Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6003057 | A. BUILDING: _____ B. WING _____ | 02/18/2016 |

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| GROVE OF LAGRANGE PARK, THE | 701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526 |

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| S 000 | Initial Comments<br><br>First Probationary Licensure Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210a)<br>300.1210d) (a) 2)<br>3001810c)2)<br>3001810c)3)<br>3001820c)3)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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)<br>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:<br>2) All treatments and procedures shall be administered as ordered by the physician. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Section 300.1810 Resident Record Requirements

c) Record entries shall meet the following requirements:
2) All entries into the medical record shall be authenticated by the individual who made or authored the entry. "Authentication", for purposes of this Section, means identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

Section 300.1820 Content of Medical Records

c) In addition to the information that is specified above, each resident's medical record shall contain the following:
3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition.

These requirements were not met, as evidenced by:

1. Based on observation, interview and record review the facility failed to document the measurement of the PICC (peripherally inserted

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central catheter) line external length catheter to ensure that the physician's order and plan of care was followed.
This applies to 1 of 1 (R3) resident reviewed for PICC line care in the sample of 9.

The findings include:

R3 was readmitted to the facility on January 26, 2016 with multiple diagnoses which included right BKA (below knee amputation) and R/O (rule out) osteomyelitis based on the hospital transfer form.
R3's hospital records showed that on January 25, 2016, a right basilic PICC line was inserted on the resident.
R3's readmission observation sheet dated January 26, 2016 showed that the resident came in the facility with a vascular access. R3's vascular access evaluation dated January 26, 2016 showed that the resident has a PICC line on the right upper extremity with an external catheter length measuring 9 cm (centimeters).
On February 17, 2016 at 9:45 AM, R3 was sitting on the edge of the talking to family members. R3 was alert and oriented with right upper arm PICC line in place. R3's PICC line transparent dressing was February 14, 2016. R3's family member stated that the PICC line was inserted in the hospital for antibiotic therapy due to infection of R3's right BKA.
R3's POS (physician order sheet) dated January 1, 2016 through February 29, 2016 showed an order on January 26, 2016 to measure PICC line external length catheter every Sunday during the day shift.
R3's TAR (Treatment administration record) from January 26 through February 18, 2016 showed a nurse initial for February 7, 2016, indicating that the PICC line external catheter was measured. However, there was no documentation on the

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TAR and on progress notes to show the measurement obtained during this day. The same TAR showed no nurses' initial for January 31 and on February 14, 2016 (Sundays) to indicate that the PICC line was measured as ordered. There was no documentation on the progress notes to show that the PICC line was measured and what was the measurement obtained during those days.
R3's care plan dated January 26, 2016 showed that the resident has MRSA (Methicilline Resistant Staphylococcus Aureus) to right BKA, being treated with antibiotics via right upper arm PICC line. This care plan showed multiple interventions which included, "Measure PICC line external length weekly and as needed."
The facility's intravenous policy and procedure dated July 30, 2014 showed that the length of the external catheter will be measured weekly to monitor movement.
The facility identified only one resident (R3) in the facility with PICC line out of 111 residents in the facility.
On February 18, 2016 at 1:25 PM, E3 (Director of Nursing) stated that per protocol, if the TAR was not initialed/signed, it was not done. Per E3, the facility cannot find any documentation on R3's record to show the measurement obtained on January 31, February 7 and 14, 2016 to monitor the length of the external PICC line catheter.
2. Based on observation, interview and record review, the facility failed to ensure that the medication administration documentation reflected accurate information for a resident.

This applies to one resident (R11) in the supplemental sample observed for medication pass.

R11 was admitted on September 10, 2014 with

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diagnoses including Parkinson's disease, enlarged prostate without lower urinary tract symptoms, chronic obstructive pulmonary disease, sequelae of cerebrovascular disease, heart failure, rheumatoid arthritis and dementia without behavioral disturbance according to the electronic medical records.

The physician order summary report showed an order dated January 29, 2016 with start date of January 30, 2016 for Bumex Tablet 0.5 mg (milligrams), one tablet, oral daily related to enlarged prostate, to be given one time per day for five days.

The Medication Administration Record (MAR) from January 1, 2016 - January 31, 2016 showed that Bumex Tablet 0.5 mg, oral daily was given at 9:00 AM starting January 30,2016. The MAR from February 1 through February 29, 2016 showed nurses' initials from February 1 through February 17 to indicate Bumex was given. The last dosage should have been given on February 3, 2016 based on the physician's order.

