STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002133	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN NURSING & REHAB CENTER	1115 NORTH WENTHE EFFINGHAM, IL 62401

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S 000	Initial Comments Complaint Investigation: 24510242/IL182631	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 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 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.	S9999		

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S9999	Continued From page 1 These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to treat residents with dignity by answering call lights in a timely manner for two residents of nine residents (R1, R6) reviewed for resident rights in the sample of nine. This failure resulted in R1 and R6 experiencing feelings of embarrassment and humiliation. Findings include: 1. R1's Face Sheet documented an Admission Date of 12/3/24 and listed diagnoses including Displaced Comminuted Fracture of Shaft of Left Femur, Fibromyalgia, Polyneuropathy, Depression, and Anxiety Disorder. R1's Brief Interview for Mental Status Score (BIMS) dated 12/8/24 documented a score of 14, indicating R1 has minimal deficits in cognition. R1's Nursing Progress Note dated 12/3/24 documented, "Admitted a 76-year-old Caucasian female via ambulance from (local hospital). Brought into facility via stretcher and transferred to chair per 2 EMT's (Emergency Medical Technicians) with TTWB (Toe Touch Weight Bearing) status to LLE (Lower Left Extremity) (due to fractured left femur)." This note further stated, "Resident. States she has chronic pain due to Fibromyalgia and rates it normally at a chronic 4 (on a 0-10 scale)." On 12/18/24 at 1:40pm, R1 was alert and oriented to person, place, and time. R1 stated she had fallen while living in the community and fractured her femur and needed nursing facility care for rehabilitation. R1 stated she was admitted to the facility on 12/3/24. R1 stated call lights routinely take over an hour to be answered.	S9999		

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S9999	Continued From page 2	S9999		

R1 stated she had experienced difficulty with loose stools and had been incontinent in bed while waiting long periods on her call light. R1 stated, "That was very hard on my dignity." R1 stated when she had complained to one of the Certified Nursing Assistants (CNA) (identity unknown) about waiting so long, the CNA told her to, "Just go ahead and go in the bed and we will clean you up later."

On 12/19/24 at 10:50am, R1 was alert and oriented to person, place, and time. R1 stated, "You can't imagine how embarrassing it is to turn on your call light and wait for over an hour and then lose control of your bowels because nobody came to check on you. Then you have to have somebody clean you up. It's pretty humiliating."

2. R6's Face Sheet documented an Admission Date of 12/10/24 and documented Diagnoses including Fracture of Left Femur, Malignant Neoplasm of Colon, and Low Back Pain. R6's BIMS dated 12/17/24 documented a score of 15, indicating R6 has no deficits in cognition. R6's Nursing Progress Note dated 12/10/24 documented, "Resident arrived to facility at approx 1:45pm via facility transport van. Left hip surgery on 12/5/24, left hip dressing has moderate serosanguinous drainage with purple bruising to left hip. Maximum 2 assist pivot transfer with front wheeled walker from wheelchair to bedside commode."
On 12/17/24 at 12:25pm, R6 was alert and oriented to person, place, and time. R6 stated call lights generally take about 45 minutes at minimum. R6 stated she fell at home and broke her left leg and is dependent on staff for transfers, and she cannot ambulate at this time. R6 stated she has been having loose stools since admission and has had several accidents while

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S9999	Continued From page 3	S9999		

waiting for her call light to be answered. R6 stated she wears incontinence briefs but prefers to defecate on the commode rather than the incontinence brief. R6 stated when she has accidents, staff have to clean her up and it is very embarrassing. R6 stated, "I've pretty much thrown my dignity out the door since I've been here." V11, R6's family member, who was also in the room with R6 stated he has been present during several of these instances and he corroborated her account.

3. On 12/17/24 at 9:35am, V10, Ombudsman, stated complaints about long call light wait times comes up at almost every monthly resident council meeting.

Resident Council Meeting Minutes documented the following: 9/26/24: "Call lights not being answered in a timely manner still an issue. Leaving residents on the toilet too long. Not having beds made and leaving beds dirty." 10/24/24: "Still not having call lights answered in a timely manner."

On 12/19/24 at 8:45am, V2, Director of Nurses, when asked what her expectation is as to how long residents should have to wait on call lights. V2 stated the State Agency does not specify in any regulations as to how long it should take for call lights to be answered, but ideally, they should be answered as soon as possible. V2 stated she did not feel the problem was that call lights are not answered timely, but that resident's perception is that it takes longer than it actually does. V2 further stated a former CNA staff member contractually employed via a staffing agency had a lot of complaints from residents about her being slow to answer call lights, and since she left their employment in October 2024,

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S9999	Continued From page 4	S9999		

the problem seems to have resolved. V2 stated it is not acceptable for staff to tell residents to be purposely incontinent in bed if it takes too long to answer call lights.

