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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210d)1)3) 300.1620a) 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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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.
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 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure pain medications were available and administered as ordered for one of three

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residents (R21) and the facility failed to assess for level of pain when scheduled pain medications were omitted for two of three residents (R21 and R18) reviewed for medications in the sample of 15. This failure resulted in severe pain causing R21 to cry and refuse repositioning or incontinence care due to severe pain.

Findings include:

R21's Facility Face Sheet dated 9/28/2013 documents a diagnosis of Neuropathy, Polymath, Chronic Pain, Polymeric, and Gillian-Barre Syndrome.

The Minimum Data Set dated 8/3/2015 documents R 21 is cognitively intact.

R21's Physicians Order Sheet dated 8/1/2015 documents Hydrocarbon-Acetaminophen 7.5-325 milligrams every 6 hours orally for pain was ordered 7/6/2015 and Fentanyl 25 mcg/hr one patch administered every 72 hours ordered 7/6/2015.

R21's Medication Administration History dated 8/1/2015 through 8/26/2015 documents R 21 did not receive the prescribed dose of Hydrocarbon-Acetaminophen 7.5-325 milligrams or have pain scale assessed on 8/23/2015 at 11:00 AM, 5:00 PM, or 11:00 PM and 8/24/2015 at 5:00 AM. The Medication History also documents R 21 did not receive a scheduled Fentanyl Patch on 8/5/2015. The Medication History documents R21 received a Fentanyl patch on 8/2/2015 then not again until 8/9/2015 seven days later.

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On 8/26/2015 at 9:30AM, E2 (Director of Nursing) stated " (R21) did not receive a Fentanyl patch on 8/5/2015. The patch was not available and was not reordered until 8/8/2015. I expect that the nurses reorder the Fentanyl patch before the last one is used."

On 8/26/2015 at 8:30AM, R21 stated "I had severe pain in my hands and all over my body last Sunday (8/23/2015) and Monday (8/24/2015) in the morning because I did not get my pain pills. I hurt so bad I couldn't stand to be moved in bed that night or have my incontinence brief changed regularly that night. Any time staff touched me the pain was excruciating and made me cry. My pain level was higher than a rating of 10 on a scale of 1-10. I have constant pain especially in my hands and feet with my pain medications given it keeps my pain level down to a 7 or less rating. I also missed a pain patch once this month but I'm not sure of the date. I know any time I miss my pain medication it takes a day or two for the pain to be tolerable again."

The progress note dated 8/24/2015 at 6:09AM, documents R21 refused positioning through out the night. No pain scale document for any time on 8/23/2015 at 11:00AM through 8/24/2015 at 11:00AM.

On 8/26/2015 at 8:35AM, Z2 (R21's family) stated " (R21) cried all day in pain the day the pain medication was missed. What I don't understand is why if the medication is in the facility convenience box (R21) had to suffer. (R21) is in chronic pain if (R21) misses the pain medication it takes (R21) a day or two to get the medicine back in (R21's) system for it to work right."

R21's care plan dated 10/16/2013 documents

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"Administer medications as ordered, and return to assess effectiveness.

On 8/25/2015 at 11:25AM, E8 (registered Nurse) stated "I called (R21's) physician and the pharmacy to order the Hydrocodone-Acetaminophen 7.5-325 milligrams on 8/24/2015 at approximately 9:00AM. R21 received the scheduled 11:00AM dose. I'm not sure why the pharmacy didn't send the medication sooner. I know (R21) has chronic pain and rates pain as a 7 or 8 on a scale of 10 even when (R21) receives the scheduled pain medications."

On 8/25/2015 E9 Licensed Practical Nurse (LPN) stated " Medications are ordered at least three days before the prescription runs out. If a resident misses a medication more than three times for any reason the doctor must be notified."

On 8/26/2015 at 8:57AM, E7 (LPN) stated " I worked on 8/23/2015 when (R21) did not have any prescribed Hydocodone at the facility. (R21) is always in pain. I did call the on call physician for orders but did not receive any. I did not call the Medical director for orders. The medication is in the convenience box but we are not able to give the medication with out a code from pharmacy. (R21) needed a new order so they would not give me the code, therefore (R21) missed four doses of the scheduled Hydrocodone in a row."

