STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF ANGELS RET HOME	1201 WYOMING AVENUE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Certification 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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by:
Based on interview and record review the facility failed to notify the physician timely for two (R4, R15) of 15 residents reviewed for change of condition in the sample of 15.

Findings Include:

1. Per facility's Incident/Accident Report; On 10/4/14 at 12:45 AM, E6 (Certified Nursing Assistant/CNA) found R4 holding her left wrist with her right hand. E8 assessed R4 upon notification and R4's left ring finger was observed swollen, with purple discoloration and discomfort.

Progress Note dated 10/4/14 at 2:07 AM showed: CNA staff informed E8 (Nurse) to check R4 at 12:45 AM. Upon checking, E8 observed to have swelling and purple discoloration to R4's left ring finger. Also, R4 complained of pain when E8 touched R4's left hand. R4's Vital signs were taken. Z1 (R4's Physician) was called, but staff was waiting for a call back. Family is to be contacted in the morning and R4 will continue to be monitored.

Progress Note dated 10/4/15 at 7:36 AM showed, R4's left finger still swollen and purple in color. Still awaiting for Z1 to call back.

Hospice Progress Notes dated 10/4/14 at 6:52 PM, E9 (Nurse) informed hospice office Z1 has not called yet.

Hospice Progress Notes dated 10/4/15 at 7:50 PM, E9 informed hospice office physician called, an x-ray of R4's hand in the morning.

Progress Notes dated 10/4/15 at 10:46 PM

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F 157	Continued From page 2	F 157		

indicates; Z2 (physician covering for R1) ordered x-ray on Sunday 10/5/14. A call placed to the X-ray company for an order.

On 3/19/15 at 2:20 PM, E9 (Nurse) stated she couldn't remember everything that happened that day (on 10/4/15). E9 said there must be something in the nursing report that made her (E9) call Z2. E9 stated whatever she (E9) reported (in her progress notes) that's the time she called Z2 and got an order for an x-ray. (When the x-ray was obtained the results showed R4 had a fractured finger.

There was no evidence the facility followed up immediately or make another attempt to call a physician when Z1 did not respond to initial the attempt of notification. Z2 (Covering for Z1) was notified and order was given for R4 on 10/4/15 at 6:52 PM about 18 hours after R4's finger was first observed swollen and discolored.

2. R15's Face Sheet documents she was admitted on 2/24/2015. Nursing Notes dated 3/10/2015 show R15 was discharged on 3/10/2015.

Hospital Record dated 2/20/2015 (prior to R15's admission) showed, "For the last two days R15 says she has not been eating. R15 felt depressed and she had suicide ideation. That is why R15 was admitted and has a sitter and a psychiatry consult will be done."

The Hospital Psychiatry Consult dated 2/21/2015 states R15 was seen and was stable for nursing home placement with no further suicide thoughts. R15 was discharged from the hospital to the nursing home on 2/24/2015.

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Nursing Progress Notes dated 2/24/2015 showed R15 was admitted to the nursing home from the hospital, with previous diagnosis of worsening renal failure, depression and suicidal ideation. R15 has made previous statements of: " I don't want to live anymore, I will kill myself when I get out of here. I am a drug addict and a terrible mother."
Nursing Progress Note dated 2/26/2015 documents another suicide statement made by R15.

Plan of Care dated 2/26/2015 showed: " Notify the medical doctor and family if R15 makes suicidal statements."

On 3/18/2015 at 2 PM, E3 (Social Service Director) said R15 had a care plan for suicidal ideation. When R15 was admitted the first night R15 made a suicide statement. The nurse should have called the doctor immediately. The nurse did not notify the doctor.

On 3/18/2015 at 2:27 PM, E5 (Nurse) said that she documented on 2/24/2015 when R15 said she wanted to kill herself. E5 said the doctor should have been notified immediately, but E5 (Nurse) did not notify R15's doctor.

