| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146143 | A. Building<br>B. Wing | 05/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ignite Medical Hanover Park | 2000 West Lake Street<br>Hanover Park, IL 60133 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409<br><br>Based on observation, interview, and record review, the facility failed to provide toileting hygiene for residents who required assistance with incontinence care.<br><br>This applies to 4 of 4 residents (R1, R2, R4, R5) reviewed for ADL's (Activities of Daily Living) in the sample of 5.<br><br>The findings include:<br><br>1. On May 28, 2024 at 12:31 PM, V6 (Certified Nursing Assistant/CNA) was providing incontinence care for R2. When R2's gown was lifted, R2 was observed with two incontinence briefs on. V9 (CNA) came to assist V6 with incontinence care, and R2 asked who had entered the room and asked where V9 had been. R2 said he had been waiting a long time to receive incontinence care. R2's MDS dated [DATE] showed R2 was cognitively intact. On May 29, 2024 at 10:59 AM, R2 said it has taken an hour or more for the staff to respond when he needs to be changed. R2 said the staff put two briefs on to avoid his stool from overflowing.<br><br>On May 28, 2024 at 12:37 PM, V9 said he had last changed R2 before breakfast, around 7:30 AM (five hours earlier). On May 29, 2024 at 11:33 AM, V9 said they are supposed to check residents every two to three hours and they should only be putting one brief on. V9 said he had changed R2 before breakfast on May 28, 2024, but he was not sure who had put two briefs on the resident. V9 said he thought it may have been night shift who put two briefs on R2.<br><br>On May 29, 2024 at 11:37 AM, V5 (CNA) said they should only put one brief on the residents and she was not sure why anyone would put on more than one. V5 said when she sees two briefs on a resident, she takes them off and puts just one on. V5 said she was supposed to offer incontinence care every two hours.<br><br>On May 29, 2024 at 12:38 PM, V7 (RN/Registered Nurse) said residents should be checked every two hours for incontinence care and they should only put one incontinence brief on the resident. V7 said if a resident was on a water pill, the staff might put two incontinence briefs on them, but they should only be putting one.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The EMR (Electronic Medical Record) shows R2 had diagnoses including cerebral infarction, legal blindness, type 2 diabetes mellitus, dependence on renal dialysis, hypertension, ischemic cardiomyopathy, end stage renal disease, and palliative care. R2 required supervision for eating, partial assistance from staff for oral hygiene, upper body dressing, and substantial assistance from staff for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off footwear. R2 required substantial assistance for rolling left to right, sitting to lying, lying to sitting on side of bed, chair/bed to chair transfer. R2's care plan dated February 7, 2024, showed R2 was at risk for alteration in skin integrity, with interventions to provide peri-care after each incontinent episode and apply barrier cream and to keep linens dry and wrinkle free. R2's February 15, 2024 care plan also showed R2 has bladder incontinence, with interventions showing [R2] uses disposable briefs. Change as needed. Check as needed for incontinence. Change clothing [As Needed] after incontinence episodes. R2's care plan did not show any documentation regarding R2 wearing two incontinence briefs.<br><br>2. On May 28, 2024 at 9:30 AM, V6 (CNA) said she is scheduled to work from 6:30 AM to 2:30 PM, and all her residents are changed twice during her shift.<br><br>On May 28, 2024 at 12:37 PM, V6 (CNA/Certified Nurse Assistant) and V9 (CNA) were providing incontinence care to R4. When V6 and V9 removed R4's blanket and lifted her gown, R4 had two incontinence briefs on, and her flat sheet was wet underneath the right side of her body. V6 verified the sheet was wet. V9 said he last changed R4 in the morning around 7 AM. On May 29, 2024 at 11:03 AM, R4 said the staff put two incontinence briefs on her, but she did not know why they put two briefs on her.<br><br>On May 29, 2024 at 3:03 PM, V2 (DON/Director of Nursing) said R4's family member preferred R4 to wear two incontinence briefs. V2 said when he was rounding on the floor today (during the survey), he was made aware of R4's family member preferring two briefs to be applied.<br><br>On May 29, 2024 at 12:20 PM, V11 (LPN/Licensed Practical Nurse) said the staff should only be putting one brief on the residents. V11 said she has had a resident in the past who wanted two briefs on, but she was no longer in the facility. V11 said she did not know of any residents on the second floor who requested more than one brief and she did not have any residents who had two briefs on. V11 said she was the nurse for R2 and R4. V11 said even if a resident requests two briefs, they would let their managers know about the situation.