STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004139	A. BUILDING: _____ B. WING _____	C 07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HEALTH CARE CENTER	15600 SOUTH HONORE STREET HARVEY, IL 60426

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigation 2095695/IL124986	S 000		
S9999	Final Observations Complaint Investigation 2095695/IL124986 Statement of Licensure Violations 300.1035a)3)4)5) 300.3240a) Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 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;	S9999	**Attachment A** **Statement of Licensure Violations**	

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5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

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 Regulations were not met as evidenced by:

Based on observation, interviews and record reviews the facility failed to follow their policy and protocol for respiratory assessment. This failure affects (R1) one of 3 residents reviewed for difficulty breathing. R1 was observed unresponsive by staff after receiving a breathing treatment and later died.

Findings include:

MDS(Minimum Data Sheet) dated April, 2020, shows R1 has diagnosis of shortness of breath. POS(Physician Order Sheet) dated June, 2020 shows R1 is a full code.

V3 Nurses progress note dated 6/30/2020 at 4:43a.m, documents, "At 1:30am R1 asked for a breathing treatment. Treatment given for fifteen minutes, lungs auscultated and clear. Resident conversed with writer and aide. Resident (R1) allowed to rest. Upon doing 4:00 a.m. rounds resident observed in bed with no signs of life. No

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palpable pulse. No respirations. 911 called code blue initiated by all staff. Emergency services arrived and noted resident was unable to be coded. 4:25a.m. emergency services exited the facility."

On 7/10/2020 at 4:07p.m V7(CNA/Certified Nursing Aide) said on 6/30/2020 at approximately 1:30 a.m., R1 complained of difficulty breathing. However, at this time, V7 changed his story and said it was 2:00a.m when R1 was complaining of difficulty breathing. V7 said he informed the nurse (V3) right away and V3 came and gave R1 a nebulizer breathing treatment and once the treatment finished the nurse came back to the resident room and removed the mask.

On 7/10/2020 at 4:50p.m, V5(Nurse) said, "At approximately 1:00 a.m.,V7 came to the first floor nurses station and stated that R1 complained of difficulty breathing. V5 said she stood up, asked V3 if R1 had anything for difficulty breathing. She went to the medicine cart and retrieved the medication (Duoneb), took the medication to the room, asked R1 if he needed a treatment, put the medication in the in apparatus and placed the mask on R1's face. V5(Nurse) said she administered the breathing treatment for R1. V5 said she did not complete an assessment (listen to R1 lungs, and check vital signs and check oxygen levels) prior to giving R1 the breathing treatment.

When asked about R1's condition prior to V5 giving R1 the breathing treatment V5 continued to say she did not complete the respiratory assessment she thinks that V3 completed the assessment.

Nurse's progress notes dated June 30th, 2020

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did not show documented assessment of R1's vitals(blood pressure, temperature, respiration, pulse), oxygen levels or lung sounds completed prior to R1 receiving the breathing treatment. There was no documented assessment completed of R1 vital signs (blood pressure, respiration, pulse, temperature) or oxygen levels for R1 post the breathing treatment.

MAR(Medication Administration Record) dated 6/30/2020 indicates there was no documentation showing duoneb treatment for respiratory symptoms was given.

A review of R1's plan of care does not show a plan of care of management of shortness of breath.

On 7/14/2020 at 9:27a.m, V2 (Director of Nursing) said the nurse should assess the blood pressure, temp, pulse, respirations, oxygen levels and complete an assessment of lung sounds prior to administering breathing treatment. V2 said the nurse should stay with the resident during a breathing treatment. V2 said CPR should be initiated by the first person to observe the resident with no pulse, and no respiration. V2 said the aide(V7) should not have left R1 whom was unresponsive. He should have called out for help, continue to stay with the resident and initiate CPR.

On 7/14/2020 at 12:51p.m, V4(NP-Nurse Practitioner) said he visited R1 on 6/29/2020 and R1 did not have any concerns related to shortness of breath or difficulty breathing. The cause of death cannot be determined without having an autopsy. R1's death was sudden. A heart attack, pulmonary embolism and Covid 19 can cause sudden death without warning but he

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cannot make that determination. V4 said he was not notified of R1 having difficulty breathing on 6/30/2020, he was not on call. He said the duoneb treatment was appropriate for a resident experiencing shortness of breath. The breathing treatment did not cause R1's death. V4 said when a resident is having difficulty breathing the provider should be notified to try and determine the cause of the difficulty breathing especially since covid 19 is causing a pandemic right now. There could have been many reason any person experience difficulty breathing, and further testing may have been warranted. It's just a difficult circumstance because R1's death was sudden. V4 said he would expect the nurse to complete an assessment if the resident is complaining of difficulty breathing.

On 7/14/2020 at 11:08a.m., V6 (Nurse) observed administering breathing treatment to R2. V6 assessed R2 lungs sounds. She took R2's vitals prior to administrating the breathing treatment. V6 said the rational for assessing the lungs and vitals pre and post treatment is to determine if the medication was effective, also explained the rationale for staying with the resident while the treating is going, to encourage the resident to take deep breaths and also to ensure the resident gets all the medication. V6 observed documenting the vital signs and oxygen level post treatment. There were no concerns with V6.

Administering Med Via Nebulizer Policy dated 06/2019 shows in part: Administering medications via nebulizer for medications to be dispensed into the respiratory tract. Equipment stethoscope, medication, nebulizer tubing and chamber and air compressor or oxygen hook up. Procedure shows to gather equipment check order against MAR, perform hand hygiene, knock

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before entering the room and identify yourself, explain the procedure to the resident, complete necessary assessment before administering medication, open nebulizer cup and place premeasured unit dose inside and close cup, turn on air compressor or oxygen, instruct resident to inhale slowly and deeply through the mouth, continue inhalation until all mediation in the nebulizer cup has been aerosolized, stay with the resident while receiving medication. Reassess lung sounds and document medication administration.

On 7/10/2020 at 4:07p.m during an interview with V7(CNA), he stated rounds are done every 2 hours or as needed. He said at about 3:30a.m he was doing rounds. R1 was laying in the bed. V7 called R1's name and shook R1 but he did not respond. V7 said he checked for a pulse on R1's neck and R1 did not have a pulse. V7 said he did not initiate CPR, he left the room to go get the nurse. V7 said he felt that the nurse could take care of R1 better than he could. V7 has active CPR certification dated 9/28/2019.

On 7/10/2020 at 4:50p.m during an interview, V5(Nurse) stated that at approximately 4:00a.m she announced Code Blue for R1 because R1 was not breathing. V5 said she was doing chest compressions for R1. V5 said she called 911. When asked who assisted her with the code, V5 didn't give an initial response. However, a few minutes later, V5 said, "We all(V5 and V3) were doing CPR. V5 said when the paramedics arrived, they did not administer CPR because R1 had expired.

Cardiopulmonary Resuscitation Policy dated 06/2019 shows in-part: The American Heart Association guidelines will be followed.

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S9999	Continued From page 6 Cardiopulmonary resuscitation (CPR) will be initiated on all residents, employees or visitors whom this intervention is indicated. CPR will be initiated by any staff member certified in CPR. See guidelines from American heart association. BLS (basic life support) consist of these main parts: chest compressions airway, breathing, defibrillation. Step 4 shows begin cycles of 30 chest compressions and 2 breaths cycles. Figure 12 shows two rescuer CPR. The first rescuer performs chest compressions the second rescuers performs bag mask ventilation using a mask with supplemental oxygen (when available). The second rescuer ensures that the chest rises with each breath. Rescuers should switch roles after cycles of CPR (about every 2 minutes). (A)	S9999		