Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005144	A. BUILDING: _____ B. WING _____	C 04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARIDGE HEALTHCARE CENTER	700 JENKISSON LAKE BLUFF, IL 60044

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S 000	Initial Comments Complaint Investigation #1912717/IL111326 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.610a) 300.1030a)1)2) 300.1210b) 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 300.1030 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 example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic	S9999	Attachment A Statement of Licensure Violations	

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pain, cardiac failure, or cardiac arrest).

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. Restorative measures shall include, at a minimum, the following procedures:

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 were not met as evidenced by:

Based on interview and record review the facility failed to immediately initiate cardiopulmonary resuscitation (CPR) when a resident (R1) had no vital signs or respirations. The facility failed to ensure staff could identify a residents' code status. The facility failed to verify the presence of a resident's (R1) advance directives. The facility failed to ensure nursing staff were certified in CPR. The facility failed to ensure a resident's advance directives matched a resident's physician order (R10-R14).

These failures contributed to a delay in cardiopulmonary resuscitation (CPR) due to staff being unable to quickly verify R1's code status, on March 30, 2019, after R1 sustained an

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unwitnessed cardiac arrest. R1 was hospitalized and subsequently expired on April 4, 2019.

This applies to 6 of 8 residents (R1, R10, R11, R12, R13, R14) reviewed for advanced directives in the sample of 17.

The findings include:

R1's Admission Record printed April 16, 2019 showed R1 was initially admitted to the facility on December 17, 2014 with a readmission date of October 11, 2018.
R1's Care Plan dated March 3, 2017 showed R1 had no advanced directives.
R1's Physician Order Sheet dated March 1, 2019 showed R1 was a "Full Code".

R1's Nurse's Note dated March 30, 2019 at 7:00 PM showed R1 was eating dinner in her room. At 7:20 PM, R1 was found unresponsive by staff, not breathing and with no pulse, in her room. This nurse's note showed CPR (cardiopulmonary resuscitation) was not initiated by staff on R1 until 7:25 PM, five minutes after R1 was found pulseless and not breathing. R1 was transferred to a local hospital via ambulance at 7:50 PM on March 30, 2019.
On April 16, 2019 at 4:00 PM, V11(POA/power of attorney for R1) stated, "After the incident (on March 30, 2019), (R1) never returned to the facility. She never regained consciousness. She had no brain activity and couldn't breath off the ventilator so we took her off the ventilator on April 4 (2019) and she died."

R1's Ambulance report dated March 30, 2019 showed upon arrival of the ambulance crew at the facility, R1 was unresponsive with CPR in progress. This report showed, "Patient had

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obvious airway obstruction with food in her airway..."

R1's Hospital Record dated April 1, 2019 showed, "Patient is a 78 year old female who was admitted post cardiac arrest. Now intubated in the ICU (intensive care unit). EEG (echoencephalograph/study for brain activity) has shown generalized slowing and is consistent with severe generalized encephalopathy with minimal activity...Likely an anoxic encephalopathy...Patient remains unresponsive. Patient at this time is not responding to stimuli, has fixed and dilated pupils, and has no reflexes...there is no meaningful activity on EEG..."

R1's Hospital Record dated April 4, 2019 showed, "Family meeting with POA (power of attorney) and medical staff held...Plan for terminal extubation today."

On April 16, 2019 at 12:30 PM, V12 Certified Nursing Assistant stated on March 30, 2019, she entered R1's room and found R1 unresponsive. V12 stated, "(R1) was pale and her eyes were closed. I shook her and she didn't respond. I didn't check for a pulse or if she was breathing. I ran out of the room, down the hall, to the nurse's station to get the nurse. I didn't think about checking for a pulse or starting CPR on (R1). I just wanted to get the nurse. I was scared. I froze..." V12 CNA stated, "It was about 2-3 minutes from when I found (R1) like that and the nurse (V13) came in." V12 CNA also stated she was CPR certified.

