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
	IL6000335	A. BUILDING: ______ B. WING ______	02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF WESTMONT	**512 EAST OGDEN AVENUE WESTMONT, IL 60559**

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1210b)
300.1210d)3)
300.1220b)2)
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

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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:
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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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

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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 are not met as evidenced by:

Based on interview and record review facility failed to follow it's pain management policy and procedure and failed to thoroughly assess and evaluate one resident's (R13), complaints of persistent, recurring, relentless, excruciating severe pain in a timely manner as a means to determine location, origin, etiology and root cause of the pain. This failure applies to 1 of 9 residents (R13), reviewed for pain related to ill fitting medical devices.This failure resulted in 10 days of prolong, relentless pain and suffering due to delayed timely medical evaluation and intervention.

The findings include:

R13 was admitted to facility 01/21/2014 with a diagnosis including right tibia / fibula fracture. R13 was admitted with a long leg posterior mold brace attached to the right leg, secured with adhesive closure straps across the anterior portion of leg. The brace encompass the upper thigh down to, under and around the right foot.

R13's 01/28/2014 minimum data set assessment (MDS), includes assessment: always able to understand and be understood, alert, with

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independent cognitive skills and no behavior or mood problems. This MDS also includes presence of constant pain at a level 10 on a scale of 0-10
(10 being the worst pain imaginable), that interferes with ability to function, including ability to sleep at night.

During a 01/30/14, 12:20PM interview, R13 stated, "I wish they could stop my pain, it's horrible. The staff know about it and tell me they can not do anything about it." R13 also said the pain medication provided only works for a little while without much relief.

During a 02/04/14, 9:45AM interview, R13 stated, "I had horrible pain in my ankle, inner ankle, heel and inner upper thigh area. The pain was a level 12 on a scale of 1 - 10. The pain was so horrible I could not sleep at night, I'd scream all night and I know I was keeping my room mate up. The nursing staff knew about my pain and they said they couldn't do anything about it, I'd have to wait for the orthopedic to fix it. I did not get relief from the pain until the orthopedic doctor fixed my brace on 01/31/14. The brace was too tight, causing severe pressure and hurting me. I had horrible pain from the time I was admitted (01/21/14), until the orthopedic doctor fixed my brace last Friday, (01/31/14 = 10 days). Now that the brace is adjusted, my pain is much better."

During a 02/04/2014, 2:30PM interview, E18 (nurse aide), said, (R13) complained of pain to his right leg from the day he was admitted and frequently there after. On 01/25/2014, (R13), was holding the sides of his face and rocking back and forth complaining of severe pain to the right leg. E18 attempted to reposition the leg but R13 continued to voice severe pain so E18 notified

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E19 (the nurse). E19 contacting R13's doctor and then removed R13's right leg brace. R13's right heel and area above the heel (pointing to Achilles area), was the color "Black."

During a 02/04/14, 4:00PM interview, Z5 (physiatrist), said R13 was admitted with a right tibia / fibula fracture and was first assessed by Z5 on 01/24/2014 (4 days after admission). Z5 said, R13 complained of severe uncontrollable right lower extremity pain and was very agitated about it. Z5 said she is involved with R13's pain management and stated, "I believe we all (facility staff), thought [R13's] complaints of pain was due to his fractures. We should have done a more thorough pain assessment to evaluate exact location and possible etiology of the pain." Z5 also stated, "I did not do a comprehensive pain assessment to determine the root cause of [R13's] pain." Z5 said, R13 was placed on a long acting OxyContin twice a day due to ineffective pain relief from the Norco. R13 continued to voice complaint severe right leg pain, so more OxyContin was ordered for break through pain, as needed (PRN).
Z5 finished her interview saying, "I don't think [R13's] pain got worst, because it was always severe."
On 01/24/14 Z5 ordered OxyContin 10 mg every 12 hours for 7 days, then on 01/28/14, Z5 ordered to discontinue Norco and administer OxyContin 5 mg every 4 hours PRN for pain, please administer one one hour before therapy.

R13's 01/21/2014 admission physician orders include complete pain evaluations, Norco 5-325mg one tablet every 4 hours PRN for pain, Tramadol 50mg one tablet every 12 hours PRN for pain and Tylenol 325mg 2 tablets every 4 hours PRN for pain. There were no parameters

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ordered or obtained to define when to administer one pain medication verses the other.

Facility pain management policy and procedure includes:
Initial evaluation : "Whenever possible the underlying cause of pain is identified and addressed through review of relevant medical history and completion of comprehensive pain evaluation."

