-28-23 does not include documentation of R2's fall or an assessment following R2's fall. On 5-26-23 at 3:45 PM V21 (Agency RN/Registered Nurse) stated, "I was not aware that R2 had fell on 4-28-23 during my shift so I did not do an assessment of R2 or document anything at all about R2. I had no idea R2 had hurt her leg. No staff had reported to me that R2	S9999		

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S9999	Continued From page 4	S9999		

had fell."
On 5-26-23 at 4:35 PM V6 (RN) stated, "I was working on 4-29-23. I seen R2 in the morning 4-29-23 when I gave her medications to her. R2 was lying in bed that morning and did not get up. R2 normally lays in bed throughout the day when she does not have dialysis. Later, that day around 2:00 PM R2 was trying to get out of bed without assistance. I asked R2 what she was doing and R2 told me her leg was hurting and that she had fell the night before. R2's right leg had bruising to almost the entire leg and R2 was in pain. There was no documentation in (R2's) medical record about R2 falling the night before, so I called (V2/Director of Nursing) and reported what R2 had reported to me and R2's injuries to the right leg. I called the physician and got orders to obtain x-rays of the right knee and give pain medication as needed."

On 5-26-23 at 7:45 PM V24 (R2's Power of Attorney) stated, "I met R2 at the hospital on 4-29-23. R2 was in excruciating pain and was crying. R2 told me she had fell the day before and was put into bed by the staff. R2 stated her leg hurt after the fall but she just stayed in bed and tried not to move her leg. R2 told me V24 a nurse did not help her until the next day when R2 stated the pain had gotten to a 20 out of a 10. R2 should have been assessed immediately after the fall and received medical treatment immediately for the injuries to her leg."

On 5-26-23 at 5:15 PM V2 (Director of Nursing) stated, "I had no idea that R2 had fallen and sustained an injury on 4-28-23 until (V6/Registered Nurse) called me on 4-29-23 around 2:00 PM and reported to me that R2's right leg was bruised extensively. V6 called to obtain orders for an x-ray. The x-ray company did

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S9999	Continued From page 5 not come timely and R2's pain worsened so R2 was sent to the emergency room around 9:30 PM for treatment. I started an investigation immediately and found out by (V20/CNA/Certified Nursing Assistant) and (V22/CNA) that R2 had a fall the night before on 4-28-23 around 5:00 PM and V20 and (V22) used a (mechanical lift) to transfer R2 back to bed from the floor. I tried to notify R2's nurse (V21/Agency RN) but did not get an answer. V21 was R2's nurse on shift the night R2 had the fall on 4-28-23 around 5:00 PM. There was no documentation in R2's medical record or an assessment of R2 after the fall on 4-28-23. An assessment should have been completed immediately after R2 fell and R2 should have received treatment for the fracture immediately after the fall." (A) Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 300.1620e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually	S9999		

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S9999	Continued From page 6 by this committee, documented by written, signed and dated minutes of the meeting. 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 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: 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	S9999		

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S9999	Continued From page 7 made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1620 Compliance with Licensed Prescriber's Orders e) The resident's licensed prescriber shall be notified of medications about to be stopped so that the licensed prescriber may promptly renew such orders to avoid interruption of the resident's therapeutic regimen. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to provide pain management, assess a resident for pain as ordered and when experiencing an increase in pain for one of three residents (R3) reviewed for pain management in the sample of four. This failure resulted in R3 experiencing severe, sharp, and stabbing pain for over a week that radiated from the buttock down to the right knee. Findings include: The facility's Pain Policy dated 7-28-22 documents, "It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. For pain complaints and for situations that might result to pain the nursing staff may document it in any part of the resident's medical record that	S9999		

