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WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint #1876169/IL105921 and 1876050/IL105791 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1035)3)4) 300.1210b) 300.1210d)2) 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 300.1035 Life-Sustaining Treatments	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 3)procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 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: 2)All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met evidenced by :	S9999		

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Based on interview and record review the facility failed to initiate CPR (Cardio-Pulmonary Resuscitation) rescue breaths for a resident designated as a full code. The facility also failed to ensure that staff had current healthcare provider CPR certificates for staff on duty, and failed to ensure that staff was knowledgeable and competent in assessing residents in cardiac/respiratory distress. Also, the facility failed to provide BiPAP (Bi-level Positive Airway Pressure) equipment as ordered by the physician, for a newly admitted resident with a history of acute respiratory failure. As a result of this failure, R2 experienced respiratory failure on September 18, 2018 at 6:30 AM, resulting in hospitalization, intubation, and the need for mechanical ventilation.

This applies to 4 of 7 residents (R2, R9, R10, R11) reviewed for improper nursing in the sample of 11.

The findings include:

The EMR (Electronic Medical Record) shows R2 was admitted to the facility on September 15, 2018 at 6:00 PM with multiple diagnoses including end-stage renal disease, pleural effusion, diabetes, and acute respiratory failure, shortness of breath, insomnia, and anemia.

The POS (Physician Order Sheet) shows the following order dated September 15, 2018: "Full Code."

The POS (Physician Order Sheet) for R2 shows the following order entered on September 16, 2018 at 12:34 AM: "BiPAP at bedtime."

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S9999	Continued From page 3 On September 16, 2018 at 12:40 AM, V11 (RN-Registered Nurse) documented, "BiPAP machine has to be ordered. [V16] (Physician) notified." On September 17, 2018 at 11:05 PM, V11 documented, "BiPAP at bedtime - still waiting for delivery." On September 18, 2018, V3 (LPN-Licensed Practical Nurse) documented, "6:30 AM Observe [R2] was not responsive, not breathing but able to palpate pulse. O2 started at 10 LPM (Liters Per Minute) ...Called 911." On September 26, 2018 at 10:00 AM, V23 (Paramedic) said, "We responded to a call at the facility on September 18, 2018. We went to [R2's] room. No staff was present in the room with the resident. I remember there was another resident in the room, so we weren't sure which resident we were supposed to attend to, and there was no staff in the room with the resident for us to ask. [R2] was wearing a non-rebreather mask with oxygen, and when we assessed him, we determined he had agonal breathing, which is ineffective breathing at a rate of 4 breaths per minute. A non-rebreather mask with oxygen would not be effective for this resident because of his poor respiratory effort. He had a low blood pressure and a strong pulse. This resident needed CPR support breaths. No one at the facility was providing that to the resident." Paramedic documentation dated September 18, 2018 shows the paramedics were notified at 6:30 AM of a cardiac arrest/death event for R2. The primary symptoms were unconsciousness and unresponsive. Paramedic documentation shows the paramedics arrived at R2's bedside at 6:34	S9999		

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AM. Vital signs taken by the paramedics at 6:35 AM showed R2 was unresponsive, had a blood pressure of 74/42, a pulse of 74, a respiratory rate of 4 breaths per minute, and R2's respiratory effort was weak and agonal. At 6:35 AM, paramedics applied a bag-valve mask. At 6:38 AM the paramedics inserted an oropharyngeal airway, and at 6:58 AM the paramedics arrived at the local hospital.

Hospital documentation dated September 18, 2018 shows: "[R2] presents with mental status change noted at nursing home. When paramedics arrived patient was bradypenic (slow respiratory rate) and no staff in room. Thready pulse. Oral airway placed and [R2] bagged during transport. Patient arrives obtunded, very shallow respirations assisted by bag-valve mask. Diagnostic impression: AMS (Altered Mental Status), acute hypercapnic (carbon dioxide retention) respiratory failure - patient intubated in the ER, acute hypotension, OSA (Obstructive Sleep Apnea)."