The facility Controlled Substance Box documents the following contents: Fentanyl 25 mcg/hr patch two patches and Hydrocodone- Acetaminophen 7.5-325 milligrams six tablets.

On 8/26/2015 at 3:15PM, E2 (Director of Nursing)

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stated "(R21) is not currently going to a pain management physician or clinic for pain control."

2) R18's Physician's Order Sheet (POS) for August 2015 states Hydrocodone-Acetaminophen 5-325 milligrams every 6 hours orally was ordered on 5/16/15. R18's Medication Administration History for 6/1/15-6/30/15 states R18 did not receive her prescribed dose of Hydrocodone-Acetaminophen on 6/17/15 at 11:00 PM, 6/18/15 at 5:00 AM, and 6/18/15 at 11:00 AM. R18's Medication Administration History for 6/1/15-6/30/15 indicates R18 was not assessed for pain on 6/18/15 at 11:00 AM.

On 8/26/15 at 11:30 AM, R18 stated there was an occasion when she did not receive her prescribed dose of Hydrocodone-Acetaminophen. R18 could not recall when this occurred but stated she receives Hydrocodone-Acetaminophen for pain in her shoulder.

(B)

300.615 f)1 Resident Background Checks

The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

This requirement is not met as evidenced by:

Based on record review and interview the facility failed to check the Illinois Department of Correction's sex registrant search page for 10 of 10 new resident admissions. This affected one

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S9999	Continued From page 6 resident (R19) in the sample of 15 and nine residents (R23-R31) in the supplemental sample. The findings include: The resident criminal background checks and website checks were reviewed for the last ten resident admissions. The facility had documentation that they had conducted an Inmate Search on the Illinois Department of Corrections website for each resident instead of a sex registrant search. E14 Receptionist stated on 8/25/15 at 8:45 am that she has conducted the resident background checks for the past 6 years and has always done a "Inmate Search". E14 was not aware of the sex registrant parolee tab on the drop down menu that displays the names of registered sex offenders on parole in the system. The facility "Compliance with Felon/Sex Offender Regulations" policy dated July 2005 states:"The facility will check the sex offender website at www.isp.state.il.us and the inmate search website at www.idoc.state.il.us on all existing residents. The facility will keep a copy of the printout of the "resident not found"sheet with the residents name on it or an affidavit saying the two web sites were checked on (date) and (resident name) was not found." (B) 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:	S9999		

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S9999	Continued From page 7 1) Immediately notify the Department of State Police, in the form and manner required by 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. This requirement is not met, Based on record review, interview and observation the facility failed to immediately notify the Department of State Police or arrange for a fingerprint -based criminal history record inquiry for one of one residents R13 reviewed for Identified Offender Protocol in the sample of 15 and two residents R50, R51 in the supplemental sample. Findings include: 1. The facility's form titled Resident Admission Record dated 7/10/13 documents R13 was admitted to the facility on 7/10/13. R13's UCIA (Uniform Conviction Information Act) background check was completed on 7/11/13 and the results shows R13 has a criminal offense. 2. The facility's Resident Admission Record for R51 dated 7/3/14 documents first admission date for R51 was 9/6/13. R51's UCIA background check was completed on 10/8/13 and the results shows R50 to have a criminal offense.	S9999		

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S9999	Continued From page 8 3. The facility's Resident Admission Record dated 5/31/14 for R50 documents R50 was originally admitted to the facility oh 12/5/13. R50's UCIA background check was completed on 12/19/13 and the results showed R50 to have a criminal offense. E1, Administrator stated on 8/26/15 at 2:30 PM, "There are no CHAR (Criminal History Analysis Report) reports for R13, R50 and R51 because the facility did not do the fingerprint base back ground check for these residents. The facility did not report any of this information to Department of State Police so the reports were not completed. On 8/27/15 at 11:45 AM R13 was in her room eating lunch and watching television, on 8/27/15 at 11:43 AM R51 was in the main dining room at the table talking to his tablemates, and 8/27/15 at 11:40 AM R50 was in his room eating his lunch . The facility policy dated January 2015 titled "Identified Offender Policy and Procedure"states "The facility shall arrange for a finger-print based background check....five days after receiving inconclusive results of a name based background check..... The facility will fax Illinois Department of Public Health the name and criminal history of the identified offenders...." (B)	S9999		