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S9999	Continued From page 8 includes Nurse's Notes, Incident Report, and Medication Administration Record. If available in the convenience box or facility house stock, the pain medication ordered with be administered to the resident as soon as possible. If the resident is still in unrelieved pain despite pharmacological and nursing measures, the resident's physician will be called to refer the lack of relief." The facility Pain Assessment Sheet (undated) documents this pain assessment sheet will be completed during assessment of pain. R3's MDS (Minimum Data Set) Assessment dated 5-18-23 documents R3 has frequent pain. R3's Pain Plan of Care dated 10-25-22 documents, "Focus: R3 is at risk for pain related to the diagnoses history of NSTEMI (Non-ST-Elevation Myocardial Infraction), CAD (Coronary Artery Disease), and DM (Diabetes Mellitus), and Pain in the Right Knee. Goal: R3 states that level of pain is tolerable or has relief with interventions. No signs and symptoms of non-verbal pain. Interventions: Evaluate efficacy of pain management. Notify MD (Medical Doctor) if inadequate pain relief. Observe for non-verbal signs of pain. Provide Analgesic as ordered. Utilize non-pharmacological interventions." R3's Physician Orders dated 10-12-22 documents "Norco (Hydrocodone-Acetaminophen) Oral Tablet 5-325 mg (milligrams) one tablet by mouth every six hours as needed for severe pain. Pain Assessment every shift for pain: Numeric Scale (0=no pain; 1 to 3=mild pain; 4 to 7= moderate pain; 8 to 10=severe pain)." R3's MAR (Medication Administration Record)	S9999		

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S9999	Continued From page 9 dated 5-1-23 through 5-26-23 documents, "Pain Assessment every shift for pain: Numeric Scale (0=no pain; 1 to 3=mild pain; 4 to 7= moderate pain; 8 to 10=severe pain). This same MAR documents R3's Pain Assessment was not completed on 19 shifts from 5-1-23 through 5-26-23." R3's MAR dated 5-1-23 through 5-26-23 documents R3 last received Norco 5-325 mg on 5-18-23. R3's Controlled Drug Administration Records dated 4-21-23 through 5-26-23 document on 4-23-23 the facility accepted 30 tablets of R3's Norco and all 30 tablets were administered between 4-23-23 and 5-17-23. R3's Controlled Drug Administration Records do not include any documentation of R3's Norco getting refilled since 5-17-23. On 5-26-23 at 9:15 AM R3 was observed lying in bed. R3 had facial grimacing and was rubbing her right knee and right leg. R3 stated, "My pain has been at a level eight for over a week. I have not had my Norco for over a week. The nurses keep telling me they have ordered the Norco, but I have never received it. The nurses have been giving me Tylenol. The Tylenol does not help. I still have been having a severe, sharp, stabbing pain that has been going from my butt to my right knee. I should not have to lay in pain like this. I cannot walk, or I would get up and go get the medicine myself." On 5-26-23 at 9:30 AM (V8/LPN/Licensed Practical Nurse) stated, "I took care of R3 last night. Around 10:00 PM R3 was stating she had pain in her right leg and knee that she rated as a seven on a one to ten scale. R3 told me she	S9999		

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S9999	Continued From page 10 hurts all over and the pain was unbearable. R3 was requesting a Norco because the Tylenol was not controlling the pain. R3 did not have Norco available. I re-ordered the Norco in the computer, but the doctor needs to provide a prescription for it. R3 should not have to lay in pain and should be able to have her Norco whenever she wants it. I did not document in the progress notes or pain assessment that R3 was having pain last night." On 5-26-23 at 10:45 AM V2 (Director of Nursing) stated, R3 should never have to go without her Norco or ever have to be in uncontrolled pain. The nurses should have been doing R3's pain assessments every shift as ordered on the MAR and whenever R3 was experiencing an increase in pain. I see where the nurses have not been doing R3's pain assessments every shift as ordered. The nurses could have pulled the Norco from the back-up (automated medication dispensing system) if they would have just called the pharmacy and received a code to get into the pixus. R3's Norco should have been refilled before R3 ran out of the Norco on 5-17-23. There is no documentation that the nurses have tried to re-order R3's Norco or have notified R3') physician of R3 being out of Norco since 5-17-23." On 5-26-23 at 12:36 PM V14 (Nurse Practitioner) stated, "I work under V13/R3's Primary Care Physician. I collaborate with V13 about R3's cares. I have been responsible for R3 for the last week. The staff have not notified me that R3 was in pain and was out of Norco since 5-17-23. I should have been notified prior to R3 running out of Norco." On 5-26-23 at 5:50 PM V13 (R3's Physician) stated, "I am very sensitive to the resident's	S9999		

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S9999	Continued From page 11 needs. R3's increase of pain should have been documented and I should have been notified to ensure R3 received proper pain relief and a prescription for her Norco." (B)	S9999		