On September 19, 2018 at 4:45 AM, V10 (RN-Registered Nurse) said, "[V3] called me around 6:00 AM to her resident's room because he was unresponsive. She always calls me to check her residents. I got to the room and the resident was in bed with a non-rebreather mask on. We never opened the crash cart. He never woke up to tactile stimuli. I did not provide rescue breaths. I left the room before 911 personnel came."

On September 19, 2018 at 2:23 PM, V3 (LPN-Licensed Practical Nurse) said, "Yesterday morning I went in [R2's] room. Me and a CNA (Certified Nursing Assistant) got him up from the

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bed with a mechanical lift and put him in the dialysis chair in his room, around 5:30 AM. We left him in his room. Around 6:30 AM we went in his room to take him to dialysis. I saw he wasn't responsive. I said his name and he did not wake up. He was not breathing but he had a pulse. He was a full code resident. V3 was again interviewed on September 20, 2018 at 5:45 AM and stated, "On September 18, 2018, [R2] was not put on BiPAP because we never received the machine. He was sitting up in the dialysis chair waiting to go to dialysis in his room. I went back in the room about an hour after we got him up, which was around 6:30 AM. He was not responsive, and not breathing. I ran down the hall to get the RN (Registered Nurse). Somebody paged code blue overhead. I checked the pulse and it was weak. I did not check his blood pressure.

On September 20, 2018 at 5:38 AM, V4 (LPN-Licensed Practical Nurse) said, "I responded to [R2's] room. I was not the first nurse in the room. The crash cart was in the room, but we did not use it. I did not provide rescue breaths to the resident. I was not in the room when the paramedics arrived."

On September 20, 2018 at 5:45 AM, V3 said, "On September 18, 2018, [R2] was sitting up in the dialysis chair waiting to go to dialysis in his room. I went back in the room about an hour after we got him up, which was around 6:30 AM. He was not responsive, and not breathing. I ran down the hall to get the RN (Registered Nurse). Somebody paged code blue overhead. I checked the pulse and it was weak. I did not check his blood pressure. I did not provide rescue breaths to him. We did not use the bag-valve mask on him. I did not do CPR because he had a pulse."

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On September 20, 2018 at 5:50 AM, V5 (LPN) said, "We all went to [R2's] room. I don't know if he was breathing. He had a pulse. He was in the chair for dialysis. We used the sling and the mechanical lift to put him to bed. He had a pulse and a blood pressure so we did not do CPR. Me and [V24] (LPN) put a non-rebreather mask on him. I would say he appeared to be in a deep sleep. We were never able to wake him up before the paramedics came."

On September 20, 2018 at 9:50 AM, V16 (Physician) said, she expected the facility personnel to follow the order for R2's full code status and rescue breaths should have been provided to R2 if he was not effectively breathing.

On September 20, 2018 at 9:50 AM, V16 (Physician) said, "[R2] had a history of needing BiPAP at bedtime. I expected the facility to have the BiPAP machine for the resident upon admission to the facility. I was aware he had a history of refusing to use the BiPAP. If the equipment wasn't there, how do we offer it to him to refuse? Without the equipment, there was no choice. As a result of not having the BiPAP equipment, [R2] went into respiratory arrest at the facility, got intubated, and is now in the ICU (Intensive Care Unit) requiring mechanical ventilation. The resident has had multiple episodes of respiratory failure. The resident has never had an episode of respiratory failure when he was wearing the BiPAP equipment. I expected the facility to start the BiPAP on September 15, 2018, the night he was admitted to the facility."

On September 20, 2018 at 9:56 AM, V20 (Medical Records) said, "I am in charge of

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ordering all equipment for the residents prior to admission. I was told by the Administrator on Monday afternoon, September 17, 2018 that we needed to order a BiPAP machine for [R2]. I called the company and they said they would deliver the equipment the next day on September 18, 2018. We ordered the machine, but by the time it came, the resident had been sent to the hospital. I need to be notified, verbally, when a resident needs equipment. Someone should have called me and I could have ordered it right away. Even on the weekend, they can call me if they have to." V20 said she was never notified, prior to September 17, 2018, that R2 needed a BiPAP machine.

