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	IL6003958	A. BUILDING: _____ B. WING _____	C 06/18/2024

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S 000	Initial Comments Complaint Investigation 2484590/IL174217	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 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 300.1010 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.	S9999		

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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 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 are not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow policy procedures, failed to conduct a thorough assessment, failed to implement care plan interventions, failed to timely notify the Physician/Nurse Practitioner of resident change in condition, failed to document orders received,

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failed to request appropriate orders, and failed to determine the root cause of pain for one of four residents (R1) reviewed for change in condition. These failures resulted in R1 sustaining pain rated "50" (on a 1-10 scale), emotional distress (crying), WBC (White Blood Cell) count 17.4 (High), UTI (Urinary Tract Infection), and fecal impaction.

The facility also failed to ensure that R1's (3/29/24) referral for Neurosurgery consult was transcribed in the physician orders and failed to ensure that orders for R1's GI (Gastrointestinal) consult were obtained prior to surveyor inquiry.

Findings include:

On (6/11/24) IDPH (Illinois Department of Public Health) received allegations that R1 was not sent to the ER (Emergency Room) in a timely manner for head and abdominal pain.

R1's diagnoses include but not limited to encephalopathy, spina bifida, pain in unspecified joint, cutaneous abscess of right axilla, constipation, and UTI (Urinary Tract Infection).

R1's Physician Order Sheets include (10/8/21) Tramadol 50 mg (milligrams) every 6 hours as needed for pain. (3/11/24) pain assessment every shift, record actual score (0-10) every shift.

R1's care plan includes (6/14/21) resident is at risk for alteration in comfort. Interventions: Complete pain assessment. Administer medication as ordered and monitor for effectiveness of relief. Notify medical doctor if current pain medication management is not effective. (7/7/23) Resident is taking medication to treat constipation. Interventions: monitor,

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document, report to medical doctor signs/symptoms of complications related to constipation.

R1's (June 2024) Medication Administration Record affirms on 6/6/24 at 1:53am, R1 received Tramadol (Opioid Analgesic) for pain rated "5." On 6/8/24 at 1:45pm, R1 received Tramadol for pain rated "4." On 6/9/24 at 10:33am, R1 received Tramadol for pain rated "5." [R1's pain was rated "0" prior to 6/6/24 therefore change in condition occurred at this time].

R1's progress notes state (6/9/24) 8:07am, resident expressed to writer that she has pain over entire body, and she would like to go to the hospital. Writer offered pain medication, but resident denied. The resident was assessed by the writer, vital signs within normal limits [Physical Assessment was excluded]. Call placed to on-call service for (Physician) and was made aware that NP (Nurse Practitioner) would return a call to the facility. [A return call from the NP was not documented]. (6/11/24) 11:51am, Resident complained of general malaise, pain, and a boil under the left arm. Writer contacted NP and new orders were given to send resident to the hospital for evaluation [2 days after initial request for evaluation]. Reason for transfer: General Malaise, complaints of pain, boil under left arm, and shunt pain. 2:10pm, ambulance personnel arrived at the facility to escort resident to the hospital. (6/12/24) Patient was admitted for abdominal pain and UTI.

On 6/13/24 at 3:02pm, surveyor inquired about R1's (6/9/24) change in condition, V4 (Family) stated "She (R1) has problems with her stomach, bowel movements, headaches, and she said that she couldn't see one day last week. She was in a

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lot of distress both physically and emotionally. Yesterday, she was hysterical because of the pain and feelings of abandonment. She was going to have an upper and lower GI (gastrointestinal) test and I think she's going to have surgery as well."

R1's (4/1/24) BIMS (Brief Interview Mental Status) determined a score of 11 (moderate impairment).