The facility's, "Answering the Call Light Policy," dated July 2014 stated, "The purpose of this procedure is to respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. 8. Answer the resident's call light as soon as possible."

The facility's, "Resident Rights," policy dated August 31st, 2023, stated," The resident has a right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility, including: A facility must treat each resident with respect and dignity and care for the resident manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and promote the rights of the resident."

(B)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1210a)
300.1210b)
300.1210d)3)
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EVERGREEN NURSING & REHAB CENTER	1115 NORTH WENTHE EFFINGHAM, IL 62401

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S9999	Continued From page 5	S9999		

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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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S9999	Continued From page 6	S9999		

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.

Section 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. The plan shall be reviewed at least every three months.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to formulate a Care Plan

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S9999	Continued From page 7	S9999		

to address a resident's pain and to provide as needed pain medication in a timely fashion for one resident of nine residents (R1) reviewed for quality of care in the sample of nine. This failure resulted in R1 experiencing unresolved excruciating pain from a femur fracture, with accompanying feelings of fear and anxiety.

Findings include:

R1's Face Sheet documented an Admission Date of 12/3/24 and listed diagnoses including Displaced Comminuted Fracture of Shaft of Left Femur, Fibromyalgia, Polyneuropathy, Depression, and Anxiety Disorder.

R1's Care Plan dated 12/9/24 did not document any problem areas nor interventions addressing pain. R1's 12/8/24 Brief Interview for Mental Status Score documented a score of 14, indicating R1 has minimal deficits in cognition.

R1's December Physicians Order Sheet documented orders for hydrocodone-acetaminophen 5-325 milligrams take one tablet every 4 hours as needed for pain, not to exceed 3 grams of acetaminophen every 24 hours, and methocarbamol 500 milligrams take one tablet every 4 hours as needed for muscle cramps/spasms.

R1's December Medication Administration Record documented that R1 received the hydrocodone-acetaminophen and the methocarbamol on 12/13/24 at 4:39pm and not again until 12/14/24 at 7:34am, with V8, Registered Nurse (RN) administering the 12/14/24 dose. The same MAR documented R1's pain on 12/14/24 at the beginning of the day shift (6am) as zero on a scale of zero to ten.

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S9999	Continued From page 8 On 12/18/24 at 1:40pm, R1 was alert and oriented to person, place, and time. R1 stated she had fallen while living in the community and fractured her femur, needed nursing facility care for rehabilitation, and therefore was admitted to the facility on 12/3/24. R1 stated she has experienced a significant amount of pain from the fracture, as well as anxiety. R1 stated when she asked for her as needed pain medication and muscle relaxer, it rarely came within 20 minutes, and it generally took at least an hour. R1 stated this made her pain more difficult to control. R1 stated on Saturday 12/14/24 at 3am, she was experiencing excruciating pain from the fracture and turned on her call light and told, "One of the CNAs (Certified Nursing Assistants)," she needed the pain medication and muscle relaxer. R1 stated after several minutes, nobody came back, so she turned her call light on several more times throughout the early morning hours, and CNA staff told her the nurse was busy on another hall, the nurse had a delivery of medications she needed to put away, and that she was busy with another resident. R1 stated she did not receive the medications until about 7:30am that morning, when V8 came in to give her morning medications. R1 stated she told V8 how upset she was about waiting all that time and being in pain, and V8 stated the night nurse (V9, Registered Nurse) was new and she was overwhelmed. R1 stated when she finally received the medications, "She was in terrible pain and it took the medications a lot longer to be effective, and they didn't control the pain as well, and she was extremely upset." When R1 was told by the Surveyor that the beginning of shift documentation rated her pain at zero, R1 stated, "It wasn't a zero, it was a ten." R1 stated, "She called her husband and said, I want to go home,	S9999		

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S9999	Continued From page 9	S9999		

I'm not safe here, I'm scared, they aren't giving me my pain pills after I ask for them and they aren't answering my call light." R1 stated her husband came and got her and she left without signing any discharge paperwork. R1 stated since she left AMA (Against Medical Advice) and did not consult with staff, she did not have any discharge medications. R1 stated her pain got much worse as the day wore on, and she ended up going to the emergency room that evening. R1 stated she is still in the hospital and is being treated for Pneumonia.