On 3/18/2015 at 2:40 PM, E4 (Nurse) said she gave a message for the doctor to call the nursing home regarding R15's suicide statements, but the doctor never called back. E4 said the doctor should have been made aware of R15's suicide statements as soon as possible. E4 said she notified the doctor of the suicide thoughts on 3/2/2015(5 days later) and the doctor ordered a Psychiatric evaluation.

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F 157	Continued From page 4 Physician Services Policy dated 1/08 states, "If the attending physician is not available for an emergency health care need, the physician covering may issue temporary orders for the attending physician. The Medical Director can also be called in case of emergency. It is the Home's responsibility to notify the physician of any accident, injury or significant change in the resident's condition that threatens the health and safety or welfare of a resident." This policy was not followed for R15.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

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F 225	Continued From page 5 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report a resident's injury of unknown origin in a timely manner to the Illinois Department of Public Health (IDPH). This applies to one of three residents (R4) reviewed for reportable incidents inside the sample of 15 residents. Findings include: Per facility's Incident/Accident Report; On 10/4/14 at 12:45 AM, E6 (Certified Nursing Assistant/CNA) found R4 holding her left wrist with her right hand. E8 assessed R4 upon notification and R4's left ring finger was observed swollen with purple discoloration and discomfort to R4. An investigation was conducted 10/4/2014, but the facility was unable to determine the cause of R4's injury. The facility also obtained an order for X-ray on	F 225		

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10/4/15, but the progress notes were not clear with the exact time of the order.

The x-ray was done on 10/5/15 at around 11:00 AM and the result came in the same day at 5:29 PM which showed: "...Findings: The visualized osseous structures demonstrates a sub-acute nondisplaced fracture involving the left 4th finger proximal phalanx shaft. Mild diffuse soft tissue swelling noted."

Facility reported R4's incident to IDPH on 2/6/14 at 2:17 AM, which was about 49 hours after the incident was noted.

On 3/18/15 at around 2:30 PM, E2 (Director of Nursing/DON) was interviewed. E2 stated R4's incident happened during the weekend. E2 said she (E2) and the administrator (E1) were not in the facility during the weekend. E2 said they (E1 and E2) were notified when they came in to work. E2 stated she (E2) reported R4's incident as soon as she found out about it.

On 3/19/15 at 12:00 PM E1 (Administrator) stated, injuries of unknown origin must be reported to E1 and E2 immediately and must be reported to IDPH within 24 hours.

Facility's Incident and Accident Reporting Policy showed the following instructions for reporting to IDPH:
"The director of Nursing or designee shall notify the Illinois Department of Public Health (IDPH) of any serious incident or accident that causes physical harm or injury to a resident, by fax or phone, within 24 hours after each reportable serious incident or accident."

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F 309	Continued From page 7	F 309		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a comprehensive pain assessment and administer pain medication timely for one (R4) of six residents reviewed for pain. The facility also failed to provide needed services for one (R15) of 15 residents reviewed for change of condition. Findings Include: 1) Per facility's Incident/Accident Report; On 10/4/14 at 12:45 AM, E6 (Certified Nursing Assistant/CNA) found R4 holding her left wrist with her right hand. E8 assessed R4 upon notification and R4's left ring finger was noted swollen with purple discoloration and discomfort to R4. Progress Note dated 10/4/14 at 2:07 AM indicates: CNA staff informed E8 (Nurse) to check R4 at 12:45 AM. Upon checking, E8 observed a swollen, purple discoloration to R4's left ring finger. R4 complained of pain when E8 touch R4's left hand. Z1 (R4"s Physician) contacted, but staffing waiting for call back.	F 309		

