STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145478	A. BUILDING _____ B. WING _____	C 11/03/2016

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NOKOMIS REHAB & HEALTH CARE CENTER	**505 STEVENS STREET NOKOMIS, IL 62075**

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F 000	INITIAL COMMENTS Complaint #1646098 /IL89406 A Partial Extended Survey was conducted.	F 000		
F 157 SS=D	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.	F 157		

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of incident of pulling out a tracheostomy tube for 1 of 4 residents (R2) reviewed for physician notification in the sample of 12. Findings include: R2's Physician Order Sheet (POS) for 9/2016 documents, in part, "Diagnoses: Intracranial Hemorrhage, Respiratory Failure, Tracheostomy, Gastrostomy Tube. 9/2/16 Order Clarification: O2 (Oxygen) at 5 liters per tracheostomy mask at 35% humidity." R2's Physician's Order (PO) dated 9/7/16 documents, "May place mitt on left hand." R2's Care Plan undated documents, "Resident newly admitted with tracheostomy size #6 shiley. Routine tracheostomy care every shift and prn (as needed). Suction prn. 9/7/16 Wear mitt on left hand due to pulling at tracheostomy tube, feeding tube and (indwelling) catheter." R2's Nursing Admission Assessment, dated 9/2/16, documents "Admitting Diagnosis: Intracranial Hemorrhage, Respiratory Failure requiring Tracheostomy, Gastrostomy tube, Rectal tube. ADL (Activities of Daily Living) Functional Abilities: Right arm and right leg with no movement since Intracranial Hemorrhage on 8/21/16." R2's Nurse's Note, dated 9/5/16 at 2000 documents, "Resident noted pulling at trach (tracheostomy) mask."	F 157		

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R2's Nurse's Note, dated 9/6/16, at 0100 documents, " Resident restless in bed pulling at Oxygen mask and removing it, replace each time."

R2's Nurse's Note dated 9/7/16 at 1315 documents, "Resident has pulled on tracheostomy times 2 - has removed inner cannula. Family reports hospital had left hand restricted as to not pull on trach. Phoned MD (Medical Doctor) for mitt for left hand."

R2's Nurse's Note, dated 9/18/16 at 0020 documents, "Resident continue to pull at G-tube and tracheostomy this shift."

R2's Nurse's Note dated 9/25/16 at 2300 documents, "Resident resting quietly. Respirations even, unlabored."

R2's Nurse's Note, dated 9/25/16 at 2330 documents, "Went to resident room to give medication. Went to get flush kit. Noted resident trach out and resident not breathing. 911 called. CPR (Cardiopulmonary resuscitation) started. EMTs (Emergency Medical Technicians) arrived took over CPR." The Nurse's Note documents at 2335 "(Z3, Coroner) here, CPR stopped. No sign of life."

R2's Resident 15 Minute Check Monitoring Sheets for 9/2016 document R2 was monitored from 9/3/16 through 9/25/16 for being at risk due to tracheostomy.

On 10/26/16 at 10:40 AM, E2, Director of Nursing (DON), stated the facility had only one resident with a tracheostomy and that was R2 and the

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facility did not have any resident with tracheostomy after R2 expired. E2 stated she worked on the floor and took care of R2 on 9/18/16 and caught R2 with her mitt off several times and pulling at her trach and gastrostomy tube. E2 stated she has not actually observed R2 taking her mitt off.

On 10/26/16 at 11:20 AM, E3, Licensed Practical Nurse (LPN), stated she had seen R2 without her mitt on but she had never seen R2 take her mitt off.

On 10/26/16 at 12:15 PM, E6, Certified Nursing Aide (CNA), stated that in the past she had caught R2 with the inner cannula of her trach out and reported it. E6 stated she had seen R2 with her hand on her trach but had not actually seen her take it out because she would stop R2 from pulling it out.

On 10/26/16 at 1:40 PM, E4, LPN, stated she had never seen R2 remove her mitt but she had seen her without it and immediately put it back on.

On 10/26/16 at 4:10 PM, E5, LPN, stated she has not seen R2 take her mitt off. E5 stated she had seen R2 without it and put the mitt back on R2's left hand.

On 10/26/16 at 4:12 PM, E7, CNA, stated she had not witnessed R2 took off her mitt or pull out her tracheostomy but she has seen R2 without her mitt and reported it to the nurse on duty.

