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
	IL6004451	A. BUILDING: _____ B. WING _____	03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

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S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1220b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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 were not met as evidenced by: Based on observation, interview and record review the facility failed to assess and monitor two residents (R11 and R15) change in bowel elimination, notify the Physician of these changes, and failed to utilize appropriate assessment tools for pain management/comfort for one resident (R1). This deficient practice resulted in R11's hospitalization and diagnosis of severe fecal impaction and R1 received ineffective pain management causing R1's pain to escalate over the course of 2 weeks.	S9999		

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This applies to 2(R11, R15) of 6 residents reviewed for incontinence/bowel management in the sample of 15, and one (R1) of 13 residents reviewed for hospice pain management in the sample of 15.

The Findings Include:

The facility's medical record documents that R11 is a 66 year old female admitted on January 30, 2017 with the following diagnoses: Bilateral (both) above the knee amputations, sacral pressure ulcer, hypertension, and coronary artery disease.

The admission Minimum Data Set (MDS) for R11 dated March 3, 2017 documents: Toilet use- total dependence (full staff performance every time) and always incontinent for bowels.

The POS (Physician's Order Sheet) and MAR (Medication Administration Record) for R11 documented the following orders: Hydrocodone/APAP (Norco) 10-325mg oral every 4 hours as needed for pain (February 25, 2017); Anusol HC (Hydrocortisone) suppository, insert rectally twice a day (March 15, 2017); Review of R11's MAR for March/2017 showed that R11 had been taking the Norco up to 4 times a day.

The facility's nurse's notes dated February 1, 2017 documented R11 had 2 bowel movements (BMs).
The next documented BM was February 6, 2017.

Nurse's notes dated February 8 & 9 documented, R11 complained of sharp abdominal pain, R11 stated she has to use the toilet, had a small pasty

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bowel movement with firm abdomen and bowel sounds hypoactive. R11 was given Senna Laxative and fleet enema and had BM.

The nurse's notes contained no documented BMs from March 1-9, 2017.
However, one note dated March 3, 2017 documented, resident stated she feels like "she has to go."

March 10, 2017 the nurse's notes documented that R11 had a BM which contained blood. R11 had emesis (vomit) on March 11, 2017 and was refusing lunch due to upset stomach. She was given Norco at 8:30 am and 12:35pm.

On March 12, 2017 the nurse's notes documents that R11 complained of feeling the need to have a BM but can't get it out. CNA (Certified Nursing Assistant) staff states resident has stool seen in the rectum that is hard and cannot be passed. At 10:30pm, she did not void (urinate) all day, and there was blood in her stools. Z1 (Medical Doctor) ordered laxative and straight catheterization.

On March 14, 2017, R11 was again complaining of constipation.

On March 15, 2017, the nurse's notes documents that R11 complained of abdominal pain at 7:20am and received an order for Anusol HC (Hydrocortisone) suppository.
At 10:38am, R11 was in bed and appeared drowsy. E3 (Registered Nurse/RN) entered R11's room to administer Anusol suppository and Norco for pain. Upon entry into the room, R11 was under her covers and lying on a bed pan. E3 stated she would come back once R11 was done. At 11:14am, E3 went back to R11's room and

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emptied the bed pan. There was a hard dark colored stool noted in the bed pan, along with some soft stools. E3 stated R11 was constipated. E3 wiped R11 with tissue, and then there were liquid and pasty stools coming from her rectum. Z1 entered as E3 wiping the stools from R11. There were pasty stools on her buttocks at the time. Z1 then assessed R11's stomps, and stated "we have to get you eating." E3 got E5 and E6 (both Certified Nursing Assistants/CNAs) to finish cleaning/bathe R11. As staff cleansed R11, she groaned and complained of severe abdominal pain. R11 was sent to the hospital at 2:45pm after continued complaints of abdominal pain.

On March 15, 2017, E2 (Director of Nursing) provided R11's bowel and bladder tracking. On March 16, 2017 at approximately 9:00 am, E2 stated the facility does not have a bowel and bladder program. R11 remained in the hospital. E2 stated that tracking forms are kept in the binders by the CNAs on the unit. As of 1:50pm on March 16, 2017, there was no bowel and bladder tracking provided. There were no tracking sheets in the CNA binder for R11. Upon entry into E2's office, E7 (RN) was sitting at a desk documenting on papers. There were a pile of bowel and bladder tracking forms on the desk. E2 stated she has the tracking sheets for R11. E2 then provided sheets for March 1- 15, 2017, which documented R11 was having 1-4 bowel movements daily. This was inconsistent with her nursing notes, and no description of all the stools documented. E2 provided the tracking forms for January-February 2017. E2 then searched through the pile by E7 and located the forms. E2 stated that E7 came in to assist with forms. There were several days of the incontinence section not being completed. The tracking sheets

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were not consistent with R11's nursing notes.