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F 309	Continued From page 8 Z4's Hospice Progress Notes dated 10/4/14 at 2:30 AM indicates; E8 (Facility Nurse) called to report R4's left ring finger is swollen, bruised and painful. E8 wanted to know if it's okay to put cold compress. Z4 (Hospice Nurse) asked E8 if she (E8) she gave R4 medication for pain and E8 replied "not yet." R4 has a standing order of Acetaminophen as needed. Z4 instructed E8 to give cold compress and to administer Acetaminophen. This was one hour and 45 minutes after R4 was observed with signs of an injury. Medication Administration Record (MAR) dated October 2014 indicates, R4 was given Acetaminophen 325 mg 2 tablets at 2:30 AM. Result of medication stated "helpful." R4's Progress Notes and MAR did not show R4 was given any treatment immediately for her injury until one hour and 45 minutes later. Z5's Hospice Note dated 10/4/14 at 9:45 AM to 10:35 AM showed; Z5 received R4 sitting up on her wheelchair in the dining room. R4 has a noticeable purple discoloration on the top side of left hand. No one at the facility knows what happened and R4 was unable to tell staff (due to cognitive deficit) what happened to her. Z5 assessed R4, and R4 replied she's in pain. Z5 administered Morphine 0.25 ml by oral/sublingual for pain. Z5 notified R4's son/POA (Power of Attorney) with regards to R4's condition. R4's son called back stated he's coming later that day to visit R4. R4's son didn't want to send R4 to hospital for it would confuse her (R4) more but son consented to X-ray.	F 309		

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Progress Notes dated 10/4/154 at 10:42 and 10:46 PM indicates the following; R4's left hand 3rd finger appears purple, swollen and painful. R4's son was at bedside and asked if R4 would have to go to the hospital and for x-ray. E8 informed R4's son hospice would call back to get ok to for physician's order. E8 called hospice and had an approval to do x-ray. E8 called Z2 (covering for Z1), Z2 ordered x-ray to do on 10/5/14.

X-ray done on 10/5/15 at around 11:00 AM and result came in the same day at 5:29 PM which indicates;

Findings: The visualized osseous structures demonstrates a sub-acute nondisplaced fracture involving the left 4th finger proximal phalanx shaft. Mild diffuse soft tissue swelling noted.

On 3/18/15 at around 2:30 PM, E2's (Director of Nursing/DON) response with regards to why it took a while for R4 to get an order for x-ray, E2 stated, the facility has to get an approval from hospice every time it makes a decision regarding treatment of a hospice resident.

On 3/19/15 at 10:40 AM Z3 (Hospice Staff) stated the following; If a trauma like fracture or something that need stitches happened to a hospice resident then facility can send resident to the hospital without approval of hospice provided that hospice and family is notified during or after. The extent of treatment administered to a resident depends upon the family's decision. Hospice pain medications (Morphine) can also be administered by facility nurse.

On 3/19/15 at 2:15 PM E2 (DON) once a resident

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complained of pain, staff should medicate them (residents) then staff must assess for effectiveness. A comprehensive assessment are required to be made for a resident upon admission, annually and new onset of pain.

Facility's Pain Management Policy/Procedure indicates:

Management of pain is a priority of quality care delivery at this facility. All residents who have pain will be assessed using the Pain Intensity Scale and/or Faces Scale. Pharmacological and non-pharmacological measures will be implemented to ensure resident's pain is appropriately managed.

There was no comprehensive assessment made for R4's pain for the swollen/bruised left 4th finger and other pain assessment made after Acetaminophen was given. R4 received next pain reliever when Z5 came in to visit at 9:45 AM, during which R4 complained of pain upon assessment.

There was no evidence that facility followed up immediately or make another attempt to call a physician when Z1 did not respond to initial attempt of notification. Z2 (Covering for Z1) was notified and order was given for R4 on 10/4/15 at 6:52 PM about 18 hours later after the incident was noted. X-ray was made on 10/5/14 with a result of fracture to left 4th finger.

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2). Face Sheet documents that R15 was admitted on 2/24/2015. Nursing Notes dated 3/10/2015 state R15 was discharged on 3/10/2015.

Hospital Record dated 2/20/2015(prior to R15's admission) document R15 was admitted for suicide ideation.

