STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ IL6000236 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE OAK LAWN, IL 60453 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Complaint: 2293600/IL146692 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300,1010h) 300.1210b) 300.1210c)2)3) 300.1220b)2) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies The facility shall notify the resident's physician of any accident, injury, or significant Attachment A change in a resident's condition that threatens the Statement of Licensure Violations health, safety or welfare of a resident, including.

Ilinois Department of Public Health

Illinois Department of Public Health

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6000236 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE **OAK LAWN, IL 60453** (X4)ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 Continued From page 1 S9999 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 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. Restorative measures shall include, at a minimum, the following procedures: Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. All treatments and procedures shall be administered as ordered by the physician. 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.

Section 300.1220 Supervision of Nursing

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ IL6000236 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE OAK LAWN, IL 60453 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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) These Regulations were not met as evidenced by: Based on interviews and record reviews this facility failed to consistently and accurately assess, monitor, and implement interventions such as: adequate weight monitoring, cardiology

Illinois Department of Public Health

Illinois D	epartment of Public	Health	23	14	FORM	APPROVED	
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S9999	Continued From page 3		S9999				
	symptoms of congeresident reviewed for nursing assessment This failure resulted medications to treatesting to monitor the having significant was significant.	I in in R1 not receiving t CHF or having laboratory ne disease progression, and eight gain unmonitored. On d a cardiac arrest at this					
	Findings include:						
	stated that V6 was a condition since it was outside appointment order a BNP (B-type monitor a person's list any change in a redema (swelling) or determine if the resistance to notify him comedical condition, who trecall if R1 was to treat CHF, such a Coverting Enzyme) (Angiotensin Receptions)	tor Blockers).			P4		
	of nursing) stated the aides) will obtain results in the resider V2 stated that the dimonitoring if there a On 6/14/22 at 12:15 stated that the nurse	am, V2 DON (interim director at the CNAs (certified nurse sident weights and document nt's electronic medical record. etitian is responsible for re any weight discrepancies. pm, V8 (social services) is responsible for scheduling pointments for residents. V8					

PRINTED: 08/17/2022 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000236 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE OAK LAWN, IL 60453 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 stated that the nurse documents in the resident's electronic medical record name of physician being seen, date, time, transportation arrangements. Review of R1's medical record notes R1 with diagnoses including: ventricular tachycardia. covid-19, generalized muscle weakness, history of falling, heart attack, recurrent syncope and collapse, coronary artery disease, heart failure. atrial fibrillation, AICD (automatic implantable cardioverter defibrillator) pacemaker, chronic total occlusion of coronary artery, and high blood pressure. Review of R1's POS (physician order sheet). dated 2/4/22, notes an order to have R1's AICD checked. There is no documentation found noting R1 had an appointment to have AICD checked during R1's stay at this facility to ensure it was functioning appropriately. Review of R1's POS (physician order sheet). dated 3/9/22, notes R1's first appointment to be seen by V13 (cardiologist) was scheduled for June 2022. V13 managed R1's cardiac care while in hospital 3/25/21-4/12/21. V13 (cardiologist) was unavailable for interview during this survey. Review of R1's cardiac care plan related to CHF. initiated 4/23/21, notes to obtain weights as

Illinois Department of Public Health

needed, report significant changes.

Review of R1's weight documentation notes: On 4/4/22, R1's weight was 159.2 pounds -- 1.6 pound increase in one month; 8% increase in 3

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED IL6000236 B. WING 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE OAK LAWN, IL 60453 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 months; 13.6% increase 6 months. On 3/11/22, R1's weight was 157.6 pounds --6.9% increase in one month; 9.89% increase in 3 months. On 2/4/22, R1's weight was 147.4 pounds -- 5 pound increase in one month. On 1/3/22, R1's weight was 142.4 pounds. On 12/6/21, R1's weight was 142 pounds. On 11/2/21, R1's weight was 142.8 pounds. On 10/6/21, R1's weight was 140.1 pounds. There is no documentation found in R1's medical record noting R1's physician was notified of significant weight changes. There is also no documentation noting R1 was re-weighed to verify the accuracy of the results obtained. Review of R1's medical record, dated 4/8/22. notes an order for a diuretic 40mg by mouth twice a day x 7 days, comprehensive metabolic panel in one week, and compression stockings as directed. Review of R1's MAR (medication administration record), dated April 2022, does not note R1 received the diuretic medication on 4/13/22 at 8:00am. There is also no documentation noting staff were applying compression stockings to R1's lower extremities as prescribed. On 3/29/22, the nurse practitioner noted R1 with chronic bilateral lower extremity edema. There is no documentation noting R1's chronic bilateral lower extremity edema was addressed and interventions implemented prior to 4/8/22. Review of R1's medical record does not note R1 had BNP level checked during R1's entire stay at this facility. R1's BNP result was 3,022 (normal

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Illinois Department of Public Health

unresponsive. A code blue was called, 911 called.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6000236 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE PROMEDICA SKILLED NURSING OLE OAK LAWN, IL 60453 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 7 S9999 CPR continued. R1 ws transferred to a stretcher and sent out to hospital. Review of R1's death certificate, dated 4/26/2022, notes cause of R1's death: congestive heart failure. Review of this facility's weight management guidelines, revised 01/2022, notes when accurately measured, weight is a primary screening and monitoring indicator. The degree of weight change has direct correlations with impact on health status. Review of this facility's weight measurement policy, dated 03/2018, notes to compare weight to previous weight. If there is a discrepancy, weigh the resident again. Discrepancies are considered to be 5 pounds if resident is over 100 pounds. Validation of weights should be done as soon as discrepancy is noted or by end of shift. Validated weights are entered into the electronic health record by the end of shift. Significant weight change is defined as 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. Notify the physician and responsible party. Per the American Heart Association guidelines 2022, a weakened or stiffened heart muscle pumps less blood to the body with each beat. As a result, fluid backs up into the lungs and throughout the body. Heart failure most often causes swelling (edema) indicating the body is retaining extra fluid. Swelling can be in the hands, abdomen, ankles, legs, and feet. Fatigue occurs when the body doesn't get enough oxygen-rich blood. People may feel more tired or have less energy than usual, even at rest. BNP level greater than 900 could mean one's heart

Illinois Department of Public Health

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