On September 20, 2018 at 1:30 PM, V2 (DON-Director of Nursing) said she would expect facility staff to support respirations if the resident was a full code and was not breathing. "No code blue sheet was filled out by the facility staff because R2's situation was not a code blue. The resident had a pulse. [V3] is very challenged in her nursing skills. I am going to have to bring her to day shift to keep an eye on her."

On September 20, 2018 at 1:30 PM, V2 (DON-Director of Nursing) said, "The BiPAP machine never came for [R2]. The equipment should be in the building before the resident gets admitted."

On September 24, 2018 at 9:40 AM, V12 (RN/Dialysis Nurse) said, "I am CPR certified. The day of [R2's] code, the nurses called me and asked me to come to the room to look at him. They had already called 911. I observed the resident. He was not breathing. I told them they needed to do something. I suggested putting him on a non-rebreather mask with oxygen. They

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were not giving him rescue breaths."

On September 25, 2018 at 10:00 AM, V11 (RN-Registered Nurse) said, "I admitted [R2] to the facility around 6:00 PM on Saturday, September 15, 2018. The BiPAP machine wasn't available when he came to the facility. The nurse who gave me report from the hospital told me the resident had BiPAP orders and he didn't like to use the BiPAP. When the resident came to the facility, the hospital sent the tubing but not the BiPAP machine. I called the hospital and they said we had to use our own machine. This was the first time I ever admitted a resident to the facility who needed BiPAP so I didn't know what to do. I notified [V22], the MOD (Manager on Duty). She said the equipment needed to be ordered. I notified the physician that we didn't have the BiPAP equipment and the hospital had said he had a history of refusing the BiPAP. The physician said she was aware of his history of refusing the BiPAP, but we needed to get the equipment. I endorsed the information to the next shift. I didn't return to the facility for a couple of days and when I came back, the equipment was not in the room. I asked [V20] (Medical Records), and she said no one ever told her the equipment needed to be

On September 25, 2018 at 12:01 PM, V22 (MOD/Activities Director) said, "I was the last manager in the building on Saturday, September 15, 2018. There was a report that there was an admission coming in that day. All the managers receive an email that there's a move in. It's generated from our Admissions Department. I think I saw the email on the morning of the admission. [V2] (DON-Director of Nursing) is the person who reviews the resident coming in and she alerts us to what is needed for the resident.

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We make sure that everything they need is in place. We don't usually get resident admissions on Saturdays. I didn't read the whole profile. I just read the part about activities. I was told by [V11] that the resident needed a BiPAP machine. I told her we don't keep those in the building. I told her BiPAP machines need to be obtained from an outside vendor. Medical Records should order needed equipment when they learn of the admission and get the information from [V2]. When [V11] called me she said there's a resident coming and he needs a BiPAP machine. I told her to let the doctor know and get some other recommendations from her since we did not have the BiPAP machine in the building. I also told her to let [V2] know about the situation. I was told the hospital nurse reported that [R2] was refusing to use the BiPAP machine in the hospital. I told her to endorse the physician's order to the next shift to ensure the machine was obtained as soon as possible. It was [V11's] responsibility as a nurse to get the recommendations from the doctor to better serve the resident. Other options we could have explored would have been borrowing the equipment from our sister facility. I'm not sure if they ever explored looking at a sister facility for the BiPAP machine."

The facility did not have documentation to show V16 (Physician) provided alternative orders due to the absence of the BiPAP machine.

On September 25, 2018 at 2:15 PM, V15 (Director of Admissions) said, "[R2's] initial referral from the hospital was sent to us on September 12, 2018. I went to the hospital that same day to verify the resident was not on a ventilator. I talked to the nurses and the case manager and confirmed he was not on a ventilator. The resident was approved for

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admission to our facility. We were told the resident would admit to our facility on September 14, 2018 after he finished dialysis. I am not sure why, but the resident didn't end up transferring to our facility until Saturday, September 15. The DON determines the medical equipment needed for the resident."