On March 16, 2017 at 3:00pm, Z1 stated R11 had been having hard stools, with some solid dark color stools. Z1 stated there would be blood noted after R11 had hard stools. Z1 stated R11 received suppositories and enemas but her stomach pain was not related to constipation. Z1 added when R11 had a soft stool, it meant at that time she was momentarily relieved. Z1 stated R11's stools are not consistent with constipation. Z1 also stated that it is the facility's responsibility, and not his to monitor R11's stools every day.

A hand written Interim Care Plan dated January 30, 2017 for R11 documented: Constipation- will have a bowel movement every 2-3 days. Monitor for bowel movements and record. Computer generated care plans with a reviewed/revision dated of February 9, 2017 did not contain a care plan for constipation or elimination.

R11's CT (Computed Tomography) report from the local hospital dated March 15, 2017 documents:
Impression: Severe fecal loading and rectal impaction with findings suggestive of stercoral colitis.

The facility's policy titled "Effective Bowel Elimination" documents:
When a potential problem, constipation/diarrhea, is identified, a care plan will be developed by the interdisciplinary team, to include nursing and dietary.
-Each day, the bowel record will be reviewed and the laxative list for residents who have not had a bowel movement in three days will be initiated.
Face Sheet documents R1 was admitted on 10/26/2013 with admitting diagnosis of debility,

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arthritis, muscle weakness and difficulty walking.

On March 14, 2017 at 10:02 AM, R1 was laying in bed with a large bruise on the temporal forehead and attached steri-strips. R1 also had bruises to the face and hands. R1 was unable to answer any questions about the bruising. Z2 (power of care for R1) was in the room visiting, Z2 said she visits twice a week and hopes everything is well.
On March 15, 2017 at 9:49AM, E2(Director of Nursing) said the wound care physician had just changed R1's stage 3 pressure sore wound.
On March 15, 2017 at 10:00AM, R1 was laying in bed, there was no one else in the room. R1 was moving her head from left to right and groaning, "my butt hurts." There was no accessible call light. E4(Nurse) was immediately made aware at the nursing station and responded R1 had a sacral wound treatment with the wound care physician earlier and received no pain medicine. E4 went into the room and quickly exited and said, R1 did not complain of any pain. E4(Nurse) went back into R1's room, shortly after communicating there was no pain. At 10:07AM, E4 asked R1 if she was in pain, R1 looked from the left to the right and in a low voice said " my butt, my butt hurts." As E4 began to verbally question R1 about the pain R1 became confused, and said, "I don't know , I don't know" with tears in her eyes. E4 said she assesses R1 using a verbal pain scale, then E4 said she would get the aides to change R1's position in bed. E4 said she would administer Tylenol to R1.

On March 15, 2017 at 10:12AM, E15(Certified Nursing Assistant, CNA) entered the room to change R1's position. R1 eyes enlarged and she began to cry during the turning.
On March 15, 2017 at 10:15AM, E17(Social Worker) said R1 always grimaces and moans,

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that is her usual state.
On March 15, 2017 at 1:09 PM, R1 was sitting in an adult recliner slumped down, crying facing the window in the room with the door opened. There was no one else in the room. R1 repeated several times in a low pitched voice "help me , help me." There was no call light accessible. Immediately E4(Nurse) was informed at the nursing station. E4 responded, "I will send the aids down to her room to reposition R1". E4 made no observation assessment.
On March 15, 2017 at 1:12 PM, E13(CNA) and E14(CNA) both entered the room and began to move R1 from the adult recliner to the bed. R1 was groaning and grimacing during the procedure. During the transfer, E13(CNA) said she is very familiar with R1 and said R1 is always in pain and is on hospice and R1's pain and comfort is not being managed. E13 said she worked on March 11, 2017 and came into the dining room and saw R1 on the floor with a pool of blood all over. That is why R1 has all of the bruises. R1 fell out of the chair because of the pain on her butt. With all of the blood on the floor due to the facial laceration, R1 just kept complaining about butt pain. They want us to move R1 in bed every 2 hours, get her up in the adult recliner, "R1 can't take all of this she is on hospice. R1 has been in significant pain for the last 2 weeks, I told the nurse, no one listens. I care about this resident, R1 is just not getting what she needs".
As R1 was placed in bed, the dressing on R1's sacrum was soiled and dated 3/14/2017.

On March 15, 2017 at 1:26 PM E7(Nurse) entered the room and said moving forward she will call and get hospice to make new pain management/comfort orders for R1 because R1 should be kept pain free and comfortable, that is

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the goal of hospice.
On March 15, 2017 at 1:36 PM E4(Nurse) entered the room and said she used the verbal pain scale for R1 earlier and she was rated a 4 on a scale of 1-10, and administered Tylenol. E4 said R1 has an order for Morphine and E4 administered Morphine at this time. At 1:40 PM, E7(Nurse) changed the dressing for R1's stage 3 sacral sore.

