STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	02/04/2025

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)1)2) 300.1630d) 300.3210t) 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. 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	S9999		

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a residents' pain regimen was adequate to relieve her pain for one of 13 residents (R14) reviewed for pain in the	S9999		

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S9999	Continued From page 2	S9999		

sample of 13. This failure resulted in R14 experiencing unrelieved pain for three days.

The findings include:

R14's Physician Order Report dated January 3, 2025-February 3, 2025 shows she was admitted to the facility on December 2, 2024 with diagnoses including nonrheumatic aortic valve stenosis, acute diastolic congestive heart failure, depression, gastrointestinal stromal tumor of stomach, age related osteoporosis, scoliosis thoracic region, muscle weakness, and abnormalities of gait and mobility. R14's medications orders show an order for ibuprofen 200 mg two tablets every four hours as needed to start on December 6, 2024, an order for ibuprofen 200 mg three tablets twice a day for pain to start on December 10, 2024, and morphine liquid 10 mg every two hours as needed to start January 30, 2025.

R14's Care Plan created December 17, 2024 shows, "Resident has complaints of chronic back pain. History of fall with minor injury. Assess past effective and ineffective pain relief measures, monitor and record any nonverbal signs of pain. R14's Care Plan created December 3, 2024 shows, "Pain: evaluation of pain will be performed routinely to address pain management needs. I will receive pain medication per physician/nurse practitioner orders. Pain medication effectiveness will be documented and reported as needed."

R14's Progress Notes dated December 2, 2024 shows, "Spoke to doctor in regard to residents fall and complaints of back pain. Order received and noted." R14's Progress Note dated December 10, 2024 shows, "Reports general aches and pains this morning. Ibuprofen administered as now

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S9999	Continued From page 3	S9999		

scheduled..." R14's Progress Note dated January 9, 2025 shows, "Resident is alert and oriented. Refuses all medications except ibuprofen. States pain is related to her skin tear on her right upper arm."

R14's Progress Note dated January 26, 2025 shows, "Resident has very poor appetite only taking a few bites at each meal. Also only wanting to take ibuprofen and no other medications. Requesting to stay in bed or go back to bed quickly after getting up in chair. MD (medical doctor) and power of attorney notified of general decline..." January 29, 2025 shows, "Daughter (V20) here to meet with hospice. Daughter upset stating that she does not feel that residents pain is adequately controlled..." January 30, 2025 shows, "Need for comfort meds communicated to doctor and new orders morphine and Ativan received. Power of Attorney notified." February 2, 2025 shows, "Resident putting on call light several different times requesting to have morphine and be repositioned, she was repositioned every single time, this nurse gave her ibuprofen and am waiting on morphine to arrive from pharmacy. I informed her as soon as we receive her morphine, I will bring it in. She stated, 'so I am just supposed to suffer until then?' I reassured her I gave ibuprofen to help for now."

On February 2, 2025 at 10:23 AM, R14 was lying in bed. R14 said that the had pain in her heart and pain in her back. R14 said she was waiting for her morphine. R14 said before her ibuprofen was administered, her pain was rated a 9/10. After the ibuprofen, R14's said her pain is rated at 8/10. R14 was thin and frail. R14 had 4-5 blankets on.

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S9999	Continued From page 4	S9999		

On February 3, 2025 at 10:15 AM, V20 (R14's Daughter/power of attorney) was sitting at R14's bedside. R14 was pale and barely breathing. R14 was unresponsive. V20 began crying and stated her mom was actively dying. V20 became tearful when interviewed in regard to R14's pain. V20 said her mom always had chronic pain. V20 said she has been asking for something stronger for pain for R14 since R14 was admitted to the facility. V20 said R14 took ibuprofen at home for pain, but always took more than the recommended amount. V20 said that V4 RN (Registered Nurse) got the process started for a stronger pain medication for R14 but then V20 said she did not know what happened after. "Someone dropped the ball."V20 said it took the facility three days to get an order for morphine. V20 said she was very upset. V20 said R14 has aortic stenosis, no stomach due to stomach cancer, was a post-polio baby, and shrunk five inches in height. V20 said that she was told by the facility that staff could not take the morphine out of the emergency box because their pharmacy said the morphine was already on its way to be delivered. V20 said she was very upset when she came in to visit on February 2, 2025 and the morphine still was not in the facility for R14.

R14's Medications Administration History dated January 1, 2025-January 31, 2025 shows that R14 asked for her ibuprofen early 17 times.

