STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6019723	A. BUILDING: _____ B. WING _____	04/05/2018

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S 000	Initial Comments Annual Certification and Licensure Survey Complaint Investigations #100934/IL1891571 - no findings #100882/IL1891519 - no findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 300.3240a) 1of 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.
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:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

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S9999	Continued From page 2 These requiremetns were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their physician prescribed care plan and failed to implement pressure sore interventions to prevent the development of a facility-acquired pressure sore for one resident (R76) of four residents reviewed for pressure sores in a sample of 24. This failure caused R76 to develop an avoidable pressure sore to the sacrum. Findings include: R76 Face sheet dated 4/4/18 shows R76 with diagnoses listed in part with cellulitis, cerebral infarction, hemiplegia following unspecified cerebrovascular disease affecting right dominant side, aphasia, cerebral infarction, and type 2 Diabetes Mellitus. On 4/3/18 at 10:38am, R76 was observed asleep in bed on her back and the head of the bed up at a 30 degree angle. R76 was atop an air mattress with a pump attached to the footboard with the pump showing it was on static mode and not on alternating pressure to off-load pressure and was set at 280 lbs pressure. At 10:49 am, V10 (Wound care director) and V11 (Wound Care Nurse) prepared R76 for her daily wound care dressing changes. V11 with gloved hands removed a comforter and blanket off of R76 who was wearing a hospital gown and diaper underneath her gown. V11 lifted up R76's gown and started removing the diaper and turned R76 to her left side and showed an old dressing applied to her sacral area. The wound dressing	S9999		

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S9999	Continued From page 3	S9999		

was heavily stained with a brown color and had a noticeable fecal odor. V11 stated, "They must have just changed her." V10 and V11 proceeded to change her soiled wound dressings after applying the prescribed ointment onto the wound and replacing it with a clean dressing. V10 then asked V11 to turn R76 to the other side in order to remove the layers of sheets that were observed under R76 which included several sheets, an incontinence pad, and a fitted sheet. After the procedure, V10 was asked who made the bed for R76, V10 stated, "The CNA's make the beds but they shouldn't be using fitted sheets for those mattresses, is that why you're asking."

On 4/3/18 at 12:56 PM, R76 was again observed laying on her back with her head raised at 30 degrees and in the same position. The mattress pump was again set at 280 lbs (facility records show R76 to be at 156 lbs)
04/04/18 1:50 AM R76 was asleep lying on her back with the air mattress set on 150 lbs. and with the static light turned on showing no alternating pressure to off-load pressure was occurring.

On 4/4/18 at 3:00 am R76 was observed in the same position with no one turning and repositioning R76. At 3:50 am R76 was observed in the same position on her back. V13 (CNA) was asked what his duties were during the night, V13 stated "I'm supposed to turn and reposition only the ones with wounds."

Asked which ones on his side of the floor he turned and repositioned V13 could not answer which residents he was to turn and reposition.

Asked if he was the only one to work his side of the floor, V13 stated, "There's three of us (CNA's)

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S9999	Continued From page 4	S9999		

we all have our own sections."

Direct observations of R76's room do not show V13 or any other staff going into R76's room from 1:50am -3:50 am to turn and reposition R76 who remained asleep on her back.

MDS (Minimum Data Set) dated 2/7/18 section G functional status shows bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) at extensive assistance and two-person physical assistance.

This same MDS section M for skin conditions shows: Is resident at risk for developing pressure ulcers? Answer: Yes. Current number of unhealed pressure ulcers at each stage; all answered as "zero" for none showing that R76 had no pressure ulcers upon admission/entry or reentry.

MDS CAA (Care Area Assessment) completed by V10 (wound care nurse) dated 2/7/18 states "No" for existing pressure ulcer showing R76 did not have any pressure ulcers at the time of this assessment. V10 writes on the same form, "Resident is high risk for pressure sore."