R1's Nursing Progress Note dated 12/3/24 documented the following:
"Admitted a 76-year-old Caucasian female via ambulance from (local hospital). Brought into facility via stretcher and transferred to chair per 2 EMT's (Emergency Medical Technicians) with TTWB (Toe Touch Weight Bearing) status to LLE (Lower Left Extremity) (due to fractured left femur)." This note further stated, "Resident states she has chronic pain due to fibromyalgia and rates it normally at a chronic 4 (on a 0-10 scale)."

R1's Nursing Progress Note, authored by V8, dated 12/14/24 at 10:15am documented the following: "This morning this nurse went to residents' room to give her morning meds, she asked for pain pill along with her meds. Resident took meds without any further complaints. Shortly after the stepson came in facility and said resident called him and wanted to go home. This nurse went to resident room to speak with resident. Resident stated "I was supposed to go home soon anyways, I think I am good to go home now. I will feel better being at home with my husband and my family can care for me there." Spoke with resident and stepson about the need to stay further for therapy and to be monitored.

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S9999	Continued From page 10	S9999		

Stepson stated he felt she should stay a few more days anyways because her husband would not be able to fully care for her. Resident stated, "I do not care I am leaving this place this morning either way." Spoke with resident and stepson about being toe touch weight bearing, the risk, and dangers of leaving against medical advice, she stated she understood all of that and was still adamant of leaving and going home. The stepson said the husband was on his way, I told him I would be back in to speak with him further when he arrived. Shortly after the PTA (Physical Therapy Assistant) came to inform nurse that husband just came in, grabbed residents' things, and took her out via wheelchair and they was gone without signing the paperwork. (V1) Administrator, (V2) DON (Director of Nurses), MD (Medical Doctor) and (V3) ADON (Assistant Director of Nurses) all notified."

On 12/18/24 at 11:30am, V8 stated when she came in to work at 6am on 12/14/24, nothing was said in report from the night shift about R1 being in pain or upset. V8 stated she went into R1's room about 8am to give R1 her morning medications. V8 stated R1 asked if her pain medication and muscle relaxer were being given and V8 stated no, do you need them, and R1 stated yes. V8 stated she did not recall what R1's pain level was at that time. V8 stated R1 said she had asked for them on night shift but did not receive them. V8 stated later during the morning, an extended family member of R1 came in and said R1 had called, was upset about not receiving her pain medications timely, and wanted to go home. V8 stated she went and talked to R1 and told her she was not ready for discharge and strongly discouraged her leaving. V8 stated R1 said her husband was coming to get her and she was leaving. V8 stated she told R1 she would

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S9999	Continued From page 11	S9999		

need to sign some documents before she left, and R1 said OK. V8 stated when she re-entered the room shortly thereafter, R1 and her belongings were gone.

On 12/18/24 at 2:30pm, V9, stated she worked 6pm to 6am on 12/13/24-12/14/24. V9 stated it was the first night she worked alone at the facility after having, "Trained on a couple of night shifts." V9 stated she found herself, "Working by herself with 2 CNAs and 40 something residents." V9 stated it was, "A horrible night." V9 stated she had a newly admitted resident with a blood sugar of over 600 who had no medications or insulin, and had another resident sustain a fall. V9 stated she could not remember anything about R1 and did not recall R1 having asked for pain medication, but as chaotic as it was, it's possible she did. V9 stated after that night, she texted V2, Director of Nurses, to let her know she would not be returning, as she did not feel she could provide safe resident care under those circumstances. V9 stated the Surveyor calling her was the first she had heard anything about R1 not receiving pain medication that night.

On 12/19/24 at 8:45am, V2 stated the role of the 6pm-6am nurse is to pass medications, supervise CNA staff, assist CNA staff as needed, and assess residents as needed. V2 stated she has heard no complaints from residents or families about not receiving as needed pain medications in a timely fashion. When asked about what happened with R1 as outlined above, V2 stated she had heard on 12/14/24 from staff that R1 left AMA because R1 was upset that she didn't get her pain medication timely. V2 stated she did not investigate R1's complaint, but V3, Assistant Director of Nurses, did.

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S9999	Continued From page 12 On 12/19/24 at 9:20am, V3 stated, "She did not really do an investigation into (R1's) not getting pain medication because nobody would admit to her having asked for it." V3 stated she did ask V9 about it, and V9 stated, "She had a really rough night, and she didn't remember (R1) asking for pain medication." The facility's Pain Prevention and Treatment Policy dated October 2017 documented, "Policy: To assess for, reduce, the incidence of, and the severity of pain to help residents attain or maintain his or her highest practicable level of well-being and to prevent or manage pain to the extent possible. The facility will develop and implement a plan, using pharmacological and non-pharmacological interventions to manage pain and/or try to prevent the pain consistent with resident's goals." (B)	S9999		