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S 000	Initial Comments Complaint Survey: 2486118/IL176309	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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 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		

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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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to identify and treat the cause of new pain in left arm; failed to timely review x-ray results; failed to relay x-ray results to physician; failed to obtain verbal or telephone order from physician for pain patch for one resident (R4) in a total sample of 3 residents (R4, R5, and R6). These deficient practices resulted in harm for R4 experiencing new onset left arm pain for 34 days with limited mobility due to a left humerus fracture diagnosed at an outside hospital.

Findings include:

On 08/13/24 at 12:48pm V19 Medical Doctor (MD) stated, "R4 came to the Emergency Room (ER) unable to move his (R4) left arm and was found to have a subacute fracture to the left humerus. We (medical staff) think the fracture is a pathologic fracture from the cancer, but the problem is how long did he (R4) have this fracture without it being treated. He (R4) was admitted

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with acute kidney injury (AKI), fecal impaction, dehydration, subacute fracture and pneumonia."

R4's hospital note dated 07/30/24 documents in part that R4 has a diagnosis of metastatic cancer of unknow origin (present on admission), and also noted that R4 had significant left arm pain. R4 "was unable to move arm on exam ...X-ray of the left humerus showed subacute fracture of the proximal left humerus."

R4's diagnosis includes but are not limited to Major depressive disorder, Chronic respiratory failure, Chronic obstructive pulmonary disease, Morbid obesity, Venous insufficiency, Sleep Apnea.

R4's Minimum Data Set (MDS) dated 06/13/24 has a Brief Interview for Mental Status (BIMS) score of 13 which indicates R4's cognition is intact.

On 08/12/24 at 12:01pm V20 Licensed Practical Nurse (LPN) stated, "(R4) did complain of pain to his (R4) left arm. (R4) complained of arm pain for about a week or so before (R4) left. At first, (R4) wasn't complaining about the arm then (R4) started complaining of arm pain. (R4) told me (V20) that the lady came to draw (R4's) blood and (R4's) arm had been hurting ever since then. (R4) couldn't lift (R4's) arm anymore, (R4) said the arm hurt to lift. (R4) would use (R4's) right hand to lift (R4's) left arm because the left hurt (R4) too bad to try to move. The DON (Director of Nursing) and the doctor both knew about the pain in (R4's) arm. I'm (V20) not sure if they (DON and Doctor) did anything about the pain, possibly an x-ray."

Record review of R4's physicians orders show

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that an x-ray of R4's left shoulder was ordered on 06/25/24 due to pain.

Record review of radiology results of R4's x-ray to left shoulder taken on 06/26/24 show that V2 reviewed R4's left shoulder x-ray results on 07/19/24.

Record review of R4's progress notes show that no documentation of x-ray results was communicated to V22 until 07/19/24 by V2.

On 08/13/24 at 2:00pm V2 Director of Nursing (DON) stated that R4 was having new pain and R4 denied anything happened to his arm. V2 stated that V2 was auditing the chart on 07/19/24 and noted that there was no documentation about R4's x-ray done on 6/26/24, so V2 notified V22 medical doctor.

On 08/13/24 at 1:15pm V13 Certified Nursing Assistant (CNA) affirmed that R4 started complaining of pain to R4's left arm approximately 2 weeks before R4 left the facility. V13 stated that V13 told the nurse that R4 was complaining of pain to R4's left arm.

On 08/13/24 at 2:22pm V16 CNA stated that R4 complained of pain to his (R4) left arm starting a few weeks before R4 left the facility. V15 told the nurse that R4 was complaining of pain and the nurse gave R4 Hydrocodone.

On 08/14/24 at 10:30am V22 MD stated, "I (V22) don't remember ordering lidocaine patch for (R4), the nurses might have just put the order in my (V22) name. I (V22) don't recall anyone informing me (V22) of any x-ray results. In my (V22) practice I (V22) usually don't order Lidocaine. That order I (V22) did not give. I (V22) usually

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look at what causes the pain instead of just ordering a patch. I (V22) don't have a memory of the DON calling me (V22). The nursing home has their own specific nurse practitioner (NP). I don't have an NP. It's not normal for staff to put an order in my name and I (V22) expect staff to call me (V22). My (V22) name is on (R4's) chart as the attending, so the nurse probably just picked my (V22) name for the lidocaine order."

