STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008817	A. BUILDING: _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST ANNE CENTER	4405 HIGHCREST ROAD ROCKFORD, IL 61107

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigation #1911822/IL110341	S 000		
S9999	Final Observations 300.610(a) 300.1030(a)(1) 300.1210(d)(2)(3) 300.3220(f) 300.3240(a) 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 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). Section 300.1210 General Requirements for Nursing and Personal Care 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by:	S9999		

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Based on interview and record review, the facility failed to notify the physician of a resident's change in condition.
This failure contributed to R12's condition deteriorating and a delay in treatment.

This applies to 1 of 3 residents (R12) reviewed for physician notification in the sample of 3.

The findings include:

R12's acute hospitalization discharge summary dated March 6, 2019, shows diagnosis of acute cerebrovascular accident (stroke) with resulting left sided weakness, treatment for aspiration pneumonia, and hypoxemic (low oxygen in the blood) respiratory failure possibly secondary to aspiration.

R12's progress note dated March 8, 2019, by V22 Nurse Practitioner shows there was a concern for aspiration and a feeding tube was placed on March 5, 2019 (while in the hospital).

R12's physician orders dated March 7, 2019, shows to give 45 ml (millileters) an hour continuously through the feeding tube.

R12's Video Swallow Study report dated February 25, 2019, shows it was recommended nothing be given by mouth due to aspiration and inability to eject material from the airway. Long term alternative means of nutrition was likely.

R12's nursing note (authored by V14 LPN-Licensed Practical Nurse) dated March 11, 2019, at 10:02 AM, shows resident lying in bed and coughing profusely. R12 had an emesis of a large amount of tube feeding, rattling in the throat and R12 was not able to productively cough up

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phlegm. This note shows the nurse suctioned 90 ml of phlegm and tube feeding from R12's throat and mouth.

On March 19, 2019, at 9:05 AM, V14 LPN (Licensed Practical Nurse) said she was walking by R12's room on March 11, 2019, and heard her coughing. I disconnected her tube feeding for about an hour and a half and then turned it back on. I was concerned R12 would throw up again and couldn't clear it herself. R12 would have kept throwing up if I hadn't suctioned her. Residents should have the head of their bed elevated or seated upright if a tube feeding is in progress in case they cough or vomit, to keep aspiration from choking them. At 10:54 AM, V14 said I spoke to (V22 Nurse Practitioner) and got an order to suction R12. I did not notify V22 about R12's coughing, vomiting tube feeding or what was suctioned from R12's mouth. I did not notify V22 that I stopped R12's tube feeding for an hour and a half and then restarted it.

R12's physician orders do not show orders to stop and restart tube feedings.

The facility's Enteral Nutrition Management Policy dated March 5, 2019, shows to assess for signs\symptoms of feeding intolerance such as nausea and vomiting. This policy shows to prevent aspiration, and notify the provider if vomiting or signs and symptoms of aspiration (noisy respirations, persistent cough) occur.

On March 15, 2019, at 10:25 AM, V21 CNA said he worked a double shift (5:30 AM-7PM) on March 11, 2019, and worked on R12's hall. V21 said R12 was gurgling all day. R12's breathing wasn't right all day. R12 threw up in the morning. The first time I saw her that morning I thought she

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was going to die, it was just a matter of when. That look was on her face. I didn't tell the nurse, I'm not a doctor and they saw her too.

On March 15, 2019, at 2:45 PM, V20 said that on March 11, 2019, V21 asked him to help transferring R12. When I entered the room, R12 was coughing and breathing raspy. V20 defined raspy as congested and wet. We provided perineal care to R12 and she started coughing up phlegm, mucous. I told V21 get the head of her bed up quickly because R12's breathing was worsening. We had to rush through changing her so we could get her head up. I left the room and told V18 (LPN) R12 was breathing really badly, maybe she was aspirating and she needed to check on her.

R12's physician order dated March 7, 2019, shows to elevate the head of the bed while tube feeding is in progress.
R12's nursing note dated March 11, 2019, at 7:10 PM (authored by V18) shows a CNA summoned V18 to check R12 because R12 vomited and there was a loud rattle in her throat.

On March 15, 2019, at 2:20 PM, V18 said on March 11, 2019, she was summoned to the room by R12's son and V20. When I entered R12's room, R12's tube feeding was going and she was gurgling and vomiting. I left the room and went to call V22. I did not check her vital signs, suction her or assess her lungs. "She was dying".

On March 15, 2019, at 11:17 AM, V19 LPN said on March 11, 2019, V18 was on the phone "with the doctor, I believe" and told me she didn't have a set of vital signs on R12 and asked me to get them. R12 wasn't "looking too good". R12 was having periods of apnea (not breathing). Her

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oxygen saturation was 69%, pulse went from 80 to 60 and R12 did not have a blood pressure. R12 was having respiratory distress. I did not suction her. I left the room to see what the plan was and what code status was. V18 was still on the phone. When I returned to the room R12 was not breathing and did not have a pulse.

On March 19, 2019, at 10:25 AM, V2 Director of Nursing(DON), said it is abnormal to find tube feeding in a resident's mouth. It could mean they vomited and the provider should be notified.

On March 19, 2019, at 10:35 AM, V22 said she was never notified R12's tube feeding was turned off and did not give an order to restart it, you need an order. V22 said she was not notified of R12's profuse coughing, vomiting tube feeding, or of tube feeding liquid being suctioned from her throat and mouth. V22 said she was on call that day and would have sent R12 to the hospital that morning if she had been aware of this. V22 said she did not see R12 on March 11, 2019, and did not hear any more until that evening when she was notified R12 coded.

R12's local emergency room record dated March 11, 2019, shows R12 was pronounced dead at 8:02 PM.

The facility's Change in a Resident's Condition or Status Policy dated July 2018 shows to notify the resident's health care provider of any changes in the resident's condition. The nurse will notify the president's health care provider when there has been an incident involving the resident, a significant change in the resident's condition and/or a need to alter the resident's medical treatment significantly. A significant change in condition is a major decline in the resident's

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S9999	Continued From page 6 status that will not normally resolve itself without intervention. The facility's Guidelines for Notifying Health Care Providers (Physicians) of Clinical Problems Policy dated December 2018 shows the purpose is to ensure medical care problems are communicated to the health care provider in an efficient and effective manner. (A)	S9999		