R76's care plan dated 2/27/18 states, "Resident has pressure ulcer on sacrum unstageable, resident has history of denuded sacrum, she is totally dependent for bed mobility, history of abdominal cellulitis, incontinent of bowel and bladder. Has diagnosis of CVA; Goals: skin will remain intact through staff intervention by next review date; Interventions: turning and repositioning at frequent intervals as tolerated, low air loss mattress, assess skin condition weekly/document any skin integrity impairment,

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S9999	Continued From page 5 monitor sacrum wound for significant changes and intact dressing every shift." Facility form titled, Weekly Pressure Ulcer Report (dated 3/26/18), shows (R76) with facility-acquired unstageable pressure sore to sacrum and an unknown date as to when the wound was first identified. Measurements shown for the sacrum wound measures 2.8 centimeters (length) X 1.8 centimeters (width) X "unknown" depth. This same form asks "Is resident seeing wound specialist with the answered "No." 4/4/18 at 11:00 pm with V1 (Administrator) states, "We've in-serviced the staff about the air mattresses. I know what you mean about the over padding but it's a habit that's hard to break. We've in-serviced before but it looks like we need to do more." 4/4/18 interview with V14 (Wound Doctor) at 12:45 pm states, "I've just started seeing (R76) and I'm normally brought for debridement (surgical removal of dead tissue) of a wound if the family approves and from my recollection we are treating her with Santyl ointment to the wound. I do expect as I do with all my patients that the facility follow their wound protocols for off- loading (relieve pressure) of the wound which includes turning and repositioning and should be placed on a group II- type bed (alternating air mattress). In order to facilitate wound healing, as you may already know, the area of the wound should have some cooling effect and the mattress will do this if there isn't an overabundance of padding or sheets as this defeats the whole cooling process that I just explained. This has been a challenge in most facilities that I'm in and they (the facility) should all know this yet it's still a challenge for them to keep staff from overly	S9999		

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S9999	Continued From page 6 padding these types of residents." Policy and procedure titled, Pressure Ulcer/Wound Management (dated 10/04) states: "Policy: to promote healing of pressure ulcers, facility will use standardized protocols or follow physician's specific orders for wound care. Treatment objectives to promote optimal wound healing are: Relieve pressure, clean the wound bed of necrotic tissue (if present), protect healthy tissue, evaluate/correct nutritional deficiencies, treat consistently with appropriate products. (B) (2 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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.	S9999		

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S9999	Continued From page 7 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 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	S9999		

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S9999	Continued From page 8	S9999		

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 evidencded by:

Based on observation, interview and record review, the facility failed to ensure that a resident received hospice orders that specifically addressed pain management and symptom control for anxiety and shortness of breath which affected one resident (R164) of six residents reviewed for hospice in a sample of 24. This deficient practice caused R164 to experience pain over a two day time frame, anxiousness and shortness of breath.

Findings include:

R164 was admitted to the facility on 3/31/18.

R164's hospital records dated 3/28/18 document no significant past medical history except for a significant episode of pain in her back for one week. R164 was admitted to the hospital after a fall and lower extremity weakness. In the emergency room, R164 was found to have cord compression and lower extremity paralysis. A computerized tomography (CT) scan of the chest and abdomen revealed: Lesion centered in left T3 (thoracic level 3) with a posterior element extending to the spinal canal resulting in severe canal stenosis with a right renal mass measuring 6.2 centimeters. CT of the thorax revealed: A

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S9999	Continued From page 9	S9999		

large destructive paraspinal mass involving T2 (thoracic level 2), T3 and T4 (thoracic level 4) with encroachment of left spinal canal T2-T3. IMPRESSION: 1) Acute cord compression 2) Paraspinal mass 3) Right renal mass likely renal cell carcinoma 4) Status post fall 5) Lower extremity paralysis.
Per the hospital physician progress note dated 3/28/18, it is documented, in part: PLAN: Likely patient is not a candidate for aggressive treatment, likely she can be pain-free, likely to meet the hospice eventually.
R164's hospital records dated 3/28/18 document that her pain medication regimen included: Morphine 1 mg (milligram)/0.5 ml (milliliters) IVP (intravenous push) every two hours as needed, Acetaminophen 650 mg oral every six hours as needed, Tramadol 50 mg oral every eight hours as needed and dexamethasone 4 mg oral every six hours.

