

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Ignite Medical Hanover Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 West Lake Street Hanover Park, IL 60133	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on observation, interview, and record review, the facility failed to meet resident ADL (Activities of Daily Living) cares for residents who need assistance with eating and showering.</p> <p>This applies to 5 of 7 residents (R2, R3, R4, R5, and R6) reviewed for ADLs.</p> <p>The findings include:</p> <p>1. On 8/06/2024 at 10:42 AM, R4 was in bed. R4's breakfast tray was untouched on her bedside tray table. R4's bedside tray table was not within R4's reach and it was positioned parallel to R4's head of bed. R4 said she was really hungry but could not see nor reach her breakfast tray. R4 said she last ate the day prior on 8/05/2024. V2 (Director of Nursing/DON) was alerted to R4's situation and came to R4's room. V2 asked R4 if she was hungry and R4 replied Yes, I'm hungry. V2 proceeded to assist R4 by setting up her breakfast and then prompted her to use her utensils. R4 was observed having difficulty finding her utensils and food items on her tray. Then R4 told V2 her food was really iced cold. V2 said he would get R4 a new breakfast tray. At 11:05 AM V4 (Dietician) brought R4 a new breakfast tray. V4 proceeded to assist R4 by opening her food items and preparing her bagel. V4 said dietary aides delivered breakfast room trays to the units between 7:30 AM and 8:30 AM. R4 started to eat her breakfast and told V4 she was so hungry and now her food was warm. V4 left R4's room and R4 proceeded to eat her breakfast. R4 was again observed with difficulty finding her utensils and food items on her tray. R4's MDS (Minimum Data Set) dated 7/03/2024 showed R4 was cognitively intact and was dependent on staff for showers and required supervision or touching staff assistance with eating.</p> <p>On 8/07/2024 at 2:15 PM, R4 was interviewed about her ADLs. R4 said she last received a shower 2 weeks ago and she would like to receive showers more frequently.</p> <p>R4's comprehensive care plan dated 8/07/2024 showed R4 was visually impaired and required assistance with her ADL self-care performance. The care plan said R4 was dependent on staff assistance with showers and needed partial to moderate staff assistance with eating.</p> <p>R4's EMR (Electronic Medical Record) document titled POC Response History showed R4 last received a shower on 7/30/2024 (seven days earlier). A facility document titled Shower Sheet said R4 received a shower on 8/02/2024.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 8/06/2024 at 10:30 AM, R2 was in bed leaning on her left side trying to reach for her untouched breakfast tray on her bedside tray table. R2's bedside tray table was not within R2's reach and it was positioned parallel to her bed. R2 was confused and non-interviewable. At 10:40 AM V14 (Certified Nurse Assistant/CNA) was going to remove R2's breakfast tray and said R2 was not hungry. At 10:52 AM R2 still had the same breakfast tray untouched not within reach. R2's comprehensive care plan dated 8/07/2024 showed R2 had a diagnosis of dementia and required assistance with her ADL self-care performance.</p> <p>R2's MDS dated [DATE] showed R2 was severely cognitively impaired and required setup or clean-up staff assistance with eating. The care plan said R2 required setup or clean-up staff assistance with eating.</p> <p>3. On 8/06/2024 at 10:33 AM, R5 was in bed in a flat position and R5's hair was unkempt. R5's breakfast tray was untouched on her bedside table and the table was not within R5's reach. The table was positioned parallel to the foot of R5's bed. R5 said she did not eat breakfast because she could not reach her tray. V2 (DON) was alerted to R5's situation and came to R5's room. V2 said he would ask R5's CNA if R5 was going to eat breakfast. Then V7 (CNA) came and removed R5's tray to warm it up. At 10:54 AM R5 was observed having difficulty eating her eggs and was drinking her juice at a fast pace.</p> <p>On 8/07/2024 at 2:15 PM, R5 was in bed. R5's hair was unkempt.</p> <p>R5's comprehensive care plan dated 8/07/2024 showed R5 required assistance with her ADL self-care performance. The care plan said R5 required extensive staff assistance with bathing and supervision with setup staff assistance with eating.</p> <p>R5's MDS dated [DATE] showed R5 was severely cognitively impaired and was dependent on staff for showers and required setup or clean-up staff assistance with eating.</p> <p>R5's EMR document titled POC Response History showed R5 last received a shower on 7/18/2024 (18 days earlier).</p> <p>4. On 8/07/2024 at 2:06 PM, R6 was interviewed about her ADLs. R6 said she needed set-up assistance with her showers. R6 said she does not get offered showers frequently and she last received a shower last week. R6 said sometimes on Mondays, Wednesdays, and Fridays she refuses her shower because she's too tired after her dialysis treatments. R6 said she would like to receive at least 2 showers per week.</p> <p>R6's comprehensive care plan dated 8/07/2024 showed R6 required assistance with her ADL self-care performance. The care plan said R6 needed staff assistance with bathing/showering as necessary.</p> <p>R6's MDS dated [DATE] showed R6 was cognitively intact and required supervision or touching assistance with showers. R6's EMR document titled POC Response History showed R6 last received a shower on 7/23/2024 (15 days earlier).