On 10/27/16 at 10:32 AM, E8, LPN, stated she had seen R2 rubbing her mittened left hand against her side to take the mitt off. E8 stated she noticed R2 doing this shortly after R2 was

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F 157	Continued From page 4	F 157		

ordered the mitt. E8 stated she would put the mitt back on R2 right away.

On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 without the mitt on while doing the 15 minute checks and E10 would put the mitt back on R2 right away. E10 stated she had not seen R2 with her trach tube out.

On 10/27/16 at 10:42 AM, E9, CNA, stated she had seen R2 try to take off her mitt by putting it under her right arm and wiggle her left hand out of it. E9 stated she would always put it back on R2's left hand and report it to the nurse. E9 stated she had noticed R2 trying to take off her mitt as soon as R2 was made to wear it.

On 10/27/16 at 3:10 PM, E2 stated she was not aware prior to 9/18/16 when she took care of R2 as the floor nurse that R2 was pulling at her trach.

On 10/31/16 at 8:48 AM, Z3, R2's Physician, stated, "There is no record the facility notified me that (R2) was able to take her mitt off and pulling at her trach. I expected them to contact me when it happened."

R2's clinical record has no documentation the facility has notified Z3 that R2 was able to remove her hand mitt and had pulled at her trach.

The Facility Policy on Notification for Change in Resident Condition or Status, dated 7/1/12, documents, "Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: b. An accident or incident involving the resident."

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F 280	Continued From page 5	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to review and revise the care plan for effectiveness to address current care needs for 1 of 4 residents (R2) reviewed for care plans in the sample of 12.

Findings include:

R2's Physician Order Sheet (POS) for 9/2016 documents, in part, "Diagnoses: Intracranial Hemorrhage, Respiratory Failure, Tracheostomy, Gastrostomy Tube. 9/2/16 Order Clarification: O2

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at 5 liters per tracheostomy mask at 35% humidity." R2's Physician Order (PO) dated 9/7/16 documents, "May place mitt on left hand."

R2's Nursing Admission Assessment dated 9/2/16 documents, "Admitting Diagnosis: Intracranial Hemorrhage, Respiratory Failure requiring Tracheostomy, Gastrostomy tube, Rectal tube. ADL (Activities of Daily Living) Functional Abilities: Right arm and right leg with no movement since Intracranial Hemorrhage on 8/21/16."

R2's Nurse's Note dated 9/5/16 at 2000 documents, "Resident noted pulling at trach (tracheostomy) mask."

R2's Nurse's Note dated 9/6/16 at 0100 documents, "Resident restless in bed pulling at Oxygen mask and removing it."

R2's Nurse's Note dated 9/7/16 at 1315 documents, "Resident has pulled on tracheostomy times 2 - has removed inner cannula. Family reports hospital had left hand restricted as to not pull on trach. Phoned MD for mitt for left hand."

R2's Nurse's Note dated 9/18/16 at 0020 documents, "Resident continue to pull at G-tube and tracheostomy this shift."

R2's Nurses Note, dated 9/25/16, at 2300 documents, "Resident resting quietly. Respirations even, unlabored."

R2's Nurse's Note dated 9/25/16 at 2330 documents, "Went to resident room to give medication. Went to get flush kit. Noted resident trach out and resident not breathing. 911 called.

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CPR (Cardiopulmonary resuscitation) started. EMS (Emergency Medical Service) arrived took over CPR." The Nurse's Note documented at 2335 "(Z3, Coroner) here, CPR stopped. No sign of life."

R2's Resident 15 Minute Check Monitoring Sheets for 9/2016 document R2 was monitored from 9/3/16 through 9/25/16 for being at risk due to tracheostomy. The Resident 15 Minute Check Monitoring Sheet dated 9/25/16 at 11:15 PM check documents R2 was sleeping and calm.

On 10/26/16 at 10:40 AM, E2, Director of Nursing (DON), stated she worked on the floor and took care of R2 on 9/18/16 and caught R2 with her mitt off several times and pulling at her trach. E2 stated she did not actually observed R2 took her mitt off.