R164's Medication Administration Record from the hospital indicates that she received the following pain medications while in the hospital over a 3 days period: Dexamethasone as scheduled every six hours, Morphine 1 mg/0.5 ml IVP and Tramadol 50 mg orally.

R164 signed a consent for hospice on 3/31/18. R164 was assessed and admitted to Hospice by V27 (Hospice Nurse) on 3/31/18 prior to transferring to the nursing home facility. V27 documented, in part, in R164's Clinical Notes, "Patient ....made it very clear she wants no aggressive measures and prefers comfort care." V27 continues to document, "Patient has had increasing pain to bilateral shoulders since 3/28 but rarely complains-states pain remains 3 to 5/10 despite Tramadol given regularly. Patient will need increasing pain management and perhaps

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S9999	Continued From page 10	S9999		

adjunct medications to control spinal metastasis pain like steroids." V27 did not obtain transfer orders for R164 or orders for pain management despite the documentation of constant pain. V27 documented, "Admission RN (Registered Nurse) can call (physician) for assist in reconciling meds at the facility. Profiled patient with (pharmacy) but did not order or call (primary physician) since facility and admission RN will need to anyway."

Upon admission to the facility on 3/31/18, R164 was seen by V21 (Hospice Nurse). On 4/5/18 at 9:10am, V21 indicated that she saw R164 on 3/31/18. V21 indicated that R164 was in pain, short of breath and moderately anxious when she assessed her. V21 stated, "I did not order oxygen or Ativan because the resident refused. Goal of Hospice is aggressive symptom management." V21 indicated that R164 complained that Tramadol did not help her pain. So despite R164 indicating that Tramadol did not help her pain, V21 indicated that Tylenol was ordered for the pain. V21 stated, "Another nurse was coming on 4/1. We address symptoms as they come up." R164's assessment on 3/31/18 is documented as V21 described it in R164's Hospice Clinical Notes.

On 4/1/18, V22 (Hospice Nurse) visited R164. V22 documented, "(R164) complained of pain in neck and shoulders with no relief from Tylenol." V22 documents that she lets the facility nurse know about R164's pain and to administer Tylenol. V22 documents, "No other medication at this time to give patient. Team to follow up this week."

On 4/5/18 at 9:32am, V22 stated, "I saw (R164) at 6:30pm. Patient complained of pain in shoulders and neck. She said Tramadol and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6019723	A. BUILDING: _____ B. WING _____	04/05/2018

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ROSEWOOD CARE CENTER NORTHBROOK	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

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S9999	Continued From page 11	S9999		

Tylenol did not work. I told her the case manager would get the pain medication as soon as possible." V22 indicated that she was surprised that no pain medications were ordered by admission nurse. V22 stated, "She should've had stronger pain medications on board. I was to follow up to the admission and make sure that resident had medications ordered. I sent out an e-mail to the (Hospice) manager to find something for pain control. If I was more proactive then she wouldn't have had to wait until 3:30pm on 4/2/18 to get stronger pain medication. Hospice goal is to provide end of life care and provide comfort care." On 4/1/18, no pain medications, anxiety medications or oxygen was ordered for R164.

On 4/2/18 at 10:47am, this State surveyor found R164 in bed, highly anxious and in pain. R164 indicated that she let the nurses know about the pain. At 11:05am, R164 indicated that she was short of breath, very nervous and in pain in the back. R164 stated, "I was getting Morphine in the hospital but here I only get Tylenol. And it's not helping. I've been in pain for two days."