Physician Orders, Hospice Visit and Social Service Notes dated November 22, 2016 shows R1 was admitted to hospice. Physician Order dated November 30, 2016 documents the initiation of Morphine Sulfate 5 milligrams by mouth every hour as needed for pain. Hospice Intake Sheet dated February 23, 2017 states, R1 was switched to another Hospice provider on 2/23/2017 with orders for Morphine Sulfate 5-10 Milligrams every 4 hours for moderate to severe pain/dyspnea and Acetaminophen Suppository 650 Milligrams rectal every 6 hours for mild pain/fever. The last Pain Questionnaire implemented for R1 was dated December 8, 2016. Wound Care Specialist Initial Evaluation Notes dated January 25, 2017 document R1 developed a stage 3 pressure ulcer of at least 1 days duration and Fall Incident Report dated March 11, 2017 states, R1 fell out of the adult recliner sustaining facial and hand lacerations. There was no Comprehensive Pain Assessment for R1 following the development of the sacral sore or the fall. Social Service Note dated March 2,2017 states, R1 is on Hospice due to cognition and health decline and recently changed hospice providers. R1 is confused and short and longterm memory is not good. The Medication Administration Record for March of 2017 was reviewed. The Pain Assessments are rated no pain for March 1, 2017 through March 14, 2017

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and R1 received Tylenol 650 milligrams on March 6, 2017 and March 13, 2017 and received Morphine on March 11, 2017. No further pain medications were administered.

The Hospice Care Plan dated November 22, 2016 and revised on March 2, 2017 goals is as follow, " For facility and Hospice to work together as a team in creating an environment and level of care that will focus on building R1's needs. There is no pain management or comfort interventions in the plan of care. The pressure ulcer care plan initiated on January 2017 does not address pain but does list to turn and reposition and lay down after meals. Restorative Program for March 2017 documents R1 is still on Passive Range of Motion and turning and repositioning programs. Minimum Data Set Brief Status for Mental Health dated March 2, 2017 documents R1 with moderately impaired cognition.

The Facilities' Policy titled Pain Management last revised July 2014 states, " Residents should be evaluated and treated for pain upon admission, and at least quarterly, with any fall, development of pressure ulcer and with any significant change, staff will assess the resident for pain and record the assessment on the pain Assessment Form.

On March 16, 2017 at 10:00AM, E2(Director of Nursing, DON) said we are moving forward and initiated a PANAID scale for R1 to utilize for pain assessment, this is for confused residents. We should work together with hospice to ensure residents are assessed and managed effectively for pain and comfort. E2 said there was no comprehensive pain assessment and it will be implemented along with additional pain/comfort measures/orders for R1.

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On March 16, 2017 at 3:11 PM, Z1(Medical Doctor) said he was the physician for R1 and pain/comfort are the goals for hospice. Z1 said the nurses should contact the hospice doctors for pain/comfort order and changes.
R15 admitted to facility December 22, 2016 with complaint of abdominal pain. No further assessment of abdominal pain. R15 was being consulted for hospice services on admission.
December 24, 2016 nurses notes documentation includes the only December 2016 bowel movement monitoring, stating "had a loose BM" (bowel movement), "resident stated "It's been a while."
R15's January 03, 2017, 5:15 PM progress note documents "resident complaint of rectal pain at 5 PM. Dilaudid given per request. Looked at bottom, no open sores, no discoloration noted, barrier cream applied, will monitor." No further monitoring was documented related to rectal pain.
The next nurse's progress note is dated January 11, 2017 documenting physician ordered a stool softener (Senna tab 8.6 milligram daily).
R15's next descriptive bowel movement documentation was January 14, 2017 "R15 had one time (X1), small mushy BM."
The next nursing progress note dated January 20, 2017, 5:50 PM including complaint of pain on urination. No further documentation of assessing R15 for pain or difficulty with urination.

The next nursing progress note dated January 21, 2017 9:00PM including "R15 had blood on anus when nurse aide changed R15. No wounds noted, area opening red and somewhat excoriated." R15 vomited brownish liquid. Nurse called to bedside by nurse aide. There is no documentation R15's physician was notified of these condition changes. No monitoring of

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residents rectal bleeding or vomiting documented after initial observation January 21, 2017 at 9:00PM.

The next nursing progress note January 22, 2017 at 9:15AM, including resident is slow responding to verbal stimuli, blood pressure 100/78, significantly lower than previous readings / baselines documented. No documentation of physician notified of sluggish response and decreased blood pressure.

The next nursing progress note January 22, 2017 4:00PM including blood pressure lower 92/56, no documentation of physician notification.
The next nursing progress note January 22, 2017 4:20 PM stating "no respirations, no blood pressure or pulse, confirmed with another nurse." R15's physician was called at 4:40 PM.
Other than the December 24, 2016 and January 14, 2017 nursing progress notes, there is no other descriptive documentation of R15's bowel movements / even with symptoms of gastrointestinal changes.
During interview March 17, 2017, 9:55 AM E2 (director of nurses), stated after reviewing R15's medical records E2 was unable to locate any other documentation than that listed above regarding change in condition, descriptive bowel movement monitoring or physician notification of change in condition.

(B)