On 10/26/16 at 11:20 AM, E3, Licensed Practical Nurse (LPN), stated she had seen R2 without her mitt on but she never saw R2 take her mitt off. E3 stated that on the night of 9/25/16 she saw R2 without her mitt on but R2 was not trying to pull her trach when she did rounds at 11:00 PM. E3 stated when she returned to give R2 her medication at 11:30 PM, R2's mitt was off, and her trach was out. E3 stated R2 was not breathing and she called 911 and initiated CPR. E3 stated EMS arrived and continued CPR and attempted to reinsert the tracheostomy tube without success, E3 stated R2 was pronounced at 11:35 PM.

On 10/26/16 at 12:15 PM, E6, Certified Nursing Aide (CNA), stated that in the past she had caught R2 with the inner cannula of her trach out and reported it. E6 stated she had seen R2 with

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her hand on her trach but had not actually seen her take it out because she would stop R2 from pulling it out.

On 10/26/16 at 1:40 PM, E4, LPN, stated she had never seen R2 remove her mitt but she had seen her without it and immediately put it back on.

On 10/26/16 at 4:10 PM, E5, LPN, stated she had not seen R2 take her mitt off. E5 stated she had seen R2 without it and put the mitt back on R2's left hand.

On 10/26/16 at 4:12 PM, E7, CNA, stated she had not witnessed R2 taking off her mitt or pulling out her tracheostomy but she did see R2 without her mitt and reported it to the nurse on duty.

On 10/27/16 at 10:32 AM, E8, LPN, stated she had seen R2 rubbing her mittened left hand against her side to take the mitt off. E8 stated she noticed R2 doing this shortly after R2 was ordered the mitt. E8 stated she would put the mitt back on R2 right away.

On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 without the mitt on while doing the 15 minute checks and E10 would put the mitt back on R2 right away. E10 stated she had not seen R2 with her trach tube out.

On 10/27/16 at 10:42 AM, E9, CNA, stated she had seen R2 try to take off her mitt by putting it under her right arm and wiggle her left hand out of it. E9 stated she would always put it back on R2's left hand and report it to the nurse. E9 stated she had noticed R2 trying to take off her mitt as soon as R2 was made to wear it.

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F 280	Continued From page 9 On 10/27/16 at 3:10 PM, when asked if the facility has reviewed or reassessed the current interventions in place to prevent R2 from pulling at her tracheostomy tube, E2 stated, "It took (R2) awhile to take off the hand mitt and staff were there to check on (R2) every 15 minutes." R2's Care Plan undated documents, "Resident newly admitted with tracheostomy size #6 shiley. Routine tracheostomy care every shift and prn (as needed). Suction prn. 9/7/16 Wear mitt on left hand due to pulling at tracheostomy tube, feeding tube and (indwelling urinary) catheter. " The Care Plan did not document any revision of the approach/es that was in place that did not work and did not identify new or alternative intervention/s to address pulling at R2's trach and tubes and/or preventing pulling out the trach or prevent dislodging the trach. The Facility Policy on Comprehensive Assessment/Care Planning, undated, documents, "7.c Care Plan - Plan of care describing a need/problem, and indicating approaches/interventions to be instituted to assist the resident in maintaining/receiving proper care in relation to the problem."	F 280		
F 328 SS=J	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

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F 328	Continued From page 10 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement effective interventions to prevent pulling out a tracheostomy tube for 1 of 1 resident (R2) reviewed for tracheostomy care in the sample of 12. This resulted in asphyxiation and death of R2 on 9/25/16 at the facility. This failure resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 11/3/16, the facility remains out of compliance at Severity Level 2, while the facility continues to educate staff and evaluate the effectiveness of the Facility policies and procedures for safe monitoring of residents with tracheostomy. Findings include: R2's Physician Order Sheet (POS) for 9/2016 documents, in part, "Diagnoses: Intracranial Hemorrhage, Hemiplegia, Respiratory Failure, Tracheostomy, Gastrostomy. 9/2/16 Order Clarification: O2 (Oxygen) at 5 liters per tracheostomy mask at 35% humidity." R2's Physician Order (PO) dated 9/7/16 documents, "May place mitt on left hand." R2's Minimum Data Set (MDS) dated 9/15/16 documents R2 has severely impaired cognitive skills for daily decision making, and totally dependent on staff for all activities of daily living (ADLs).	F 328		