On February 4, 2025 at 9:07 AM, V2 DON (Director of Nursing) said there was an order for hospice for R14 on January 26, 2025. V2 said R14 was refusing to eat and only wanted to take her ibuprofen. V2 said on January 27, 2025 R14's daughter (V20) was upset that R14 did not have morphine for pain. On January 29, 2025 V20

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S9999	Continued From page 5	S9999		

came and talked to V2 again and stated, "she just needs to relax so she can die." V2 said that R14 was saying she wanted ibuprofen. V2 said on January 30, 2025, V4 RN contacted R14's doctor to get something stronger for pain because V4 could see that R14 was declining so V4 wanted to get the pain medications so R14 did not have to go through the weekend with no pain medications. V2 said the problem was that the doctor did not call in the morphine prescription into the pharmacy. On February 2, 2025, R14's nurse came to V2 and V4 and said R14 was still asking for morphine. The nurse called the pharmacy and the pharmacy said they did not have a prescription for morphine. So, the nurse called the doctor again and the doctor put the order in to the pharmacy. At 5:18 PM, V2 said the morphine was delivered on February 2, 2025 but did not know why R14 did not get morphine until February 3, 2025. V2 said if R14 was asking for more ibuprofen or asking for it early, then that meant that R14 was in pain.

On February 4, 2025 at 9:16 AM, V4 RN said she called the doctor on Thursday night January 30, 2025. V4 said she asked the doctor to get the medication on board because she knows R14 would need them. V4 said she felt that R14 was declining rapidly. V4 said she put the order in the computer, and she knew the medication would not be at the facility until later the next day. V4 said R14's nurse came to her on Sunday February 2, 2025 and said R14 did not have morphine yet. V4 said she told the nurse that V4 would come help the nurse take the morphine out of the emergency box. V4 said staff was not able to take the morphine out of the emergency box because the pharmacy said the morphine was already on the delivery truck.

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S9999	Continued From page 6	S9999		

R14's Medications Administration History dated February 1, 2025-February 4, 2025 shows an order for morphine was ordered to start January 30, 2024. This same document shows that R14 did not receive morphine until February 3, 2025 at 7:41 AM. This document also shows that R14 was actively dying at 7:41 AM, 10:05 AM, and 12:06 PM. R14 passed away at 12:30 PM.

The facility's Pain Management Policy dated April 2020 shows, "The goal is to facilitate resident independence, promote comfort and preserve resident dignity. Residents will be encouraged to report pain early so that pain management can be more effective. Nursing will address pain management issues as soon as they are brought to their attention. Physician or extender notification of inadequate pain management will occur. Nursing will inform the physician or extender about the admission, current pain medications and the need for potential supplemental pain medications if appropriate." (B)

Statement of Licensure Violations (2 of 2):

300.625c)1)2)

Section 300.625 Identified Offenders

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

1) Immediately notify the Department of State Police, in the form and manner required by

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S9999	Continued From page 7	S9999		

the Department of State Police, that the resident is an identified offender.

2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

These REQUIREMENTS were NOT met as evidenced by:

Based on interview and record review the facility failed to order fingerprints on a resident with a HIT for a qualifying offense on their registry background checks for 1 of 5 residents (R201) reviewed for the identified offender protocol/new admissions to the facility in the sample of 13.

The findings include:

R201's Admission Record showed R201 was admitted to the facility on 1/12/25.

R201's criminal history background check record (CHIRP) dated 1/7/25 showed a "HIT" for the offense of disorderly conduct.

On 2/2/25, R201's admission background checks

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S9999	Continued From page 8	S9999		

showed no documentation that the facility notified the State Police of R201's "HIT" on his CHIRP. The checks showed no documentation that fingerprinting was ordered on R201.

On 2/2/25 at 2:12 PM, V6 Admission Director stated, "I do the background checks on new admissions to the facility. I was aware that (R201) had a HIT on his CHIRP. When I find that a resident has a HIT on their background check, I tell (V5 Social Services/SS) and she takes it from there. (V5 SS) orders the fingerprinting. I did not notify the police of (R201's) HIT. I let the team know about his HIT during our morning meeting. I don't know if he ever got fingerprinted."

On 2/2/25 at 2:20 PM, V5 Social Services Director/SS stated, "I was not aware (R201) had a HIT on his CHIRP. I am responsible for ordering fingerprinting on residents, but I didn't know (R201's) HIT so I didn't order them. I have not spoken to the State Police about (R201)."

The facility's Identified Offender Policy and Procedure Addendum dated 1/2/14 showed, "It is the policy of (facility) to provide a culturally sensitive and a safe environment. (Facility) will check the criminal history background on any resident seeking and or admitted to the facility in order to identify previous criminal convictions... The admissions director and social service director shall work together to ensure federal and state laws, regulations and the facility policy and procedures are followed when admitting an identified offender. The admission director will inform the interdisciplinary team (IDT) of an identified offender admission to the facility. The admission director will initiate the finger print and/or background check and notify all appropriate agencies as per the facility Identified

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S9999	Continued From page 9 Offender Policy and Procedures of the resident's admission to the facility. The admission director shall notify the social services director as to the status of the background check and/or fingerprint results..." (C)	S9999		