On April 16, 2019 at 3:00 PM, V13 Registered Nurse (RN) stated on March 30, 2019, he was at the nurse's station when "a CNA came to get me

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about (R1). I went into (R1's) room, she had no pulse and wasn't breathing. She was blue. She had food on her gown and under her chin." When V13 was asked why CPR was not initiated immediately on R1, V13 stated, "I didn't know if she was a full code or not so I left the room. I went back to the nurse's station to check (R1's) chart. No one had started CPR on (R1) yet. I went through her chart and couldn't find an advanced directive or the POLST (Physician Order's for Life Sustaining Treatment) form which is usually in the front of the chart. I looked through her physician orders and saw the order for a full code. I called a code blue over head, ran back to R1's room and staff started CPR on her..."

On April 16, 2019 at 1:40 PM, V5 Registered Nurse (RN) stated on March 30, 2019, she did CPR on R1 after "she (R1) had choked." V5 stated, "When I entered (R1's) room, no one was doing CPR or the Heimlich on (R1). She had food coming out of her mouth and on her gown. I opened her mouth and pulled food out of her mouth. She didn't have a pulse. I heard the code blue page overhead. As (V13) came running back into the room, I started CPR..I don't know why CPR wasn't started right away on (R1)..."

On April 16, 2019, V5 RN and V13 RN each stated there was no quick way to identify which residents were full codes versus DNR's (do not resuscitate) at the facility. V5 RN and V13 RN each stated if they were unsure of a resident's code status, they would have to look in the resident's written medical record, kept at the nurse's station, for verification.

On April 18, 2019 at 10:30 AM, V3 Assistant Director of Nursing (ADON) stated, "We have no

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quick way to identify residents that are full codes versus DNR's. There is nothing in the resident's rooms to quickly identify this. The nurse would have to go to the nurse's station and look in the chart for a DNR sticker and the POLST form."

On April 16, 2019 at 11:25 AM, V3 ADON and V4 Nurse Consultant each stated if a resident is a full code (not a DNR), CPR should be started immediately if the resident is pulseless and staff should yell for help.

On April 22, 2019 at 9:15 AM, V3 ADON stated, "All nursing staff which includes nurses and CNAs are to be CPR certified. If a CNA finds a resident pulseless and not breathing, they should yell for help and start CPR immediately."

On April 18, 2019 at 10:05 AM, V16 Physician stated, "Residents that are found pulseless and apneic (not breathing) should have CPR started on them immediately if they are a full code. Any delay in CPR can cause an increase in morbidity and mortality. A delay can lead to an increase in bad outcomes which can include an anoxic brain injury or never getting a pulse back."

On April 16, 2019 at 11:25 AM, V3 ADON and V4 Nurse Consultant each stated they were unable to find a POLST form in R1's medical record. V3 ADON stated, "Our social services makes sure the POLST form gets completed as soon as possible once a resident is admitted and puts them in the chart."

On April 16, 2019 at 4:00 PM, V11 (POA for R1) stated, "I was never asked to sign any advanced directive forms for (R1). When (R1) was admitted to the facility years ago, she was of sound mind so I advised them to speak with her.

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She wanted to be a full code, not a DNR. When she was readmitted last fall (2018), I was contacted by someone at the facility, I don't remember her name, and was told we needed to discuss (R1's) code status. I again asked for her to speak with (R1) about this and said we can all talk about this the next time I visited with (R1). No one ever brought this up to me again or approached me about signing any advanced directive forms when I was at the facility. I was never emailed any advance directive forms to sign."

On April 17, 2019 at 8:00AM, V15 Social Services stated, "I don't know why a POLST form was never completed on (R1). We start trying to get the POLST forms completed as soon as possible after a resident is admitted. We want to get the advanced directives confirmed immediately so if the resident is cognitively intact, we approach the resident and have them sign the form. If they aren't, we approach the POA to sign the form." R1's Social Service note dated February 5, 2019 showed, "Resident has POAHC (power of attorney for health care/V11). This writer left a voicemail for POAHC to educate on POLST form." When V15 Social Services was asked if she followed up with V11 (R1's POA) regarding the voicemail left for V11 on February 5, 2019, V15 stated, "I'm not sure."

