

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014906	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/20/2023	
NAME OF PROVIDER OR SUPPLIER PEARL OF HILLSIDE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162		
(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
S 000	Initial Comments Complaint Investigations: 2393107/IL158714 2392587/IL158090 2393984/IL159808 2393718/IL159488	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610 a) 300.1210 b) 300.1210 c) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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. The plan shall be reviewed at least every three months.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>order related to continuous oxygen treatment for one (R2) of three residents reviewed for quality of care. This failure resulted in R2 becoming hypoxic, with respiration rate of 30 breaths per minute, and oxygen concentration at 82% on room air.</p> <p>Findings include:</p> <p>R2 is a 55 year old, female, admitted in the facility on 02/25/2022, with diagnoses of Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-dominant Side; Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing (4/14/23); Acute and Chronic Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia; Chronic Obstructive Pulmonary Disease (COPD), Unspecified; Morbid (Severe) Obesity Due to Excess Calories, and Dependence on Supplemental Oxygen.</p> <p>POS (Physician Order Sheet) documented the following: 02/25/22 - O2 (oxygen) at 2 liters per nasal cannula - keep O2 sat greater 92% every shift 04/17/23 - O2 at 2 lpm (liters per minute), maintain O2 saturation at 92% or greater every shift.</p> <p>Care plan on Congestive Heart Failure, dated 06/17/22, documented: "Intervention - Oxygen settings: O2 via nasal at 2 liters continuously. Humidified."</p> <p>There was no care plan formulated regarding R2's behavior of taking off oxygen.</p> <p>On 07/17/23 at 2:00 PM, R2 was observed lying</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>in bed, with ongoing oxygen treatment at 2 lpm (liters per minute) via nasal cannula. R2 stated she always has her oxygen on, and does not take it off.</p> <p>Progress notes, dated 04/12/23, documents R2 was found to have a fracture of the right femur and was ordered to be send out to the emergency room. Paramedics were called and came to facility at 6:42 PM, per ambulance report dated 04/12/23. Ambulance report also stated, in part, but not limited to: the following: Narrative: "Oxygen tank is running next to patient (R2). No oxygen is attached to patient. RN (Registered Nurse) states, 'Patient likes to take nasal cannula off.' Crew attaches patient's nasal cannula to patient; oxygen set to 4 lpm. Vitals assessed. Patient is hypoxic." Vital signs recorded as follows: 6:50 PM - Pulse 104; Respiratory was 30, rapid regular; SPO2 at 82% room air; 6:56 PM - SPO2 at 88%.</p> <p>On 07/17/23 at 3:03 PM, V25 (Hospital Staff) stated, "Her (R2) oxygen saturation was low when we received her in the hospital. She could have died with the low O2 saturation level."</p> <p>On 07/18/23 at 2:11 PM, V15 (Registered Nurse, RN) was asked regarding R2's oxygen treatment. V15 replied, "On 04/12/23, I was the nurse who received an order for her to be sent out. She is on oxygen, but she normally takes it off. Normally when we do rounds, we have to make sure she has it on. That time, I was sure that she had the cannula on. When I came at the beginning of the shift, she was not on it, but I put it back on."</p> <p>On 07/18/23 at 3:46 PM, V2, Director of Nursing, stated, "She is on a continuous oxygen treatment. I am not aware of any concern that she has a</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>behavior of taking off her oxygen. Physician orders need to be followed at all times."</p> <p>V19, Licensed Practical Nurse, stated, "She is on a continuous oxygen treatment at 2 lpm via nasal cannula. She has COPD (Chronic Obstructive Pulmonary Disease). She does not have any behavior of removing her cannula. I worked with her a few times, and she just laid there. She needs to maintain oxygen saturation at 92% or more."</p> <p>On 07/19/23 at 3:02 PM, V24, Physician stated, "Physician orders should be followed."</p> <p>Facility's policy titled "Medication and Treatment Orders" reviewed date 07/20/22 documented in part but not limited to the following: Policy Statement: Facility will ensure that orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>(B)</p> <p>2 of 3</p> <p>300.610 a) 300.1210 b) 300.1210 d)6)</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure that two person assist was provided per care assessment for one (R2) of three residents reviewed for falls and injuries. This failure resulted in R2 sliding off the bed during incontinence care and landing on the floor; R2 subsequently complained of pain on the right knee and was diagnosed with a right distal femur fracture.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>Findings include:</p> <p>R2 is a 55 year old, female, admitted in the facility on 02/25/2022, with diagnoses of Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-dominant Side; Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing (4/14/23), and Morbid (Severe) Obesity Due to Excess Calories.</p> <p>R2's MDS (Minimum Data Set), dated 04/01/23, documented: Section C - BIMS (Brief Interview for Mental Status) score of 8, which means moderate impairment in cognition. Section G - bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture): needs extensive assistance from two persons' physical assist.</p> <p>Incident report, dated 04/11/23, recorded on 04/07/23, R2 was receiving ADL (activities of daily living) care. She was repositioned to right side and slid from the air loss mattress towards the wall. Nurse on duty heard R2 yell out and came into the room. R2 was noted on the floor. R2 was assessed, with no complaint of pain. On 04/11/23, R2 reported she was having right knee pain. An X-ray was done, but result was inconclusive. A repeat X-ray was performed. On 04/12/23, X-ray report showed right femur fracture. R2 was sent to the hospital for further evaluation and treatment.