STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 000	Initial Comments	S 000		
	Complaint Investigation 2398417/IL165317			
S9999	Final Observations	S9999		

Statement of Licensure Violations (1 of 2):

300.610a)
300.1210b)
300.1210c)
300.1210d)1)
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 300.1210 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

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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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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 have a comprehensive care plan upon admission that included effective interventions to address history and risk of substance abuse for a

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resident with a history of substance use disorder. This failure applied to one (R3) of four residents reviewed for comprehensive care plans and resulted in R3 having an overdose while in the facility with no related interventions in place; the facility subsequently failed to update R3's plan of care to include interventions for when substance use is suspected or identified upon R3's return to the facility after being hospitalized for overdose.

Findings include:

R3 is a 62-year-old female with history of COPD, substance use disorder, hypertension, failure to thrive, and aphasia. R3 was admitted to the facility on 05/01/23 and discharged to home on 09/11/23.

Prior to being admitted into the facility, R3 was discharged from local hospital, where she was admitted on 4/30/23 for adult failure to thrive, requiring extensive assistance with ADL's (activities of daily living) and rehabilitation to build strength. Hospital reports medical history of cognitive dysfunction, COPD, hypertension, right hemiplegia, and polysubstance abuse, opioid use disorder, depression, and PTSD.

Pre-Admission, hospital orders include Methadone 10mg oral daily and Hydrocodone-Acetaminophen (Norco) one tablet oral every 4 hours as needed. Barriers for discharge include abuse/neglect concerns: possible financial abuse. Assessment and Plan: (include) Polysubstance abuse: follows at Center for Addiction Problems (CAP - address/phone number provided) - remotely was on methadone 80mg QD (daily). Dose was checked during last admit 12/2022 w/CAP (phone number) and currently on 10mg. - continued home methadone

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10mg QD (daily).

Hospital discharge paperwork includes information related to safe opioid use and includes there is a potential for serious increased sedation and life-threatening respiratory depression when taking an opioid pain product at the same time as a benzodiazepine (such as Xanax, Ativan, Klonopin, etc.).

Review of R3's nursing progress notes document the following:
06/13/2023 15:43 Health Status Note
Note Text: At 2:20pm resident came back from ER via ambulance on stretcher assisted by 2 staff. A/Ox3, responsive and verbalized feeling nauseated. Vitals checked B/P113/92, P64, R 18, T97.6F O2 sat 89%-91% RA denies difficulty breathing. At 2:27pm NOD called ER to get discharge report and per operator no nurse available to take the call. At 3:20pm NOD f/up called ER and per nurse (name) resident was given Narcan at 12:50pm d/t Opioid overdose with no discharge instructions. At 3:38 pm NOD notified V23 (Primary Physician) of discharge Dx and made aware that resident current orders for Norco and Methadone and asked for parameter orders for B/P and P and Oxygen at 2-3L per NC PRN for SOB. At 3:30pm (son) made aware that resident returned to facility and notified of current condition.

R3's care plan includes the following:

R3 has been determined by community access assessment to be able to access the community with supervision. Date Initiated: 7/25/23.
Intervention (includes): I am on supervised access to the community.

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R3 is receiving Methadone/Norco for pain. Date Initiated: 5/3/23. Interventions (include): For respiratory depression: Monitor respirator rate, depth and effort after administration of pain medications. Monitor for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress, sedation, urinary retention. Observer for adverse reactions with every interaction with the resident.

Behavioral Symptoms - Narcotic Seeking
R3 has a history of substance abuse and chemical dependency and engages in medication seeking behaviors. R3 demands medications be provided to her outside of physician prescription and prior to the time medications are scheduled to be provided to her and makes demands that personnel assist her with obtaining illegal substances.
R3 and her son demand to be provided high dosages of medication and then claim that she receives too much medication. When blood pressure is low and the physician orders medications held, R3 and her son demanded that methadone/medications be provided to R3 anyway.
R3 is receiving psychological services and participating in substance mitigation programming to address addictions, substance use/abuse, and healthy/productive coping strategies. Date Initiated: 8/2/23. Interventions are included in the plan of care with date initiated 8/8/23.

R3's physician orders upon admission to the facility include Methadone and Norco; both are opioid medications.

Physician Orders include:

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Methadone HCL Oral Tablet 10 MG (Methadone HCL) Give 1 tablet by mouth one time a day for pain - Order Date 05/01/23, Start Date 05/02/23.

Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain - Order Date 05/01/23, Start Date 05/02/23.

It is to be noted that there was no physician order or care plan interventions for R3 related to history or risk substance abuse disorder or opioid reversal medication at the time of admission.

On 01/26/24 at 1:58PM, V7 (RN) confirmed she was the nurse on duty when R3 had the overdose on 6/13/23. Surveyor asked V7 what symptoms R3 was exhibiting when she assessed R3. V7 said R3 was unresponsive, cold, clammy, and sweaty. V7 said (overdose) did not cross her mind because R3 took Methadone regularly and if the resident had a history of opioid overdose, then maybe it would have "clicked" in her mind. V7 added R3's son would visit often and sometimes V7 would hear them argue.

On 01/26/24 at 4PM, V1 (Administrator) stated he believed R3 was a drug addict, and he suspected her son was bringing her drugs. Surveyor asked what made V1 think R3's son was bringing her drugs and V1 responded her behavior would change, like she was "disconnected" when he was here. Surveyor asked what if anything the facility did to act on this "suspicion"? V1 responded nothing was ever confirmed but if it was, it would have been something social work would have been involved with but V1 didn't think anything was ever confirmed.

01/26/24 at 4:12PM, V10 (Social Services

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Director) was asked if she was ever made aware of any concern R3's son was providing R3 with illicit drugs. V10 responded, it was never brought to her attention as a concern. V10 added she was aware R3 had a history of drug use.

01/26/24 at 4:19PM V11 (Social Service Designee) stated she facilitates care between the facility and CAP (methadone clinic) and is responsible for care planning residents for substance abuse and the Methadone use.

It is to be noted there was no physician order or care plan interventions for R3 for any substance abuse disorder or opioid reversal medication at the time of admission.

R3's care plan was updated on 8/2/23 to reflect Behavioral Symptoms - Narcotic Seeking, with Date Initiated: 8/2/23. Interventions are included in the plan of care with date initiated 8/8/23.

On 1/31/24 at 2:03PM, V11 (Social Service Designee) was asked what changed on 8/2/23 when R3 had an addition to the care plan related to narcotic seeking behaviors. V11 responded, "On this particular day I got a report one of the CNA's went to the nurse and told the nurse the resident (R3) asked her for some type of illicit drug. She (R3) had never done this before. This was a really big surprise to me because she (R3) was always very proud of her sobriety. She (R3) said she's been sober for years, ever since she went to rehab. After the overdose in June, I did talk to her (R3) because she didn't feel well and was wondering what happened. We focused on her blood pressure was maybe low". Surveyor asked V11 if she talked to R3 about the overdose after it happened and if she questioned R3 about taking any illicit substances. V11 responded she

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did not. V11 said, "I did not ask her any questions. (i.e... did you take something, etc.). I did not feel comfortable asking her those questions. That's why I had the psychotherapist come with me; because she had a good rapport with her. It didn't cross my mind she n(R3) had possibly taken anything".

1/31/24 at 12:18PM V22 (Regional Director of Clinical Services) was asked why there was no care plan related to R3's substance abuse risk or use of Naloxone per their Naloxone Clinical Guidelines policy. V22 responded the policy was created on June 5th, but it wasn't started until the in-services were done. So, guideline didn't take effect until it was completed - June 23rd. Prior to this we didn't have a policy. V22 then affirmed they accepted a resident (R3) with a history of substance abuse and on Methadone without having a plan in place if R3 was to overdose.

1/31/24 at 1:47PM, V23 (Medical Director) stated, "When this (overdose) happened to her (R3), they (facility) did notify me the patient was sent out. I think no one knew. It looks like someone might have given her something or she took something illicit. I think the nurse thought it was more of a cardiac issue. I have been the medical director there for 25 years and this is the first time something like this happens. The nurses have been there for a long time and can recognize when the patients are inebriated or something. Proactively, I think we will institute in-service for the nurses on recognizing the signs and symptoms of overdose and when to administer the Narcan".

Facility provided documented titled, Naloxone Clinical Guidelines, dated June 5, 2023, which reads:

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I. Purpose:
Upon a physician's medication order per resident or facility standing order, naloxone may be administered by a licensed nurse or authorized staff to resident as indicated for the complete or partial reversal of suspected opioid-induced respiratory depression and/or unresponsiveness and/or possible respiratory/ cardiac arrest.