On 08/14/24 at 10:55am V2 stated, " Residents with pain need to be assessed to find out where the pain is and the level of pain and then give them (residents) PRN (as needed) pain medications. New pain is considered a change of condition. Some residents have psychological pain. For new pain an SBAR (situation, background, assessment and recommendation) should be done, the doctor should be notified and the family of the resident if the resident is not alert, and then give the resident whatever the doctor orders. For severe pain we (nurses) should send the resident to the hospital. We (nurses) check for swelling and bruising in the area of pain, and for safety purposes do an x-ray."

R4's progress notes dated 06/25/24 through 07/29/24, show no SBAR for new pain, no documentation that physician was notified of new pain, and no documentation of next of kin notification of new pain for R4 found as V2 stated in above interview should be completed for new pain.

On 08/14/24 at 1:55pm V23 LPN stated, "I (V23) am not familiar with R4. I (V23) don't know how my (V23) name can be on an order for R4 because I (V23) don't ever take care of R4. R4 was in room with others and sometimes when R4

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would put the call light on, I (V23) would answer the call light and R4 would ask me (V23) to tell R4's nurse (R4) needs pain medication, water or that (R4's) oxygen wasn't working but that's it. I (V23) don't know how the order was entered under my (V23) name."

On 08/14/24 at 2:41pm V1 Administrator stated, "Staff are not allowed to share passwords. The nurse should transcribe the order correctly. With any change in condition the nurse is to notify the doctor. The nurse cannot enter an order without contacting the doctor."

On 08/14/24 at 2:50pm V24 RN stated, " Actually there was a time when R4 came from an appointment, and I (V24) saw a prescription for lidocaine patch to his (R4) left arm. Normally nurses have to advise the doctor or the NP if we (nurses) get an order from a resident's appointment. I (V24) don't know when the pain in R4's arm started. Normally R4 would just ask for the Norco for pain but then one day R4 wanted the Norco and the lidocaine patch."

R4 Physician Order Set (POS) dated 07/19/24 documents in part, "Lidocaine External Patch 5%...apply to left arm."

Facility's undated policy titled "Pain - Clinical Protocol" documents in part, "Assessment and Recognition ...1. The physician and staff will identify individuals who have pain or who are at risk for having pain ...a. This includes reviewing know diagnoses and conditions that commonly cause pain ...2. The nursing staff will assess each individual for pain whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain ...5. The staff and physician will evaluate how pain is

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affecting mood, activities of daily living, sleep, and the resident's quality of life."

Facility's undated policy titled "Change in a Resident's Condition or Status" documents in part, "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and /or status ...1. The nurse will notify the resident's attending physician or physician on call when there has been a ...d. significant change in the resident's physical/emotional/mental condition ...2. A "significant change" of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions ...8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."

Facility's undated policy titled "Activities of Daily Living (ADL's), Supporting" documents in part, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's) ...1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADL's) do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADL's are unavoidable ...a. The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADL's."

Facility's undated policy titled "Resident Rights" documents in part, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's

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right to ...c. be free from abuse, neglect, misappropriation of property, and exploitation."

(A)

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300.1210b)

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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to properly assess and manage oral fluid intake, urinary output and bowel output in a resident (R4) who was at risk for dehydration. .

Finding include:

R4's diagnosis includes but are not limited to Major depressive disorder, Chronic respiratory failure, Chronic obstructive pulmonary disease, Morbid obesity, Venous insufficiency, Sleep Apnea.

R4's Minimum Data Set (MDS) dated 06/13/24 has a Brief Interview for Mental Status (BIMS)

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score of 13 which indicates R4's cognition is intact.

R4's nursing progress note dated 07/29/24 documents in part, "V22 Medical Doctor (MD) requests for resident (R4) to be sent out to hospital due to critical BUN (blood urea nitrogen) 150 mg/dL (milligrams per deciliter)."

R4's nursing progress note dated 07/30/24 documents in part, "Staff called the hospital and spoke with the nurse who stated that R4 had been admitted for AKI (acute kidney injury) possible pneumonia."