</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On 8/06/2024 at 10:10 AM, R3 was in bed. R3's hair was unkempt. R3 was confused and unable to engage in the interview. R3's bed did not have a fitted sheet. V7 (CNA) was alerted and said she would change R3's bed sheets. R3 stood up to allow V7 to change her linen. When R3 stood up, the personal nightgown she was wearing had stains and there was a rolled sheet that had been underneath her that had a foul odor. V7 said the sheet did not appear to have soil stains but agreed it had a foul odor. V7 placed a new fitted sheet over R3's bed and instructed her to go back to bed.</p> <p>R3's comprehensive care plan dated 8/07/2024 showed R3 had a diagnosis of dementia and required assistance with her ADL self-care performance. The care plan said R3 required partial to moderate staff assistance with showers.</p> <p>R3's MDS dated [DATE] showed R3 was severely cognitively impaired and required partial to moderate assistance with showers.</p> <p>R3's EMR document titled POC Response History showed R3 last received a shower on 7/23/2024 (14 days earlier).</p> <p>On 8/06/2024 at 11:00 AM, V2 (DON) said residents who need assistance with eating should be assisted to ensure they receive warm food and their nutritional needs are met.</p> <p>On 8/07/2024 at 5:15 PM, V3 (Assistant Director of Nursing/ADON) said residents are scheduled to receive 2 showers per week. V3 said CNAs are to follow the residents' shower schedule and when done assisting them with their showers, they are to document them in the residents' EMRs or a Shower Sheet.</p> <p>The facility's policy titled ADL with a last review date of 04/2024 showed The facility will provide each resident with care, treatment and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff will ensure that each resident's abilities in activities of daily living do not diminish .including bathing .eating. The facility's policy titled Meal Service with a revision date of 05/2024 showed All residents able to receive oral feedings are positioned, served and encourage to eat their meals. The facility's policy titled Bathing with a revision date of 04/2024 showed All residents are given a bath or shower in accordance with their preferences. If no preference on a bath is voiced, a bath or shower will be offered twice per week.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on observation, interview, and record review, the facility failed to monitor a resident's (R6) blood glucose level as ordered.</p> <p>This applies to 1 of 4 residents (R6) reviewed for quality of care.</p> <p>The findings include:</p> <p>R6's EMR (Electronic Medical Record) showed a diagnosis of type 2 diabetes. R6's MDS (Minimum Data Set) dated 7/11/2024 showed R6 was cognitively intact. R6's Care Plan dated 8/07/2024 showed a focus problem for diabetes with an intervention for blood glucose checks before meals and at bedtime for monitoring.</p> <p>On 8/06/2024 at 10:00 AM, R6 was sitting in her bed, eating breakfast. R6 was Spanish-speaking. R6 said she woke up late and was just now starting to eat her breakfast. At 11:32 AM, V12 (Licensed Practical Nurse/LPN) said she was going to check R6's blood glucose level. V12 proceeded to obtain R6's blood glucose level and said the result was 270 mg/dL (milligrams of glucose per deciliter of blood). R6 tried to explain to V12 that her blood glucose level was high because she just finished eating. V12 said she understood some Spanish and proceeded to record R6's results in the EMR.</p> <p>On 8/07/2024 at 2:05 PM, R6 said she was still unsure why V12 obtained her blood glucose level right after she finished her breakfast. R6 said she has been a diabetic for [AGE] years and knows that blood glucose levels should not be checked right after eating because the result will be high and inaccurate.</p> <p>On 8/07/2024 at 3:32 PM, V16 (Regional Nurse Consultant) said blood glucose monitoring levels should be checked as ordered.</p> <p>R6's Order Summary Report dated 8/07/2024 showed an order Accucheck before meals and at bedtime - before meals and at bedtime for monitoring.</p> <p>R6's EMAR (Electronic Medication Administration Record) showed R6's recorded blood glucose level at 11:00 AM on 8/06/2024 was 270.</p> <p>The facility's undated document titled Food and Nutrition Services showed the meal service schedule for R6's unit starts at 12:15 PM.</p> <p>The facility's policy titled Physician's Orders with a review date of 11/2020 showed Policy: All medications will be administered as ordered by a health care professional .Procedure: Orders for treatments will include . Frequency of treatment, Specific precautions or directions if need .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on observation, interview, and record review, the facility failed to administer and document scheduled medications as ordered for residents. The facility also failed to reorder residents' prescribed medications.</p> <p>This applies to 10 of 14 residents (R1, R9, R10, R11, R14, R15, R16, R17, R18, and R19) reviewed for medication services.</p> <p>The findings include:</p> <p>1. On 8/07/2024, a continuous observation was done at the second floor nurses' station from 8:00 AM through 9:00 AM. During the continuous observation, V9's (Registered Nurse/RN) medication cart was stationed at the nurses' station and was not in use. At 9:05 AM V9 was asked to be observed for medication administration, V9 said she had already completed her morning med pass. V9 said she was instructed that the facility had a policy for liberalized medication administration. V9 continued to say she believed she was allowed to administer residents' scheduled 9 AM medications from 7 AM through 11 AM. Then V9 was asked to review her assigned residents' EMARs (Electronic Medication Administration Records) and V9 proceeded to say she had not documented in R10, R11, R14, R16, R17, R18, and R19's EMARs their already-administered 9 AM medications for 8/07/2024.