R13 had 2 pain evaluations conducted 01/21/14 and 01/26/14. Neither of these 2 assessments included sufficient information to assist in identifying the underlying cause of R13's pain.

The pain policy also includes nursing should conduct on-going subjective pain evaluations, that include description and location of the pain, when and why the pain is occurring.

R13's medication administration records (MAR's) and nurses progress notes document 14 separate times PRN Norco or PRN Tramadol was administered for pain at levels 4 - 8 out of 10. R13's nursing progress notes fail to include pain levels, 6 of the 14 times PRN pain medications were administered (01/24/14 at 4:31AM, 01/25/14 at 3:04PM, 01/26/14 at 2:06PM, 01/27/14 at 2:16PM and 6:42PM and 01/29/14 at 11:02AM.)

Per 01/29/14 record review; R13's 01/21/14 - 01/29/14 pain assessments on MAR, nurse progress notes and pain evaluations all contain conflicting information regarding pain levels: January 2014 MAR included daily pain assessment 01/24/14 through 01/29/14 scored 0 - 3, on a scale 0 - 10 (10 being the worst pain imaginable). R13's nurses progress notes document his pain at 4 -8 out of 10. R13's

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S9999	Continued From page 6 01/21/14 and 01/26/14 pain evaluation forms document pain level at a 2 on a scale of 1 - 10. No comprehensive pain assessment was performed to evaluate location and possible causes, even with the need to increase his pain medication to a long acting scheduled OxyContin on 01/24/14 and OxyContin every 4 hours PRN (as needed), for break through pain on 01/28/14. R13's physician progress notes by Z5 included: 01/24/14 = "Up the past several nights due to pain in right lower extremity (RLE)." "Per therapist reports, R13's therapy was limited by pain yesterday (01/23/14)." 01/28/14 = "OT (occupational therapy), requires maximum encouragement because of pain." "Irritable." 01/30/14 = "Anxious about pain." "Very nervous anticipating pain." presence of right foot pain. 01/31/14 = "Poor sleep at night due to pain in leg. Brace had been fitting poorly but now better. Leg pain pretty good today after brace adjusted." R13's 01/30/14 initial evaluation by Z9 (wound physician), included recommendation for R13 to be seen by Orthopod and needs brace evaluated. R13's 01/31/14 orthopedic physician progress note by Z8, include: "He (R13), is having excessive pressure from this brace. The brace has recently been modified by the brace shop to relieve pressure with additional padding. We will also have him (R13), wear it loosely." Facilities pain management policy also includes nursing should conduct on-going subjective pain evaluations, that include where, when and why. This pain protocol describes the need to develop / revise an individual pain management care plan.	S9999		

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The facility failed to develop and implement an individual plan of care for R13 to address the need to evaluate for pressure, skin alterations and circulation impairments that can result from use of a long leg brace. R13's care plan also failed to include the need to assess, monitor and evaluate recurrent, unrelieved complaints of pain as a means of analyzing possible cause / etiology of the pain.

R13 sustained prolonged (10 days), severe, unrelieved pain and suffering to right lower extremity as the result of untimely pain evaluation and intervention to relieve constant severe pressure from the leg brace.

(B)

300.1210b)
300.1210d)6)
300.1220b)2)
300.1220b)3)
300.3240a)

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.
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:

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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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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.

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These requirements are not met as evidenced by:

Based on observation, record review and interview the facility failed to conduct thorough fall risk evaluations for one resident (R7), failed to evaluate the circumstances and analyze the root cause of R7's falls, failed to assess the effectiveness of current interventions and failed to monitor and supervise R7 to prevent him from from falling and sustaining injury. This is for one of six residents reviewed for falls in the sample of 24.
This failure contributed to R7 falling and sustaining a laceration to the forehead and receiving 7 sutures.

The findings include:

Review of R7's most recent MDS (minimum Data Set) dated 12/1/13 shows R7 has diagnosis including hypertension, arthritis, non-Alzheimer's dementia, Parkinson's and muscle weakness. It shows R7 requires physical assistance with all activities of daily living except eating and is not capable of any type of weight bearing mobility without staff assistance to stabilize him. This MDS shows R7 is 68 years old, 5'10" and 278 pounds and indicates the same mobility information as the annual MDS of 3/1/13.

Review of R7's incident reports show the following:

2/8/13 2:45am Found on floor next to bed. Cut to left leg.
5/10/13 9:40am Transfer by nurse's aide from shower chair to bed.