</p> <p>Hospital Records, dated 04/12/23, documented the following: "Chief Complaint: Patient presents with fracture;</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>leg pain HPI (History of Present Illness): presented to ER (emergency room) for evaluation of right distal femur fracture following fall from bed at nursing home. X-ray shows acute mildly displaced distal femoral fracture. X-ray right knee (04/13/23): Acute mildly displaced obliquely oriented fracture of the distal right femoral diaphysis demonstrating intra-articular extension and associated lipohearthrosis. X-ray right Femur (04/13/23): Mildly displaced acute obliquely oriented fracture of the distal right femoral diaphysis with intra-articular extension."</p> <p>Progress notes, dated 04/15/23, documented R2 came back in the facility with right long leg splint.</p> <p>On 07/17/23 at 2:00 PM, R2 was observed in bed, alert, verbal, on low air loss mattress, and had an ongoing oxygen treatment via nasal cannula at 2 liters per minute. R2 was asked regarding falls. R2 replied, "I had a fractured hip. I fell on the floor. Supposedly two CNAs (Certified Nurse Assistant, CNA) should be changing me, but there was only one CNA at that time. When the CNA turned me, I slid off the bed and fell to the floor."</p> <p>On 07/18/23 at 1:13 PM, V11 (Licensed Practical Nurse, LPN) was asked regarding R2's fall incident. V11 stated, "That time of incident on 04/07/23, the agency CNA was in her room, changing her and she said, 'Come, come, she (R2) is going to the floor.' I heard the CNA. I went to the room, and I saw (R2) sliding out of bed. We assisted her (R2) to the floor. She was between the bed and the wall, sliding out. The CNA was the only one changing her at the time. We got the lift and put her back to bed. All I know was the</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>CNA was trying to change her, and the bed slipped on her. The CNA was supposed to call somebody before she changed (R2). I tried to tell her at the beginning of the shift she is a two person assist; she is a big lady."</p> <p>On 07/18/23 at 3:46 PM, V2, Director of Nursing, stated, "On 04/07/23, Agency CNA, (V18), turned her (R2) to her left side; she was using a low air loss mattress and she rolled onto the floor. It happened when she (V18) was changing her. She was the only one at the time, changing her (R2), supposedly two CNAs. When we questioned her (V18), she said she was waiting for the nurse, but she couldn't wait any longer, so she just went on and cleaned her and she rolled over. She fell to the floor. Her bed was by the wall, and she slid out of bed and landed on the floor. She (V18) was not able to catch her. She (V18) called for the nurse, (V11), and she (V11) assessed her (R2). There was no complaint of pain at the time. On 04/10/23, she (R2) complained of pain on the right lower leg. X-ray was ordered and resulted to fracture."</p> <p>On 07/18/23 at 3:38 PM, V17 (Fall Coordinator) stated, "If it's a two person assist, two persons need to be providing the care or incontinence care. If it's in the care assessment that it should be two person assist, then two staff is needed during provision of care."</p> <p>On 07/19/23 at 10:18 AM, V19 (Licensed Practical Nurse, LPN) stated, "When doing ADL care, she is a two person assist. She is a big lady and needs two staff assistance."</p> <p>On 07/19/23 at 3:02 PM, V24, Physician, stated, "I remember she rolled out of bed, had a fracture. She is morbidly obese. Falls should not happen.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>Every fall is preventable, even if its during activities or changing. Her fall is preventable because the fall happened during changing, and an appropriate number of staff should have been provided."</p> <p>Facility's policy titled "Fall Prevention and Management", reviewed date 11/10/2022, stated in part but not limited to the following: Policy Statement: Facility is committed to its duty of care to residents and patient in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained.</p> <p>(B)</p> <p>3 of 3</p> <p>300.610 a) 300.1210 b) 300.1210 d)1)</p> <p>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.</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide effective pain management, failed to identify signs and symptoms of pain, and failed provide appropriate and adequate pain relief for one (R3) of three residents reviewed for pain in the sample of 17 residents. This failure resulted in R3 experiencing severe prostate pain for several months without adequate and appropriate pain relief.</p> <p>Findings include:</p> <p>On 7/18/2023 at 9:29 AM, R3 stated last night at approximately 8:30 PM, he asked for his Norco pain medication, and an agency nurse gave him 3 pills that were round and looked nothing like his Norco medication. R3 stated he told her those</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>were not his pills, and so he refused them. R3 stated after arguing back and forth with the nurse, she finally pulled out his Norco medication, and asked if it was his name on the package. R3 stated those were in fact his Norco pills, but at this point, he did not want her to pass him any medications, due to his distrust of the nurse. R3 stated one of the CNA's/Certified Nursing Assistants called an offsite staff to complain about him protesting with the nurse about his medications. R3 stated he reported this to V2 (Director of Nursing) that a staff member would complain about him just asking for the correct pain medications. R3 stated when he was admitted, his prostate was 180% enlarged, and now it has enlarged so much, his physician says it's the largest he's ever seen. R3 stated his prostate hurts so severely, that it makes him fall down due to the pain. R3 stated he's in the facility because he is unable to get up to the 3rd floor stairs of his home because of his prostate pain. Asked how long he's been dealing with his severe pain, R3 indicated it was over several months, but has given up and felt helpless.