On 6/17/24 at 2:32pm, R1 was alert, oriented, and appropriate during interview. Surveyor inquired about R1's (6/9/24) change in condition, R1 began to speak, and an overwhelming feces odor was noted. R1 stated "I was born with spinal bifida and have a VP (ventriculoperitoneal) shunt (cerebral shunt that drains excess cerebrospinal fluid). I was sick and kept having headaches, I thought my shunt was malfunctioning. I went out to an appointment about a month ago to see the neurosurgeon for my head, but they (staff) took me to the wrong office, it was the one for seizures (neurologist), so they had to bring me back and reschedule. I don't know when it was rescheduled for. Before I was sent out to the hospital, I got my stool (feces) pulled out here (facility) they (staff) only removed some of it. I was in pain for 2 weeks, I was having pain in my stomach and having headaches." Surveyor inquired how much pain R2 was experiencing prior to hospital transfer (based on a 1-10 scale), R1 responded "I was crying I was in so much pain, it was 50. I asked to be sent to the hospital and the Nurse Practitioner said to keep giving me the stool softener pill and pain medicine. The Tramadol (Pain Medication) was constipating me. I was crying, throwing up a little bit and having pain so I asked my Nurse to send me out." Surveyor inquired if R1 remains constipated, R1 replied "Yes, the bowel smell that's coming from my mouth means I'm constipated. The plan is to

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have a bag placed for my bladder (urostomy) and place a colostomy bag for my bowel."

R1's (6/11/24) history & physical states patient with history of VP shunt and chronic constipation presenting to the Emergency Department with report of abdominal pain now for about the past 2 weeks. Patient states she has some pain in the right side of her abdomen which is typically the case when she has a UTI. She reports that she normally gets pain in her mid-abdomen when she is constipated and that is present. [Physical exam abdominal: there is abdominal tenderness]. Patient also notes that she has been having chronic, intermittent headaches not acutely changed. She notes that she has had a VP shunt for many years but has not been following up with a neurosurgeon. Urinalysis abnormal: turbid, WBC (White Blood Cells) many, bacteria many, urine yeast present. Abdominal CT (Computed Tomography) includes prolapse of the rectum by at least 9cm (centimeters). Fecal impaction at that site with rectal diameters up to 9.3 cm. Severe urinary bladder wall thickening, reflective of cystitis. There is urothelial thickening and enhancement at the right renal calyces, suggestive of an ascending urinary tract infection. White blood cells 17.4 (High). Clinical Impression: Abdominal pain, acute UTI, constipation, fecal impaction in rectum.

On 6/17/24 at 2:53pm, surveyor inquired about R1's (6/9/24) change in condition, V6 (ADON/Assistant Director of Nursing) stated "As far as I know, she said that she just didn't feel good and wanted to go to the hospital." Surveyor inquired why R1 was sent to the hospital 2 days after her request, V6 responded "I wasn't aware that she requested to go to the hospital 2 days prior, so I can't answer that." Surveyor inquired if

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the Physician and/or Nurse Practitioner were made aware of R1's (6/9/24) change in condition and/ or request to go to the hospital, V6 accessed R1's electronic medical records and stated "It says that a call was placed to the on-call doctor and the NP would call back. I see they gave pain medicine; I do not see a follow-up call." Surveyor inquired about the facility policy for resident change in condition, V6 responded "The protocol is that you should alert the Physician or Nurse Practitioner, let them know what's going on, see if they want to get some labs or diagnostic tests or whatever. We follow through with that and document." Surveyor inquired if Physician or Nurse Practitioner notification was documented (6/9/24) in R1's medical records, V6 replied "Unfortunately, I'm going to have to say no." Surveyor inquired about the plan for R1 post return to the facility, V6 stated "She came back yesterday. It says that were going to be continuing with the current plan of care." [Surgical consultation for colostomy and/or urostomy were excluded].