Hospital Psychiatry Consult dated 2/21/2015 states R15 was seen and was stable for nursing home placement with no further suicide thoughts. R15 was discharged from the hospital to the nursing home on 2/24/2015.

Nursing Progress Notes dated 2/24/2015 states R15 made the following statement, " I don't want to live anymore, I will kill myself when I get out of here. I am a drug addict and a terrible mother."
Nursing Progress Note dated 2/26/2015 documents another suicide statement made by R15.
Nursing Note dated 3/2/2015 states, " Resident was assessed for her thoughts of harming herself right now however residents did state she did have thoughts yesterday when asked if she had a plan resident states yes when she leaves she is going to jump off the bridge."

Physician Order dated 3/2/2015 states, " Psychiatric Evaluation ordered."

There was no Psychiatric Evaluation dated 3/2/2015 or after 3/10/2015 in the clinical record.

Social Service Note dated 3/10/2015 states R15

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was discharged home and R15 needs to follow up with her psychiatrist. Social Service will follow up once R15 is home to ensure a safe discharge.

On 3/18/2015 at 2 PM, E3(Social Service Director) said she wrote the social service note dated 3/10/2015. E3 said that she has not followed up with R15 after she was discharged.

On 3/18/2015 at 2:19 PM, E2(Director of Nursing) said R15 had a psychiatric evaluation on 2/21/2015 prior to admission to the nursing home.

On 3/18/2015 at 2:40 PM, E4(Nurse) said she notified the doctor of the suicide thoughts on 3/2/2015(5 days later) and the doctor ordered a Psychiatric evaluation.

On 3/19/2015 at 9:26 AM, E2(Director of Nursing) said we did not do the psychiatric evaluation that was ordered on 3/2/2015.

Physician Services Policy dated 1/08 states, " It is the Home's responsibility to notify the physician of any accident, injury or significant change in the resident's condition that threatens the health, safety welfare of a resident. This includes pressure ulcers, weight gain or loss of 5% in one month at the least. When orders are obtained, document the physician's plan of care for the care and treatment he has just prescribed. "

The policy does not state to ensure the care has been received.

On 3/19/2015 at 12:20 PM, E2(DON) said that R15 always makes statements of harming herself, but R15 will not harm herself. We did not send her out or get a psychiatric evaluation

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OUR LADY OF ANGELS RET HOME	1201 WYOMING AVENUE JOLIET, IL 60435

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F 309	Continued From page 13 because we wanted to prevent her from going to the hospital.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to sanitize pots and pans in the three compartment sink according to facility protocol/policy. This could potentially affect all of the 62 residents occupying certified beds in the facility. Findings include: On 3/16/15 during initial kitchen tour that started at 8:00 AM with E10 (Dietary Manager), The three compartment sink was observed in use. E10 stated the facility used a quaternary ammonia agent for sanitization in the three compartment sink. A test strip result came out as 100 parts per million (ppm). E10 adjusted the sanitizer and water about 2-3 times before it reached desired level. E10 stated, it's supposed to be 200 ppm. On 3/16/15 at 8:50 AM, E12 (Kitchen Staff) was	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146126	A. BUILDING _____ B. WING _____	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF ANGELS RET HOME	1201 WYOMING AVENUE JOLIET, IL 60435

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F 371	Continued From page 14 washing dishes in the three compartment sink. E13 did a test strip and result showed as 50 ppm. E12 was unable to tell what type of sanitizer the facility used for the three compartment sink. E12 also stated, to check for sanitizing level he had to dip the test strip for 2 minutes, air dry then read the result. Facility's Policy and Procedure for Pot and Pan Washing indicates: "Policy: Manual washing will be done in a sanitary manner... Purpose: To prevent food-borne illness... Procedure: - Submerge items from the rinse sink of hot water. - Remove items from the rinse sink and submerge in sanitizing sink for 1 minute. (Sanitizer: Quat-200 ppm)..."	F 371		