On 4/2/18 at 1:55pm, V26 (Family Member) came to the nurses station and requested anxiety medication for R164. At 2:04pm, V20 (Physician Assistant) was asking V19 (RN-Registered Nurse) why there were no orders for pain, anxiety and oxygen in R174's chart. V20 stated, "Hospice should have ordered a comfort kit for her. Call them as soon as possible." On 4/2/18 at 2:07pm, V19 phoned Hospice to see when R164's Case Manager was going to arrive at the facility.

R164's Tramadol 50 mg pain medication, oxygen 2 liters per nasal cannula and Ativan 0.5 mg for anxiety were not ordered until 4/2/18 at 2:30pm.

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S9999	Continued From page 12 All orders were initiated immediately. On 4/4/18 at 2:40pm, V19 stated, "Hospice expectation is that pain is controlled. When Hospice admits someone, they should already order strong pain medication. When I came on Monday there was a note that (Hospice) was aware that patient needed stronger pain medication." R164's Hospice Clinical Notes indicate that the facility called hospice on 4/1/18 at 7:42pm for medications. V19 stated, "I called hospice on Monday before 8:00am to let them know that (R164) needed pain medication." V19 indicated that on 4/2/18, R164 became short of breath and anxious so V20 was notified. On 4/4/18 at 3:40pm, V20 indicated that when she saw R164 on 4/2/18 she had to order oxygen, Ativan and Tramadol. V20 stated, "She should not have been in that condition. She was admitted on Saturday and I was seeing her Monday afternoon. There was no comfort kit or any pain medications or antianxiety medications ordered." V20 indicated that the Hospice physician should have given all the orders. V20 indicated that if the orders were in place then R164's condition on 4/2/18 could have been prevented or controlled. According to R164's physician order sheet, Dilaudid 1 milligram by mouth every two hours as needed (for pain) was not ordered until 4/2/18 at 3:30pm. Ativan-increase frequency to 0.5 mg orally every two hours as needed was also ordered. On 4/3/18, Dilaudid was changed from as needed to scheduled doses every six hours and Ativan was changed from as needed to every six hours scheduled doses as well.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6019723	A. BUILDING: _____ B. WING _____	04/05/2018

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(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 On 4/5/18 at 10:20am, V24 (Vice President of Operations for Hospice) stated, "After review of the case, this is not the protocol that we follow. Goal is to coordinate with acute care hospital but also with facility, family and care provider. Expect to provide coordination so no delay in care. We take response for pain to goals of care to formulate a care plan. Upon review, I found a few gaps in providing patient comfort. We have to anticipate needs. We have identified pain as an active problem that hospice residents have. We need to anticipate problems. The nurse should have made her visit to (R164) first thing on Monday. Again, our care pathway or clinical program was not followed." R164's Care Plan that was formulated by the Hospice agency documents: Pain/Physical Comfort, altered. Goals: Verbalizes pain control and/or appears comfortable without signs or symptoms of pain. Optimal pain control with appropriate medications. Interventions: Assess and monitor level of comfort including location, intensity and character of pain. Instruct in pain medication, administration, actions, side effects. Respiratory Status, altered. Goals: Optimal respiratory comfort. Patient and Family Goals: Goal #1-Comfort care with hospice. Interventions: Manage signs and symptoms and improve Quality of Life. An undated facility policy titled, Hospice Care, documents: PHILOSOPHY OF HOSPICE CARE: Hospice is not a place but a concept of care designed to provide comfort and support to residents who have a limited life expectancy (usually 6 months or less). The goal of Hospice care is to improve the quality of the resident's life by offering comfort, pain control, and dignity rather than a curative treatment. Hospice care	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6019723	A. BUILDING: _____ B. WING _____	04/05/2018

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S9999	Continued From page 14 addresses all symptoms of the resident's disease with a special emphasis on controlling pain. (B)	S9999		