On 6/18/24 at 10:17am, surveyor inquired about R1's (6/9/24) change in condition, V5 (Licensed Practical Nurse) stated "When I (V5) went in the room, she (R1) said that she had pain all over her body and she wanted to go to the hospital. I did offer her pain medication; she didn't want it. I did call the on-call service and I was waiting for him (NP) to return the phone call." Surveyor inquired if the NP returned the (6/9/24) call, V5 responded "He (NP) did call back I did not document that. He said don't send her out, offer pain meds again and if she refuses get a psych (Psychiatric) consult [labs and/or x-rays orders were not received to determine root cause of R1's pain]. I offered pain meds again, she accepted. The day she was sent out (6/11/24) she was complaining

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again, and she said that she wanted to go to the hospital. I called the NP, I didn't get an answer, so the ADON called and got a response, and she (ADON) got the order to send her to the hospital." Surveyor inquired about R1's (6/11/24) assessment, V5 stated "She (R1) just said she was uncomfortable and just hurting everywhere and expressed she had pain from a boil." Surveyor inquired about the smell of R1's breath, V5 replied "I didn't smell anything." Surveyor inquired if R1 reported abdominal pain on 6/11/24, V5 responded "She didn't complain of abdominal pain" [incongruent with R1's 6/11/24 history and physical]. Surveyor inquired what R1 was diagnosed with post (6/11/24) hospitalization, V5 replied "I believe it was fecal impaction." Surveyor inquired about staff requirements for resident change in condition, V5 stated in part "Alert the doctor, and we document it." Surveyor inquired if R5 documented the alleged (6/9/24) NP notification, V5 responded "I got busy and I forgot to document that."

On 6/18/24, surveyor inquired about R1's missed Neurosurgery appointment, V8 (Nurse Consultant) affirmed that she would check into it. At 12:09pm, V8 presented R1's encounter summary from hospital clinic and stated "She (R1) was seen by the neurologist on 3/29/24 and there's a follow-up appointment with neurosurgery on 7/24/24." R1's (3/29/24) neurology consult includes Neurosurgery referral for headache disorder. Plan of Treatment: ambulatory referral to Neurosurgery. Order schedule: 7/24/24. [R1's physician orders exclude the Neurosurgery consult]. Surveyor inquired about R1's surgical consult for urostomy and/or colostomy placement, V8 affirmed that the facility was unaware that she needed a consult and would check into it. At 1:49pm, V8 stated "The

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appointment for the GI consult is scheduled for 7/22/24" and affirmed it was scheduled after surveyor inquiry.

On 6/18/24 at 2:10pm, surveyor inquired about staff requirements for outpatient referrals, V7 (Medical Director) stated "We write the referral, and the expectation is that the staff execute the appointment." Surveyor inquired about staff requirements for resident change in condition, V7 responded "They should call the primary care doctor immediately." Surveyor inquired what staff should be reporting to the Physician, V7 replied "They should have vital signs and any pertinent physical exam findings." Surveyor inquired about potential harm to a resident with hydrocephalus status-post shunt reporting ongoing headaches and acute pain over their entire body, V7 responded "a stroke."

The resident admission packet (revised December 2023) states a facility must immediately inform the resident; consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s), when there is a significant change in the resident's physical, mental, or psychosocial status. When making notification, the facility must ensure that all pertinent information is available and provided upon request to the physician.

The change in resident's condition policy (reviewed 2/1/24) states Nursing will notify the resident's Physician or Nurse Practitioner when: there is a significant change in the resident's physical, mental or emotional status: It is deemed necessary or appropriate in the best interest of the resident. Appropriate assessment and documentation will be completed based on the

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resident's change in condition or indication. The communication with the resident and their responsible party as well as the Physician/NP will be documented in the resident's medical record.

The (2/2024) pain management policy states pain management is a multidisciplinary care process that includes the following: observing for potential pain. Effectively recognizing the presence of pain. Identifying pain characteristics. Addressing the underlying causes of the pain. Monitoring effectiveness of interventions. Modifying approaches as necessary. Conduct a pain assessment upon admission to the facility, quarterly and with any significant changes in condition. Licensed Nurses may notify the healthcare provider of any new development of pain, change in pain, or change in condition that could potentially cause pain.

(B)