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
	IL6003008	A. BUILDING: ______ B. WING ______	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF BERWYN, THE	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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S 000	Initial Comments Complaint Investigation: 2293585/IL146874 Complaint Investigation: 2294610/IL147926	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Findings 300.610a) 300.1210b) 300.1210c) 300.1210d)1 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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.

These Requirements were NOT MET as evidenced by:

Based on interview, observation and record review, the facility failed to follow physician orders and administer pain medication to include hydrocodone 10/325 and oxycodone 30mg. This failure affected 2 of 3 residents (R7, R6) both reviewed for pain management. This failure resulted in (R7) who was admitted following a surgical amputation being without pain medication for over 24 hours and reporting pain 8/10, and (R6) being without scheduled pain medications for 5 days with complaints of pain 7/10 in her back.

Findings include:

1. R7 was admitted to the facility on 6/3/22 with a diagnosis of orthopedic aftercare following surgical amputation, anemia, diabetes type II,

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anxiety. Disc degeneration, osteomyelitis, acquired absence of right and left toes.

On 6/14/22 at 2:55PM, R7 reported to surveyor pain 8/10 in bilateral feet. R7 said he has been without his pain medication for 24 hours.

R7's medication administration details documents R7 received hydrocodone on 6/13/22 at 8:54Am. There is no documentation of any pain medication received after that administration.

On 6/14/22 at 300PM, R7's hydrocodone medication was not available on the medication cart.

On 6/17/22 at 133pm, observation of facility convenience box observed R7's hydrocodone available for use. V4 (ADON) said that agency nurses do not have access to emergency box medications and would not be able to utilize it for medications not available.

R7 physician order dated 6/3/22 documents hydrocodone 10/325, Give 1 tablet by mouth every 8 hours as needed for pain.

R7's care plan dated 6/10/22 documents R7 is at risk for pain related to osteomyelitis, posterior neck excoriation and transmetarsal amputation. Interventions dated 6/10/22 documents: I would like the staff to monitor/report to nurse any nonverbal signs/symptoms of pain or requests for pain treatment.

R7's pharmacy notes dated 6/21/22 documents on 6/14/22 at 329PM, refill requested over the phone at 6/15/22 1243AM, 3 tablets were delivered.

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S9999	Continued From page 3 Facility Pain policy revised 7/28/21 documents: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. Under procedures: upon admission or readmission, the nurse will assess resident for pain. For those identified with pain upon admission, the nurse will assess for pain. For those identified with pain upon admission/readmission assessment, an order for pain medication will be obtained. If available in the convivence box, the pain medication ordered will be administrated the resident as soon as possible. If the resident is still unrelieved of pain despite pharmacologic and nursing measures, the resident physician will be called to refer the lack of relief. Facility physician order policy revised 7/28/21 documents: It is the policy of the facility to ensure that all resident medications, treatment and plan of care must be in accordance to the physicians orders. The facility shall ensure to follow physician orders as it written in the Physician order sheet. 2. R6 was admitted to the facility on 4/14/22 with a diagnosis of acute respiratory failure, hypertension, anxiety, bipolar, insomnia, anemia, type two diabetes, bipolar disorder, and congestive heart failure. R6's physician order sheet dated 5/25/22 documents oxycodone 30mg one tablet by mouth every 6 hours for moderate to severe pain. On 6/14/22 at 3:10Pm, R6 said she was having back pain 7/10. R6 said she has been without pain medications for a few days because they need a prescription.	S9999		

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R6 medication administration note for oxycodone 30mg document: 6/11/22 at 00:34 awaiting arrival from pharmacy; on 6/11/22 at 5:48 awaiting arrival from pharmacy; 6/12/22 at 12:25 needs prescription; 6/12/22 at 18:30 medication on order; 6/13/22 at 13:15 medication unavailable; 6/13/22 22:37 unavailable; 6/14/22 21:51 medication on order.

R6's controlled drug administration sheet for oxycodone 30mg documents: last dose of medication was given on 6/10/22 at 1700.

R6's care plan initiated 5/2/2022 documents: R6 is at risk for pain related to diabetes and generalized pain. Interventions initiated 5/2/22 document: R6 would like to receive pain relief upon request

R6 pharmacy note documents a prescription for oxycodone was received on 6/14/22 and medication was delivered on 6/15/22 at 1243am.