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The Incident Report Form - IDPH (Illinois Department of Public Health) Notification dated 10/3/16 documents, "On 9/25/16 at 2330 (11:30 PM), staff entered (R2's) room and noted tracheostomy tube out. (R2) was a full code so CPR (Cardiopulmonary resuscitation) was initiated as per protocol. EMS (Emergency Medical Services) was dispatched. EMS arrived approximately 2335 (11:35 PM) and they continued with CPR without success. Attempts were made to reinsert the tracheostomy tube without success due to swelling from the tube being pulled out with the cuff inflated. The Deputy Coroner was onsite with the EMS and pronounced (R2). Upon investigation, it was noted that (R2) had a history of pulling at her tracheostomy tube, (indwelling urinary) catheter and gastrostomy tube. (R2) had a mitt to her left hand to keep her from pulling at the tubes. She was also on 15 minute checks. Interviews with staff show that CNAs (Certified Nursing Aides) were in the room at approximately 2315 (11:15 PM) to check on the resident and she was resting quietly with her tracheostomy intact and mitt in place. At 2330 (11:30 PM) the nurse on duty entered her room and noted her tracheostomy tube was out and CPR was initiated. EMS was also dispatched and continued CPR until their arrival. Attempts were made to reinsert the tracheostomy tube without success due to swelling at the site. (R2) was utilizing a #6 shiley cuffed tracheostomy tube. Upon review of her record, (R2) had a history of difficult intubation approximately 20 years ago which caused tracheal adhesions and stenosis. Approximately 3 years ago she had balloon dilation due to episodes of choking at home and it was discovered that she had the adhesions and

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stenosis." The Final Incident Investigation dated 10/3/16 documents E3, Licensed Practical Nurse (LPN), E6, CNA, and E11, CNA, were interviewed during the investigation.

R2's Care Plan, undated, documents, "Resident newly admitted with tracheostomy size #6 shiley. Routine tracheostomy care every shift and prn (as needed). Suction prn. 9/7/16 Wear mitt on left hand due to pulling at tracheostomy tube, feeding tube and (indwelling urinary) catheter."

R2's Nursing Admission Assessment, dated 9/2/16, documents, "ADL (Activities of Daily Living) Functional Abilities: Right arm and right leg with no movement since Intracranial Hemorrhage on 8/21/16."

R2's Nurse's Note, dated 9/5/16 at 2000 (8:00 PM) documents, "Resident noted pulling at trach (tracheostomy) mask."

R2's Nurse's Note, dated 9/6/16, at 0100 (1:00 AM) documents, "Resident restless in bed pulling at Oxygen mask and removing it."

R2's Nurse's Note, dated 9/7/16 at 1315 (1:15 PM) documents, "Resident has pulled on tracheostomy times 2 - has removed inner cannula. Family reports hospital had left hand restricted as to not pull on trach. Phoned MD for mitt for left hand."

R2's Nurse's Note, dated 9/18/16, at 0020 documents, "Resident continue to pull at G-tube (Gastrostomy tube) and tracheostomy this shift."

R2's Nurse's Note, dated 9/25/16, at 2300 (11:00 PM) documents, "Resident resting quietly.

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Respirations even, unlabored."

R2's Nurse's Note, dated 9/25/16, at 2330 (11:30 PM) documents, "Went to resident room to give medication. Went to get flush kit. Noted resident trach out and resident not breathing. 911 called. CPR started. EMTs arrived took over CPR." The Nurse's Note documented "At 2335 "(Z3, Coroner) here, CPR stopped. No sign of life."

R2's Resident 15 Minute Check Monitoring Sheets for 9/2016 document R2 was monitored from 9/3/16 through 9/25/16 for being at risk due to tracheostomy. The Resident 15 Minute Check Monitoring Sheet dated 9/25/16 documents last time R2 was checked at 11:15 PM R2 was asleep and calm.

On 10/26/16 at 10:40 AM, E2, Director of Nursing (DON), stated the facility had only one resident with a tracheostomy and that was R2 and the facility did not have any resident with tracheostomy after R2 expired. E2 stated she worked on the floor and took care of R2 on 9/18/16 and caught R2 with her mitt off several times and pulling at her trach. E2 stated she did not actually observed R2 take her mitt off.

On 10/26/16 at 11:20 AM, E3, LPN, stated she had seen R2 without her mitt on but she had never seen R2 take her mitt off. E3 stated that on the night of 9/25/16 she saw R2 without her mitt on but R2 was not trying to pull her trach when she did rounds at 11:00 PM. E3 stated when she returned to give R2 her medication at 11:30 PM, R2's mitt was off, and her trach was out. E3 stated R2 was not breathing and she called 911 and initiated CPR. E3 stated EMS arrived and continued CPR and attempted to reinsert the

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tracheostomy tube without success, E3 stated R2 was pronounced at 11:35 PM.