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5/21/13 8:50pm Found on floor. R7 was looking for his wallet.
6/12/13 4:00am Found on floor. Noted large old ecchymosis on right hip/upper buttocks. New ecchymosis on left forearm.
6/13/13 10:10pm On floor by bed. Rolled out of bed. Neurologist re-evaluated without any changes on 7/13/13.
7/25/13 10:51pm Found sitting on floor. R7 was reaching for something and fell.
8/4/13 7:50am Found on floor. R7 was trying to go to bathroom.
8/21/13 7:18am Found on floor inside room. R7 stated he had to urinate.
9/21/13 8:47pm Found on floor in hallway. Had been waiting for restorative to walk him since 2:00pm.
10/5/13 1:00am Lying next to bed on floor.
10/16/13 5:30am Rolled out of bed.
12/11/13 9:55pm Found on floor
12/23/13 1:30am Found on floor in bathroom
1/7/14 5:12am Found on floor next to bed
1/26/14 7:00am Found on floor next to bed with laceration to forehead. 7 sutures to right forehead area.

R7 was observed to be sleeping in his wheelchair on 1.29.14 at 1:30pm. His right side was leaning forward with his right arm hanging down in front of his body almost touching the floor. The privacy curtain was drawn across so R7 could not be seen from the doorway. R7 responded to his name and was pleasant and cooperative. R7 stated he falls asleep off and on all day and night, for short periods. R7 knows when he has to urinate and will put the call light on but if staff don't come soon he will take himself. R7 stated he uses a urinal that is kept in the bathroom. R7's urinal was observed in his bathroom on

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1/28/and 1/29/14. R7 said it would be a good idea if the urinal could be left closer to him so he didn't have to go into the bathroom all the time. R7 also stated he has been falling a lot lately and he thinks it is because he takes so many medications at one time. "I think they make me dizzy when I stand up." R7 stated it is really important to him to keep walking as long as possible.

E4 (assistant director of nursing) stated on 1/29/13 at 2:10pm the reason for R7's falls is pretty clear, sometimes its impulsive behavior due to memory deficits from Parkinson's Dementia. Z1 (nurse practitioner) stated on 1/29/13 at 9:45am R7 could benefit from a re-evaluation by neuro-psych, the last one being in July 2013. Review of this evaluation dated 7/5/13 states R7 was being seen for re-evaluation after recent falls. No new recommendations were made. R7 has had at least 10 falls since then.

Review of these facility Fall Investigation Reports repeatedly contribute R7's falls to the fact he is a high risk for falls, very poor impulse control and resistive to redirection. While these are risk factors which contribute to R7 being a high fall risk, the facility does not perform a comprehensive and individualized analysis of why R7 continues to fall such as not having his urinal accessible, the importance of R7 wanting to maintain some mobility as long as possible and the possibility of R7 receiving too many medications at one time (18 tablets at the 9:00 am med pass was observed on 1/29/14 which were reduced to 9 tabs at 9:00am during survey.)

R7's MDS from 3/13 to 12/13 shows R7 had a decline in bladder continence from a 0 to a 2, indicating R7 has gone from being continent to

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being frequently incontinent yet this factor has not been evaluated as a contributing factor in R7's continued attempts to take himself to the bathroom.

Review of the 9/21/13 investigation states R7 was waiting from 2:00pm until about 8:00pm for restorative personnel to walk him. They were supposed to have been there at 2:00pm per R7. The nurse's aide had to convince R7 he was not going to get walked that day because restorative staff had gone home. R7 was found in the hallway on the floor at 8:45pm, trying to walk by himself.

The 12/1113 and 12/23/13 investigations both state for R7 not to be left alone in his bedroom in the wheelchair. R7 was observed alone in his room, in his wheelchair on 1/28/14 through 1/30/14 and 2/4/14. On 1/29/14 and 2/4/14 (about 1:30pm, each day), both at approximately 1:30pm, the privacy curtain was drawn and R7 was not visible from the doorway.

Review of the most recent fall care plan dated 10/20/13 do not show R7's fall interventions have been evaluated for their effectiveness. The current interventions are not individualized nor based on R7's risk factors for falls. For example, there is no mention of R7's persistent attempts and desire to remain continent and to maintain his mobility and the implications of such as they relate to his falls.

The fall on 1/26/14 resulted in R7 be sent to the ER and receiving 7 sutures to the forehead according to the incident report of 1/26/14.

(B)