Pain policy revised 7/28/21 documents: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. Under procedures: upon admission or readmission, the nurse will assess resident for pain. For those identified with pain upon admission, the nurse will assess for pain. For those identified with pain upon admission/readmission assessment, an order for pain medication will be obtained. If available in the convivence box, the pain medication ordered will be administrated the resident as soon as possible. If the resident is still unrelieved of pain despite pharmacologic and nursing measures, the resident physician will be called to refer the lack of relief.

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S9999	Continued From page 5 Facility physician order policy revised 7/28/21 documents: It is the policy of the facility to ensure that all resident medications, treatment and plan of care must be in accordance to the physicians orders. The facility shall ensure to follow physician orders as it written in the Physician order sheet. (B) 2 of 2 Findings 300.610a) 300.1210b 300.1210d)6 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	S9999		

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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 and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to follow their abuse policy by not protecting one resident (R6) from physical abuse. This failure resulted in one resident being slapped across the face by another resident and not feeling safe at the facility for one of three residents reviewed for abuse.

Findings include:

R6 was admitted to the facility on 4/14/22 with a diagnosis of acute respiratory failure, hypertension, anxiety, bipolar, insomnia, anemia, type two diabetes, bipolar disorder and congestive heart failure. R6's brief interview for mental status dated 5/31/22 documents a score of 13/15 which indicates cognitively intact.

On 6/17/22 at 1:51PM, R6 said she was in common dining room when R8 was asking about

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the remote control and then started yelling she was going to turn off R6's oxygen. R6 said she tried to ignore R8 but that made her more upset. R8 tried to unplug her oxygen concentrator and when R6 got up to stop her, R8 slapped her across the face. R6 said she felt anger and does not feel safe at the facility. R6 said R8 has been verbally aggressive with her in the past by calling her names and yelling at her unprovoked, since she moved into their room. R6 said she told the staff at the facility about yelling, and they asked R6 to move rooms. R6 said she shouldn't have to move rooms if she is not the problem.

On 6/17/22 200Pm, R10 who was alert and oriented at time of interview, said he witnessed R8 yelling at R6 and attempted to unplug R6's oxygen. R10 said she saw R8 then slap R6 across the face.

Facility abuse investigation report form submitted to state office dated 6/22/22: On 6/15/22 R8 allegedly was physically aggressive towards R6. Under did the findings indicate that abuse occurred I documents yes. Based on the interviews with the staff and residents. R8 did slap R6 but she appeared to have an altered mental status with signs of confusion. It was not R8 intent to harm R6.

On the facility reportable dated 6/22/22 that was presented to the surveyor onsite on 6/23/22 documents: Under did the findings indicate that abuse occurred it documents no. Based on the interviews with the staff and residents. R8 did make contact with R6 face but she appeared to have an altered mental status with signs of confusion. It was not R8 intent to harm R6. R8 does not recall making contact with R6's face. Also added interview with R8 that documents: R8

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said she did not hit R6.

On 6/24/22 at 12:16PM, V2 (Administrator) said that the reportable that was given to the surveyor on 6/23/22 is the correct reportable. V2 explained that he sent a final report but then sent a corrected version immediately after due to changes that were made. V2 said the updated reportable was changed to abuse not occurring because R8 did not have an intent to harm R6 due her confused state and denial of event. V2 said he is not denying the event of R6 being slapped by R8 but it is not considered abuse because R8 could not verbalize her intent to harm R6. V2 also said R8's interview was added to final report and correction to resident interview.

R6's progress note dated 6/15/22 documents: Resident placed on 24-hour monitoring after she was the target of aggression. Writer met with resident to see how she was doing. Resident stated that she is fine now. Resident was asked if she feels safe in the facility, resident states although she was the target, she still feels safe in the facility and has no further concerns. Resident says that she knows social services is at her service and will seek them when she needs counsel.

On 6/24/22 1230PM, verified with the Illinois of department of public health clerical staff that there was no corrected or any additional reportable for R6 submitted.

R6's care plan initiated on 5/26/22 documents; R6 was the recipient of aggression.

Facility policy abuse and neglect dated 1/17/22 documents: It is the policy of the facility to provide professional care and services in an environment

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S9999	Continued From page 9 that is free from any type of abuse, misappropriation of property, exploitation, neglect or mistreatment, Abuse is willful infliction of mistreatment, injury, unreasonable confinement, intimidation or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse. Physical abuse includes but not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking grabbing, pinching, twisting and rough handling. (NO VIOLATION)	S9999		