Naloxone (Narcan®, Evzio) is a prescription medication can block or reverse the effects of an opioid overdose. Prompt and timely Administration of naloxone can save the life of someone overdosing on opioids, including heroine or prescription medicines like OxyContin® or Percocet®.

II. Procedures:
1. Facility will assess a resident on admission who is at risk for opioid abuse or overdose.
o Person with recent inpatient hospitalization for suspected opioid use and overdose o Person with diagnosis of opioid use disorder o Person with history of opioid use or dependence, or diagnosed substance use disorder o Person with current prescribed opioid orders o Person with current prescribed opioid and benzodiazepine orders o Past opioid use and justice involved resident o Current or recent registrant of a methadone maintenance program, or a detox program o Visitor: Friends and family members of the above who may visit the resident and provide illicit or prescription opioids o Resident who frequently attempts to elope or leave the facility premises with current prescribed opioid or history of opioid dependence

2. Obtain Standing Order for Naloxone Use and Indication for at risk resident.
Standing Order for Use of Naloxone for Resident

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o Indication: Unresponsiveness and/or difficulty breathing due to suspected opioid-induced respiratory depression.

o Exclusions, if known: Comfort care plan, hospice, or end-of-life care; known allergy to naloxone.
o Order: Naloxone nasal spray (4mg) or available supply and dosage form, repeat dose in 2 to 3 minutes for unresponsiveness or difficulty breathing (e.g., RR < 8 cycles/min), until individual is breathing (respiratory rate greater than 10). Initiate emergency medical response protocol (call 911) and transfer the individual to the hospital emergency department. Notify the attending physician and/ or appropriate medical practitioner.

3. Signs of Symptoms of Opioid Overdose
o Slowed/ dyspnea (RR < 8cycles/min); irregular, or no breathing o Skin, nails turn blue o Extreme sleepiness o Unresponsive to sternal rub or when shaken o Pinpoint pupils o Low 02 Saturation (e.g., <85%)

4. Standardized Procedure for Naloxone Administration
1. Confirm signs and symptoms of potential opioid overdose (see item #3)
2. Call 9-1-1 and administer naloxone as follows (select dispensed dosage form). Start CPR as indicated.

A. Single-Step Intranasal Naloxone: (2mg/0.1ml or 4mg/0.1 ml) o Peel back the package to remove the device o Hold the device with your thumb on the bottom of the plunger and 2 fingers on the nozzle o Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose o Press the plunger

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firmly to release the dose into the patient's nose o Repeat if there is no response after 2-3 minutes

B. Auto-Injector Naloxone: (0.4mg/0.4ml) or Pull auto-injector from outer case and pull off red safety guard o Place the black end of the auto-injector against the outer thigh, through clothing if needed, press firmly and hold in place for 5 seconds
Repeat if there is no response after 2-3 minutes.

C. Naloxone HCl injection vial 0.4mg/ml (requires a syringe for administration)
Naloxone Hydrochloride Injection 0.4 mg/ml 11.
o Inspect the solution for injection for any particulate matter or discoloration before use.
o Remove cap from vial and clean with alcohol swab. Remove cap from needle of syringe.
o Withdraw 1mL (0.4mg) from vial.
o A deep intramuscular administration may be used and injected into a large muscle such as the thigh or deltoid muscle or if the subcutaneous route is selected, inject beneath the skin or an initial dose of 0.4 mg (1ml) of Naloxone hydrochloride may be administered intravenously as a push injection.
o Response to naloxone may be slower with an intramuscular or subcutaneous injection.
o Do not leave the resident and continue to monitor response to the medication.
o Start supportive or resuscitative measures until emergency medical assistance arrives.
o If the desired degree of counteraction and improvement in respiratory functions are not obtained, repeat the injection at two-to-three-minute intervals.
o If no response is observed after a total of 10 mg of Naloxone hydrochloride has been administered, the diagnosis of opioid-induced or partial opioid-induced toxicity should be

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questioned

References: National Library of Medicine 2013; Lippincott Manual in Nursing 2015; IDPH.illinois.gov.opioids 2010; IPRO QIN-QIO Resource Library 2021/2023.