On 10/26/16 at 12:15 PM, E6, CNA, stated she did the 15 minute check on 9/25/16 at 11:15 PM and R2 had her mitt on and she was calm, comfortable and her trach was in place. E6 stated that in the past she had caught R2 with the inner cannula of her trach out and reported it. E6 stated she had seen R2 with her hand on her trach, but had not actually seen her take it out because she would stop R2 from pulling it out.

On 10/26/16 at 1:40 PM, E4, LPN, stated she had never seen R2 remove her mitt, but she had seen her without it and immediately put it back on.

On 10/26/16 at 4:10 PM, E5, LPN, stated she had not seen R2 take her mitt off. E5 stated she had seen R2 without it and put the mitt back on R2's left hand.

On 10/26/16 at 4:12 PM, E7, CNA, stated she had not witnessed R2 took off her mitt or pull out her tracheostomy, but she has seen R2 without her mitt and reported it to the nurse on duty.

On 10/27/16 at 10:32 AM, E8, LPN, stated she had seen R2 rubbing her mittened left hand against her side to take the mitt off. E8 stated she noticed R2 doing this shortly after R2 was ordered the mitt. E8 stated she would put the mitt back on R2 right away.

On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 without the mitt on while doing the 15 minute checks and E10 would put the mitt back on R2 right away. E10 stated she had not seen R2 with her trach tube out.

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On 10/27/16 at 10:42 AM, E9, CNA, stated she had seen R2 try to take off her mitt by putting it under her right arm and wiggle her left hand out of it. E9 stated she would always put it back on R2's left hand and report it to the nurse. E9 stated she had noticed R2 trying to take off her mitt as soon as R2 was made to wear it.

On 10/27/16 at 3:10 PM, when asked if she reviewed or reassessed the current interventions in place to prevent R2 from pulling her tracheostomy tube, E2 stated, "It took (R2) awhile to take off the hand mitt and staff were there to check on (R2) every 15 minutes. " E2 stated she was not aware before 9/18/16 when she took care of R2 as floor nurse that R2 was pulling at her trach. E2 stated nobody reported to her about it.

On 10/31/16 at 8:15 AM, when asked, "Would you say that the trach being pulled out at that time led to (R2's) expiration? " Z4, Deputy Coroner stated, "Yes. The trach was her only means of breathing. I was there and I tried to reinsert the trach myself without success. When we got there (R2) was gone."

On 10/31/16 at 8:48 AM, when asked, "Would you say that the trach being pulled out on 9/25/16 when R2 was found not breathing led to her expiration? ", Z3, R2's Physician, stated, "(R2) was pretty sick. But the trach being pulled out at that time could have a lot to do with her expiration."

The Facility Policy on Tracheostomy Care, undated, documents, "Residents who have tracheostomy will have trach care done daily, or

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when needed to keep the airway clean and unobstructed. "The Facility Policy related to tracheostomy care did not address appropriate interventions to keep a resident with tracheostomy safe when they show signs of attempting to pull out their tracheostomy tube.

The Immediate Jeopardy situation was identified and determined to have begun on 9/18/16 when E2, DON, documented in the Nurses Note dated 9/18/16 at 0020, "(R2) continues to pull at G (Gastrostomy) tube and trach (tracheostomy) this shift." On 10/31/16 at 3:12 PM.E1, Administrator, and E2 were notified of the Immediate Jeopardy.

On 11/3/16, through interviews with facility staff and review of the facility policy and in-service records, it was determined the facility took the following actions:

1. Clinical team reviewed and revised tracheostomy care policy to state that if resident exhibits any behaviors of attempted decannulazation, the resident will be referred to the IDT (Interdisciplinary team) for review of care needs and interventions.

2. On 11/02/16, Administrator and Director of Nursing continued 100% staff education on all shifts: including administration, nursing, dietary, housekeeping/laundry and maintenance staff on the updated tracheostomy policy. Staff have been instructed to ensure the resident is safe by staying with the resident until danger is removed and report to the nurse immediately. The nurse will review the resident's care plan and implement new interventions immediately and report to the Interdisciplinary Team for review. No employee will be allowed to work until they have been

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