</p> <p>On 7/18/2023 at 2:34 PM, V2 (Director of Nursing) stated this morning around 7:30 AM, R3 reported when he asked the night nurse for his Norco medication, she brought him his Norco pills in a cup, and when he looked in the cup, the pills were not Norco medications. V2 stated R3 reported the pills in the cup were round, and he told the agency nurse it wasn't his Norco medication, because he knew how they looked. V2 stated R3 explained to the agency nurse he had one Norco from when he went out on pass, and only wanted the 2nd one, and she responded what she gave him in the cup was his Norco. V2 stated R3 showed the agency nurse what his Norco medication looked like, and the agency</p>	S9999		

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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	<p>Continued From page 12</p> <p>nurse then went back to the medication cart, pulled out R3's Norco, and asked if that was his name on his Norco medication. V2 stated when R3 confirmed with the agency nurse it was actually his Norco, then the agency nurse then offered him his Norco from the medication cart. V2 stated R3 reported to her the agency nurse tried to give him Tylenol instead of his Norco. V2 stated she requested the nurse be DNR'd (Do Not Return) because she was agency and did not feel safe being under the care of this nurse. V2 stated the incident was investigated, and when she interviewed the agency nurse, she reported she did give R3 a Tylenol when he requested his Norco, because he didn't express any specific pain.</p> <p>Records reviewed showed there were no doctors orders for Tylenol to be administered for R3.</p> <p>May, June and July MAR's (Medication Administration Records) all show Norco medications were given with no evaluation of pain relief, and given inappropriately, even when R1 exhibited no pain, mild pain, or moderate pain.</p> <p>On 7/19/2023 at 10:30 AM, R3 came to the conference room where surveyors were present. R3 appeared agitated, and asked if he could file a grievance with the surveyors regarding his treatment at the facility. R3 indicated he again had issues with his pain medications and getting a nurse to respond to his pain. Surveyors asked if he was in pain, R3 affirmed he was, and he had severe pain in his prostate area, pointing to his groin area.</p> <p>On 7/19/23 at 2:15 PM, V24 (Physician) indicated Norco should only be given when the resident's pain level is either a 7 and higher. V24</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014906	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/20/2023
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S9999	<p>Continued From page 13</p> <p>acknowledged Norco was prescribed as PRN (as needed), and if it was being administered daily, then he should have been informed, so R3 could have a scheduled pain medication. V24 indicated no one from the facility informed him R3 was in severe pain, nor that it was not being managed properly. Surveyor asked whether it was the facility's obligation to inform him of any pain issues with R3, V24 affirmed the nurses needed to let him know of these issues, but did not. Surveyor asked if he ever did an in-service with the nurses in the facility, but V24 indicated he could not recall when he did one. V24 acknowledged he was going to conduct one soon. Surveyor asked how nurses should treat pain management for R3 and other residents, V24 stated, "The nurses need to assess whether they (residents) are truly in pain or not. Pain is very subjective. If the resident has been using this pain medication for a long time or is aggressive about obtaining pain medications, this becomes a challenge. If the resident is always in pain, and is not enough to relieve the pain, and asks for more soon after. This becomes a challenge for the nurses, but we cannot assume they are faking, and we are obligated to assess and treat the pain immediately. Sometimes these types of patients, such as (R3), have more pain at night, and sometimes it can be truly worse at night. At night, the autonomic system starts to work and blood flow decreases, and so they will complain more pain. Again, this needs to be assessed quickly and thoroughly in order to provide good pain relief." Surveyor asked if the nurses at any time informed him of the lack of pain relief R3 was obtaining. V24 stated, "No." V24 stated he was going to examine R3, and the orders given and would re-evaluate R3's current pain medication regimen.</p>	S9999		

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S9999	Continued From page 14 On 7/19/23 at 11:55 AM, V2 (Director of Nursing) stated, "I expect that the nurses will document if the resident refused to take a medication. If the resident refuses 3 consecutive days, the nurses should report this to me and to the doctor so we can either adjust or discontinue the medication. The nurses should also come back later and try to administer the medication if the resident refused it originally. As far as pain goes, residents need to have their pain assessed and when they administer pain medications, they should go back and evaluate whether the pain was relieved or not." Pain policy, dated 10/22/2021, reads in part, "The facility will provide adequate pain assessment and management to the residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Procedure: Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or status. Pain assessment will be performed by a nurse, MD, NP or any licensed clinician. Assessment maybe performed by: Asking the patient to rate the intensity of higher pain using a numeric scale; identifying key characteristics of pain; obtaining descriptors of the pain; Determining factors that make the pain better or worse." (B)	S9999			