CMS State Operations Manual requires the following for skilled nursing facilities:
"According to the Substance Abuse and Mental Health Administration (SAMHSA), opioid overdose deaths can be prevented by administering naloxone, a medication approved by the Food and Drug Administration to reverse the effects of opioids. The United States Surgeon General has recommended naloxone be kept on hand where there is a risk for an opioid overdose. Facilities should have a written policy to address opioid overdoses.
The SAMHSA website houses a number of resources related to opioid management including this document intended for prescribers which addresses appropriate prescribing, monitoring for adverse effects, and treating overdoses: SAMHSA Opioid Overdose Prevention Toolkit: Information for Prescribers, https://www.samhsa.gov/resource/ebp/opioid-overdose-prevention-toolkit."

(A)

Statement of Licensure Findings (2 of 2):

300.690a)
300.690b)
300.690c)

Section 300.690 Incidents and Accidents

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a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This regulation was NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to report two serious incidents within 24 hours of occurring to the State

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
	IL6008916	A. BUILDING: ________ B. WING ________	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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 13	S9999		

Agency Regional Office by not reporting a fall that resulted in a fracture for one resident (R5) and by not investigating or reporting a resident opioid overdose while in the facility (R3). These failures applied to two (R3, R5) of four residents reviewed for accidents and investigations.

Findings include:

1. R5 is a 77-year-old female, originally admitted to the facility on 05/27/2008 with diagnoses that included fracture of rt tibia and rt fibula, UTI, COVID-19, history of falling, anxiety, osteoporosis, osteoarthritis, depression, and schizoaffective disorder.

Review of medical record documents that R5 experienced two falls while in the facility on 10/22/23. Initial post fall investigation documents a fall on 10/22/23 (time of incident) 7:18AM. Second fall on 10/22/23, time of incident is documented as 3PM. After both falls, R5 was transferred to local hospital for evaluation.

Hospital record documents R5 fell twice and was brought to the ER twice from the facility on the same day (10/22/23). After first fall, all x-rays were negative for fractures. After the second fall, R5 was found to have a right ankle fracture, which required a closed reduction (bone re-alignment without surgery) and cast application.

Facility staff were asked multiple times throughout the course of this survey for documentation that this injury for R5 was reported to the State Agency and it was not provided during the course of the survey.

2. R3 is a 62-year-old female with history of

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COPD, substance use disorder, hypertension, failure to thrive, and aphasia. R3 was admitted to the facility on 05/01/23 and discharged to home on 09/11/23.

Review of R3's nursing progress notes document the following:
06/13/2023 15:43 Health Status Note
Note Text: At 2:20pm resident came back from ER via ambulance on stretcher assisted by 2 staff. A/Ox3, responsive and verbalized feeling nauseated. Vitals checked B/P113/92, P64, R 18, T97.6F O2 sat 89%-91% RA denies difficulty breathing. At 2:27pm NOD called ER to get discharge report and per operator no nurse available to take the call. At 3:20pm NOD f/up called ER and per nurse (name) resident was given Narcan at 12:50pm d/t Opioid overdose with no discharge instructions. At 3:38 pm NOD notified V23 (Primary Physician) of discharge Dx and made aware that resident current orders for Norco and Methadone and asked for parameter orders for B/P and P and Oxygen at 2-3L per NC PRN for SOB. At 3:30pm (son) made aware that resident returned to facility and notified of current condition.

On 1/31/24 at 11:47AM, V2 (Director of Nursing) said, "We did not do an investigation to try to determine the cause of the overdose". V22 (Regional Director of Clinical Services) added, "It seemed like her meds, so we don't know how it happened. Social Services did a room search and didn't find anything. I don't believe the son visited that day and he had visited I think, two days prior. The nurse didn't think of anything related to opioid overdose because she was looking at her medical issues. The nurse thought it was something cardiac related". Surveyor asked how facility could determine if R3 had used illicit drugs

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versus nurse error without an investigation or review of Controlled Substance logs (Narcotic Count sheet) for R3. V2 did not respond.

During this investigation, facility failed to provide documentation that a complete and thorough investigation related to overdose for R3 was conducted. Facility was also asked to provide documentation of controlled substance count sheet for R3 during her stay at the facility and that was not provided. There was no documentation of room search in R3's medical record or per interviews with social service staff.

Facility was also asked for but did not provide documentation that this overdose incident for R3 was reported to the State agency within 24 hours of occurring.

01/27/24 at 1:50pm V19 (Medical Records) said the narcotic reconciliation forms were being looked for because forms for the entire 3rd floor were missing, and they might be in storage out of the building.

Surveyor reviewed State Agency incident reports and did not find any indication that these reports for R5 or for R3 were submitted.

(C)