R4's hospital note dated 07/30/24 documents in part, "R4 noted severe abdominal pain ...R4 also complained of constipation ...daily enemas for constipation."

On 08/12/24 at 11:50am V12 Registered Nurse (RN) stated, "Things that can cause constipation are medications like iron, not drinking enough water or not eating enough vegetables. The purpose of care plans is for improvement. We (staff) have meetings about the progression of the residents. I (V12) check the resident care plan monthly or every two months."

R4's Care plan dated 12/20/21 documents in part, R4 has potential for pain related to decreased mobility, comorbidities, and impaired skin integrity ...monitor/document for side effects of pain medication ...Observe of constipation.

On 08/12/24 at 12:01pm V20 Licensed Practical Nurse (LPN) stated, "The certified nursing assistants (CNA's) supposed to notify us (nursed) when the residents have a bowel movement (BM). Sometimes it (BM) can be missed with a

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resident not having a BM if we (nurses) don't ask about it (BM). He (R4) was incontinent of bowel and bladder. I'm (V20) am the one who sent R4 out on the day R4 went to the emergency room (ER). I (V20) notified the Director of Nursing (DON) and called R4's primary doctor, and I (V20) was told to send R4 out. R4 was a little confused, but R4 was still alert when R4 left the facility. R4 had a urinary tract infection (UTI) before and presented with the same symptoms. R4 didn't really drink water; R4 would drink a lot of diet cola and I (V20) told R4 that he (R4) drinks too much soda.

On 08/13/24 at 12:06pm V2 DON stated, "We (staff) don't do intake and output (I&O) but if the resident is on fluid restriction, then we (staff) remove the water from the bedside. We (staff) check the resident's hydration sometimes through the blood or skin turgor and we (staff) check the tongue for moisture. The CNA does the patient care and is supposed to tell the nurse if a resident did not have a bowel movement. The expectations for following the care plan interventions are that the nurses should follow the care plan 100%.

Record review of R4's progress notes show that R4 has a risk for dehydration care plan with interventions to monitor intake and output. Per V2's statement the care plan should be followed 100%. Per V2's statement, the facility does not do intake and output.

R4's Care plan dated 06/19/24 documents in part, "At possibly risk for dehydration ...R4 will be free of symptoms of dehydration and maintain moist membranes, good skin turgor ...Monitor and document intake and output as per facility policy ...Monitor/document/report PRN (as needed) and

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s/sx (sign or symptoms) of dehydration: decreased or no urine output, concentrated urine, strong odor ...confusion.

On 08/13/24 at 1:35pm V14 Certified Nursing Assistant (CNA) stated, " We (CNA) chart in the computer if the resident has a BM or did not have a BM. If the resident has loose stool, then I (V14) would report it to the nurse. If the nurse asks me (V14) if the resident did not have a BM, then I (V14) would let the nurse know, otherwise the nurse can see my (V14) charting. I V14) pass water as needed when the resident asks for water. I (V14) might refresh the water if it has been siting for a while. R4 liked ice not, water."

On 08/14/24 at 10:55am V2 stated, "If a resident is diagnosed with a UTI the doctor will order antibiotics and then we (staff) encourage fluids for the resident unless the resident is on fluid restriction. We (staff) tell the staff that the resident has a UTI and to encourage the resident to drink more water and make sure that the resident always has a pitcher of water at the bedside. We (staff) only do care plans if the resident is noncompliant or if the resident has a new problem, then we (staff) involve all the disciplines and do a care plan at that time. The facility's expectation is for the staff to keep up with the resident's elimination. The CNA should report to the nurse if the resident did not have urine output or a BM. The expectation of the nurse is to report to the doctor if the resident did not have a BM or no urine output and then follow the order of the doctor."

R4's nursing progress noted dated 06/03/24 documents in part, "Called hospital for the status of resident, resident has been admitted with diagnosis of altered mental status and UTI

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S9999	Continued From page 11 (urinary tract infection)." Facility's Job description titled "Certified Nursing Assistant" dated 03/24/16 documents in part, "Summary: The Certified Nursing Assistant (CNA) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare and safety of all residents ...Essential duties and responsibilities ...Providing fresh water and nourishment between meals ...recording intake and output information." No Violation issued	S9999		