On September 25, 2018 at 2:40 PM, V2 (DON) said, "All admissions come to me for clinical review. Initially we had a referral form with lots of information. Corporate changed the process and the form. We became a census-focused building and they wanted us to move people in quickly. That new process failed miserably. We had some resident readmissions under the new process, but [R2] was the only resident who was admitted through the new process. I did a quick scan of the record. Because of this process, the BiPAP was missed. Also, the nurse was instructed to call me about the missing BiPAP by the supervisor, but she never did."

As of September 25, 2018 at 3:15 PM, V2 (DON) said the facility does not currently have a policy and procedure or protocol in place to ensure all facility staff are aware of the steps necessary to ensure physician-ordered medical equipment is available upon admission. "The nurses need to be contacting me if they don't have the necessary equipment. I've met with many of the nurses throughout the week to tell them that, but not all of the nurses.

The facility's Admission Guidelines Policy shows: "Procedure: 2. At the time each individual is admitted, the facility must have physician's orders for immediate care that are based on a physical examination performed by a currently licensed attending physician or his/her designee, written

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on the day of admission or within 30 days prior to admission. Procurement of all medical equipment needed upon admission will be facilitated by admitting nurse per physician orders.
On September 26, 2018 at 11:45 AM, V1 (Administrator) said facility staff should fill out the code blue worksheet when a code blue situation is identified, and all facility staff are required to have current healthcare provider CPR certification. V1 said, "The Business Office Manager is supposed to be keeping track of all facility staff to ensure their CPR certification is current."

Facility documentation shows V3 (LPN), did not have current healthcare provider CPR certification. V10, the RN who was asked to assist V3 in assessing the resident did not have current healthcare provider CPR certification. As of September 20, 2018 at 4:00 PM, the facility had documentation to show 6 nurses were working at the time of R2's respiratory arrest. Of the 6 nurses, only V24 (LPN) and V7 (CNA-Certified Nursing Assistant) had current healthcare provider CPR certification. The facility did not have documentation to show V24 or V7 provided rescue breaths to R2.

The American Heart Association Basic Life Support Manual dated 2016 shows: "Look for no breathing or only gasping and check pulse simultaneously). If no normal breathing, but has a pulse, Provide rescue breathing: 1 breath every 5-6 seconds, or about 10-12 breaths/minutes. Activate emergency response system (if not already done) after 2 minutes. Continue rescue breathing; check pulse about every 2 minutes. If no pulse, begin CPR. Respiratory arrest can be identified when the victim is found to be

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unresponsive, not breathing or only gasping, but still has a pulse. BLS (Basic Life Support) providers should be able to quickly identify respiratory arrest, activate the emergency response system, and begin rescue breathing. Quick action can prevent the development of cardiac arrest."

In addition to R2, the facility provided a list of resident's code status. Multiple residents were identifed as full code on the facility's undated resident list including R2, R9, R10, and R11.

The facility's Code Blue Medical Emergency Policy dated December 5, 2012 shows: "To provide care and services to residents in accordance with Advance Directives that have been discussed with the resident or resident's legal representative in advance of medical emergencies including medical interventions used to restore circulatory and respiratory function. 6. If a resident is determined to be a full Code (No DNR-Do Not Resuscitate), 911 will be contacted at the initiation of CPR. CPR will continue until such time that EMS has arrived at the facility and assumes treatment of the resident."

The facility's undated Code Blue Worksheet shows the date and time and the person who found the resident. The worksheet shows resident assessment, including airway pulse and vital signs assessment including blood pressure, pulse rate, respiratory rate, pulse oximetry reading and blood glucose. Other documentation includes CPR initiation, oxygen, ambu bag assembled, 911, physician, and family notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001002	A. BUILDING: _____ B. WING _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

(A)