On February 17, 2016 at 9:30 AM, R11 was observed during medication pass. The medications were administered by E12 (Licensed Practical Nurse/LPN). R11 received a liquid supplement, a nebulizer treatment, and eleven oral medications. Bumex 0.5 mg was not given. R11 stated that he receives so much medications.

On February 18, 2016 at 11:05 AM, E3 (Director of Nursing/DON) said there had been a problem with the MAR electronic medical record. E3 said discontinued medications were not being deleted. E3 said the nurses should have informed her when this problem started in the medical records.

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E3 said the nurses should document in the MAR (for Bumex), "nn" to indicate that there was documentation entered in the nurses' progress notes regarding this particular order.

The nurses notes on February 6, 2016, February 7, February 8, and February 17, 2016 showed documentation of the order, "Give 1 tablet by mouth one time a day related to ENLARGED PROSTATE WITHOUT LOWER URINARY TRACT SYMPTOMS (N40.0) 1x a day x 5 days therapy finished." None of the notes on the above dates documented that the medication was not administered. E3 said the nurses should document that the medication was not given and not sign the MAR with their initials.

On February 18, 2016, the policy for electronic documentation was requested from E3 but none was provided.

(B)

300.2100

Section 300.2100 Food Handling Sanitation

Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that food/utensils were stored/prepared under sanitary conditions and was not contaminated by gloves worn by dietary personnel during lunch meal service observations.

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| S9999 | Continued From page 6<br>Findings include:<br><br>On February 16, 2016 during initial tour starting at 9:30AM, thawing ground beef (in plastic wrap) was noted placed side by side on the lower shelf with fresh lettuce (loosely packed in plastic) in the cooler. Some of the lettuce heads were exposed from out of the bag. Both the trays were within three inches from each other. This observation was pointed out to E6(Food Service Manager).<br>On February 17, 2016 at 10:05AM, E6 was observed making packed lunch for a resident in the kitchen. E6 proceeded to make a bologna sandwich made out of bread slices, bologna, cheese and lettuce leaf which was brought out of the cooler. E6 then briefly washed the lettuce leaf under cold water for one second before placing it on top of the bologna and cheese.<br>The cooler was revisited on February 17, 2016 at 10:08AM. The thawing ground beef now with running blood in plastic wrap was observed remaining within 3 inches of exposed lettuce heads.<br>The lunch meal tray line service was observed on February 16, 2016 beginning at 12:25PM on the 1st floor dining room. The lunch menu included chicken fried steak (entrée) with cream gravy, buttered mashed potatoes, green beans (vegetables), mandarin oranges, bread, coffee/tea. E10 (dietary aide) wearing gloves was observed plating the entrée, vegetables, mashed potatoes and bread for the residents. E10 was also handling the trays, tray tickets and dome covers for the plates. E10 picked up scoops allocated to each food item with gloved hands and continued to scoop out the food onto each plate. With the same gloves E10 also picked up bread slices from bagged bread and placed it atop the food on each plate. This procedure was repeated until meal service was completed on the | S9999 | | |

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1st floor.
The lunch meal service was continued on the 3rd floor nurses station on the same day beginning at 12:50PM. The plates were transported uncovered via elevator to the 3rd floor nurse's station from the 1st floor dining room. E10 wearing gloves was handling trays, tray tickets, dome covers for the plates, plating the food items and handling bread slices as was noted on the 1st floor dining room. E11(dietary aide) wearing gloves was observed using scoops plating pureed entrée and vegetables, ground meat and gravy. E11 also handled meal tickets and trays. With the same gloves E11 adjusted the ground meat on the plates. Gloves were not changed in-between tasks for the entire meal service on both floors.
The policy and procedure titled "Handling Fresh Fruits and Vegetables"(undated) showed that fragile fruits and vegetables will be washed by filling a clean sink with cold water, allowing the produce to soak while gently agitating the produce. The policy and procedure titled "Hand Hygiene Policy"(undated), showed that hand washing with soap and water be done before and after eating or handling food.
On interview with E6 on February 18, 2016 at 2:05PM, E6 stated "I don't think we have a policy for tray line or serving from the steam table"
Part 750: FOOD SERVICE SANITATION CODE
Section 750.170 Raw Fruits and Raw vegetables
Raw fruits and raw vegetables shall be thoroughly washed with portable water before being cooked or served.
Section 750.300 General-Food Transportation
Except for raw fruits and raw vegetables, during transportation, food and food utensils shall be kept and packed in covered containers or completely wrapped or packaged to be protected from contamination.

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| S9999 | Continued From page 8<br>Section 750.512 When to wash hands<br>f) During food preparation, as often as is necessary to remove soil and contamination and to prevent cross contamination when changing tasks.<br><br>(AW) | S9999 | | |