R10's Admission Record printed April 24, 2019 showed R10 was admitted on June 21, 2018 and listed no code status for R10. The facility's No POLST List dated April 24, 2019 showed R10 had no completed POLST form in his chart. R10's Physician Orders dated April 1, 2019 showed no physician order for advanced directives.
R11's Admission Record printed April 24, 2019 showed R11 was admitted on September 26,

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2017 and listed R11 as a DNR. R11's Physician Orders dated April 1, 2019, showed R11 was a "full code".
R12's Physician Orders dated April 1, 2019 showed R12 was admitted on February 19, 2019 and R12 was a "full code". R12's POLST form dated April 27, 2017 showed R12 was a DNR.
R13's Physician Orders dated April 1, 2019 showed R13 was admitted on June 17, 2016 and R13 was a "full code". R13's POLST form dated September 14, 2018 showed R13 was a DNR.
R14's Physician Orders dated April 1, 2019 showed R14 was admitted on March 12, 2018 and R14 was a "full code". R14's POLST form dated May 4, 2018 showed R14 was a DNR.
On April 24, 2019 at 10:30 AM, V2 DON stated she did not know why R10-R14's POLST forms were missing or not matching each residents physician orders. V2 stated, "Social Services does the POLST forms. I should have made sure they were matching." V2 also stated the facility had no process in place to verify or check that each resident's POLST form and physicians order for advance directive matched.

The facility Nurses Form 2019 and CNA Form 2019, both dated April 24, 2019, showed V4 RN, V17 RN, V18 RN, and V21-23 CNA's had no valid CPR certification.
On April 24, 2019 at 10:24 AM, V2 Director of Nursing (DON) stated the facility had no process in place to ensure all nursing staff were current in CPR. V2 stated she was not aware there were facility nursing staff without current CPR certification.

The facility's Cardiopulmonary Resuscitation (CPR) Policy dated July 2010 showed, "Cardiopulmonary Resuscitation (CPR) will be initiated on all patients, employees or visitors for

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whom this intervention is indicated.
Cardiopulmonary Resuscitation will be initiated by any member of the Nursing Department who has been trained in this procedure."
The facility's Advance Directives Policy dated November 26, 2014 showed, "Upon Admission:
A. Designated staff will review Advance Directive options and the Statement on Illinois Law addressing Advance Directives and Life Sustaining Treatment with the resident and/or representative...An Advance Directive form (as provided by the healthcare facility) will be completed with resident and/or legal representative to verify treatment options as well as code status (full code vs. DNR using the POLST document)..."
The facility's CNA Job Description, RN Job Description, and LPN Job Description each dated April 2019 showed each must have valid CPR certification.

(AA)

Licensure 2 of 2
300.690a)
300.690b)
300.690c)

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any

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serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review, the facility failed to investigate a serious incident involving a resident. The facility failed to notify the Department of a serious incident involving a resident.

This applies to 1 of 3 residents (R1) reviewed for Incidents and Accidents in the sample of 5.

The findings include:

R1's Nurse's Note dated March 30, 2019 at 7:00 PM showed R1 was eating dinner in her room. At 7:20 PM, R1 was found unresponsive, not

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breathing and with no pulse, in her room. CPR (cardiopulmonary resuscitation) was initiated on R1 by staff. R1 was transferred to a local hospital via ambulance at 7:50 PM on March 30, 2019.
On April 16, 2019 at 1:40 PM, V5 Registered Nurse (RN) stated on March 30, 2019, she did CPR on R1 after "she (R1) had choked." V5 stated, "When I entered (R1's) room, she had food coming out of her mouth and on her gown. I opened her mouth and pulled food out of her mouth. She had no pulse so I started CPR..."

On April 16, 2019 at 11:25 AM, V2 Director Of Nursing (DON) stated she did not complete an investigation on R1's choking incident on March 30, 2019. V2 stated, "I didn't do an investigation about what happened. I just asked around to my staff. I'm not really sure what happened to (R1)..."
On April 16, 2019 at 11:30 AM, V3 Assistant Director of Nursing (ADON) stated, "No, we never sent the Department any notification on what happened to (R1). We should have reported it since it was serious change in condition of a resident..."

The facility's Accident and Incidents - Investigating and Reporting Policy showed, "1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident."

(B)