<br><br>The EMR shows R4 was admitted with diagnoses including multiple sclerosis, weakness, seizures, dysphagia, gastrostomy status, hypertension, depression, palliative care, dementia, atrial fibrillation, and vitamin D deficiency. R4's MDS (Minimum Data Set) dated April 4, 2024 showed R4 was dependent on staff for oral hygiene, toileting hygiene, personal hygiene, shower/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear. R4 required substantial assistance from staff for upper body dressing. R4's care plan dated July 6, 2023, showed R4 was at risk for alteration in skin integrity, with interventions to provide peri-care after each incontinent episode and apply barrier cream and to keep linens dry and wrinkle free. R4's care plan did not show any documentation of R4 or family of R4's preference of R4 wearing two incontinence briefs.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. On May 28, 2024 at 12:18 PM, V2 (DON) and V10 (RN/Registered Nurse) provided incontinence care for R5. When V2 and V10 removed R5's blankets and gown, R5 had two incontinence briefs on. After cleaning R5 up, V2 applied one incontinence brief to the resident. On May 29, 2024 at 3:03 PM, V2 said the staff should only be putting one brief on unless it was a resident or family preference. V2 said the staff prefer to put one brief on, and if a resident requested more than one, they should be educating the residents and families on the risk of skin breakdown. V2 said it can also cause possible urinary tract infections. V2 said if the residents or families still wanted two briefs, they should be care planned for it.<br><br>The EMR shows diagnoses including Parkinson's disease, muscle weakness, need for assistance with personal care, lack of coordination, schizophrenia, hypothyroidism, bipolar disorder, drug induced subacute dyskinesia, and osteoarthritis of the right hip. R5's MDS dated [DATE] showed R5 had moderate cognitive impairment. R5 required set up assistance for eating, partial assistance from staff for oral hygiene and personal hygiene, substantial assistance for toileting hygiene and upper body dressing, and was dependent on staff for shower/baths, lower body dressing, and putting on/taking off footwear. R5's May 4, 2023 care plan showed R5 had bladder incontinence and required interventions including Check [R5] as required for incontinence. Wash, rinse, and dry perineum. Change clothing (As Needed) after incontinence episodes. R5's March 30, 2024 care plan showed R5 was at risk for alteration in skin integrity, with interventions including to provide peri-care after each incontinent episode and apply barrier cream, as well as keep linens dry and wrinkle free. R5's care plan did not show any documentation of R5 or family preference of R5 wearing two incontinence briefs.<br><br>4. On May 29, 2024 at 9:15 AM, R1 received incontinence care from V3 (CNA) and V4 (CNA). When V3 removed R1's gown, R1 had two green disposable briefs on.<br><br>R1's EMR (Electronic Medical Record) shows diagnoses including congestive heart failure, difficulty walking, weakness, lack of coordination, need for assistance with personal care, type 2 diabetes mellitus, dysphagia, cognitive communication deficit, cardiac pacemaker, hypertension, overactive bladder, and chronic kidney disease stage 3. R1's MDS (Minimum Data Set) dated April 26, 2024 showed R1 was cognitively intact. R1 required supervision for eating and oral hygiene, partial assistance for upper body dressing, dependent for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off footwear. R1's care plan did not show any documentation of R1 or family preference of wearing two incontinence briefs.<br><br>The facility's Incontinence Care policy reviewed on May 2023 showed Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown. Incontinent residents are checked/changed upon awakening, in between meals, afternoon, PM, [Before Bed], overnight and more frequently if needed. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>46409<br><br>Based on observation, interview, and record review, the facility failed to administer insulin as ordered.<br><br>This applies to one of three residents (R1) reviewed for insulin administration in the sample of five.<br><br>Findings include:<br><br>R1's EMR (Electronic Medical Record) showed his diagnoses include type 2 diabetes mellitus with diabetic neuropathy and hyperglycemia, congestive heart failure, cardiac pacemaker, hypertension, and chronic kidney disease stage 3.