</p> <p>On 8/07/2024 at 3:32 PM, V16 (Regional Nurse Consultant/RNC) said the facility's liberalized medication administration policy was for standard daily medications not for medications with increased frequencies such as twice a day or three times a day dosing. V16 continued to say residents with liberalized medication administration required a physician order and the order had to include a time range to allow for documentation. V16 said nurses were expected to follow the standard six rights of medication administration including right time and documentation.</p> <p>R9's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R10's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R11's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R14's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R16's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R17's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R18's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>R19's Order Summary Report dated 8/07/2024 did not show an order for liberalized medication administration.</p> <p>The facility's policy titled Medication Pass Times with a revised date of 05/2023 showed General: Medications are administered according to a standard schedule, residents needs and physician orders. Policy: 1. The following is a list of scheduled medication times: Person-centered liberalized medication pass times will be utilized when possible. Person-centered medications pass time windows are as follows: AM: 7am-10am, Afternoon: 1pm-4pm, PM: 7pm-10pm. If liberalized medication pass times are contra-indicated, the medication pass times below will be utilized according to provider orders .</p> <p>2. On 8/07/2024 at 10:10 AM V9 (Registered Nurse) was asked to check for the availability of R11, R14, R15, R17, R18, and R19's prescribed ordered medications. V9 proceeded to reconcile R11, R14, R15, R17, R18, and R19's EMARs (Electronic Medication Administration Record) ordered medications with their available prescribed medications. V9 said R11's ordered Voltaren gel and Lidocaine patches were not available. V9 said R14's ordered Heparin solution and Glargine Insulin pen were not available. V9 said R15's ordered Heparin solution was not available. V9 said R17's scheduled Tramadol and Amlodipine/Atorvastatin medications were not available. V9 said R18's Lidocaine gel was not available. V9 said R19's Voltaren gel and Hydrocortisone cream were not available.</p> <p>R11's Order Summary Report dated 8/07/2024 showed an order for Voltaren External Gel 1% apply to the right shoulder topically two times a day for pain and Lidocaine External Patch 4% apply to the affected area topically in the morning for pain.</p> <p>R14's Order Summary Report dated 8/07/2024 showed an order for Heparin Sodium Solution 5000 UNIT/ML Inject 5000 unit subcutaneously every 12 hours for clotting prevention and Insulin Glargine Subcutaneous Solution Pen Injector 100 UNIT/ML Inject 25 unit subcutaneously every 12 hours related to type 1 diabetes.</p> <p>R15's Order Summary Report dated 8/07/2024 showed an order for Heparin Sodium Injection Solution 5000 UNIT/ML Inject 1 ml subcutaneously every 12 hours for blood thinner.</p> <p>R17's Order Summary Report dated 8/07/2024 showed an order for Amlodipine-Atorvastatin Tablet 10-10 MG give 1 tablet by mouth one time a day for high cholesterol and Tramadol HCl tablet 50 MG give 1 tablet by mouth every 8 hours for moderate to severe pain.</p> <p>R18's Order Summary Report dated 8/07/2024 showed an order for Lidocaine External Gel 4% apply to the lower back and GT site topically in the morning for pain.</p> <p>R19's Order Summary Report dated 8/07/2024 showed an order for Voltaren External Gel 1% apply to the right and left shoulders topically two times a day for pain and Hydrocortisone External Cream 1% apply to the abdomen topically two times a day for itching.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy titled Medication Availability with a revision date 04/2024 showed General: To provide a strategy for the facility to ensure that drug storages and/or medications that are with limited supply from manufacturers are given . 1. Facility is to inform Pharmacy when there is a shortage and limited supply of medications.</p> <p>3. R1's EMR (Electronic Medical Record) showed R1 admitted to the facility on [DATE] and discharged home on 7/04/2024. R1's EMR showed R1 had multiple diagnoses including anxiety and urinary tract infection.</p> <p>R1's EMAR (Electronic Medical Administration Record) showed R1 did not receive his scheduled Xanax 0.5 mg (milligrams) twice a day on 6/19/2024, 6/20/2024, 6/21/2024, 6/23/2024 and his scheduled Cefepime 1 g (gram) IV (intravenous) every 12 hours on 6/26/2024.</p> <p>R1's Progress Note (PN) dated 6/21/2024 showed Xanax was not administered because it was not available. R1's PN dated 6/22/2024 showed Xanax was not administered because it was not available. R1's PN dated 6/23/2024 showed Xanax was not administered because it was not available. R1's PN dated 6/26/2024 showed Cefepime was not administered because it was not available.</p> <p>On 8/08/2024 at 11:30 AM, V3 (Assistant Director of Nursing/ADON) said nurses had access to the facility's medication convenience box if needed when medications are not available. V3 said nurses were expected to follow up with the pharmacy when medications were not available to ensure residents received their scheduled medications as ordered.</p>		