<br><br>R1's MDS (Minimum Data Set) dated April 26, 2024 showed R1 was cognitively intact. On May 28, 2024 at 10:25 AM, R1 said the nurses give him his insulin after his meals. R1 said the staff do not need to do an accucheck because he has a continuous blood glucose monitor. R1 said the staff give him his food, then come back after he eats, ask him what his blood sugar is, and give him his insulin after he is done eating. R1 said he is supposed to get his insulin before he starts eating. R1 said the staff have not gotten control of his blood glucose, and they were not going to if the insulin was given after the meals.<br><br>R1's May 2024 Physician Order Sheet (POS) showed orders for sliding scale Humalog (short-acting insulin) before meals (breakfast dose scheduled at 7:30 AM and lunch dose scheduled at 11:00 AM), and 6 units of Humalog scheduled with meals at 8:00 AM and 12:00 PM. R1's POS did not have any orders in place for liberalized medication administration times.<br><br>On May 29, 2024 at 8:46 AM, R1 was sitting in bed and said he had finished eating breakfast. R1 had eaten his scrambled eggs, cheerios with 2% milk, 8 ounces of prune juice, and a few bites of a muffin. R1 said he had not received his insulin this morning. Approximately 45 minutes later at 9:29 AM, V7 (RN/Registered Nurse) said she had not passed R1's medications yet and was going to do that now. At 9:45 AM, V7 returned to R1's room and said R1's blood glucose reading was 180 mg/dl (milligram per deciliter), and she was going to administer 6 units of Humalog insulin per the sliding scale. At 9:46 AM, V7 administered 6 units of Humalog insulin to R1.<br><br>R1 Medication Administration Audit Report for May 29, 2024 showed his Humalog scheduled at 7:30 AM was signed off as given at 10:00 AM, and the 6 units of sliding scale scheduled for 8:00 AM was also signed off as given at 10:00 AM.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 12:32 PM, V7 was with R1 to administer his next dose of Humalog insulin. V7 said R1's 11:00 AM blood glucose reading was 365 mg/dL and she was going to administer 20 units of Humalog insulin (the 6 units of scheduled, plus 14 units per sliding scale). V7 then administered 20 units of Humalog. At 1:53 PM, when asked, V7 said for R1's morning Humalog insulin administration, she had given R1 6 units of Humalog (which was ordered with each meal), and she had forgotten to give him his sliding scale dose. V7 said R1 should have gotten 6 units for the sliding scale and 6 units with the meal, and when she remembered, she returned and administered the additional 6 units of insulin at 10:30 AM. V7 said she should have given R1 his 12 units of Humalog insulin before breakfast, as not receiving the accurate amount could cause R1's blood glucose to increase.<br><br>R1's Medication Administration Audit Report for May 29, 2024 showed V7 signed off the 11:00 AM sliding scale Humalog at 12:48 PM. R1's May MAR (Medication Administration Record) showed R1's blood glucose levels on May 29, 2024 were 180 mg/dL for the 7:30 AM check, and 365 mg/dL for the 11 AM check. At the 5 PM check, R1's blood glucose level was 213 mg/dL, and at 9 PM, it was 215 mg/dL.<br><br>R1's Medication Administration Audit Report for the next day (May 30, 2024) showed a different nurse signed off both R1's 7:30 AM and 8:00 AM Humalog doses as given late at 9:54 AM and 9:56 AM. The same report showed the 11:00 AM sliding scale dose was signed off late at 12:23 PM.<br><br>On May 29, 2024 at 4:14 PM, V2 (DON/Director of Nursing) said if a resident does not get enough insulin, it may cause the resident's blood glucose to go up or not go down as much as it needs to. V2 said insulin should be given when it is ordered.<br><br>On May 30, 2024 at 10:06 AM, V8 (MD/Medical Doctor) said insulin is typically given 30 minutes before or 30 minutes after a meal. V8 said most insulins are designed to be given within a short period of time after a meal is done, not more than 30 minutes. V8 said if a resident receives a half dose of a medication and they have eaten, they are not covering the meal adequately enough.<br><br>R1's diabetes care plan (initiated 3/27/24) showed an intervention of Diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness.<br><br>The facility's Administration of Medications policy revised in April 2023 showed All medications are administered safely and appropriately to aid residents to and help in overcome illness, relieve and prevent symptoms and help in diagnosis. Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. If the medication is given at a time different form the scheduled time, indicate the reason in the comment section of the eMAR (Electronic MAR). The facility's Insulin Administration Procedure policy reviewed in May 2023 showed Insulin is only given with a physician or nurse practitioner order. |