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
	IL6002364	A. BUILDING: _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE DANVILLE	1701 NORTH BOWMAN DANVILLE, IL 61832

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S 000	Initial Comments Facility Reported Incident of November 14, 2020 #IL129151	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1220 b)3) 300.1220 b)8) 300.1220 b)9) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).)

Section 300.3240 Abuse and Neglect

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to provide timely and appropriate emergency tracheostomy care for a resident who was found unresponsive with their breathing tube removed, failed to ensure all caregivers were trained to respond appropriately to tracheostomy emergencies, failed to consult with respiratory care professionals following previous incidents of decannulation/extubation, failed to assess and develop targeted interventions for previous incidents of internal decannulation/extubation, and failed to develop and implement policy guidance for staff to follow for tracheostomy emergencies. These failures affect one of one residents (R1) reviewed for emergency respiratory care in a sample list of three. R1 died of Acute Myocardial Infarction and Acute Hypoxic Respiratory Failure after being found unresponsive without R1's tracheostomy tube.

Findings include:

R1 was admitted on 8/31/20, with diagnoses documented on the Medication Administration Record, dated November 2020, including: Neoplasm of Uncertain Behavior of Larynx and Tracheostomy Status. There are no physician orders for tracheostomy care, supplies, or suctioning documented until 10/30/20.

R1's care plan, dated 9/17/20, documents interventions for R1's pulling out tracheostomy and self- suctioning as: "Educate (R1) on the importance of leaving (R1's) tracheostomy tube in

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place, (R1) being patient with staff, (R1) allowing staff to provide (R1's) care, Staff providing (R1) encouragement and active support when (R1) uses these strategies, Staff to explain to (R1) what is being done before performing the task, Staff to talk to (R1) when passing (R1's) room and monitor behavior episodes and attempt to determine underlying cause." R1's progress notes document education as the only intervention implemented for R1's repeated tracheostomy tube removal.

R1's progress notes document R1 intentionally removing internal cannula (tube) (of tracheostomy) on the following dates: 9/18/20, 9/28/20, 10/1/20, 10/12/20, 10/30/20, 11/2/20, and 11/6/20. R1's progress notes document education as the only intervention implemented for R1's repeated tracheostomy tube removal. There is no documentation in R1's medical record that the facility consulted with a Respiratory Therapist regarding R1's repeated tracheostomy removal.

R1's progress note, dated 10/12/20 at 2:01 PM documents, "(V20) Assistant Director of Nursing (ADON) (was) called into (R1's) room by another nurse who found (R1) unresponsive. Upon assessment of (R1), this ADON found that (R1) had pulled entire tracheostomy tube out and was bleeding from the site. (R1) was gasping for air. (V20) tried to replace tracheostomy tube, but the airway was blocked. (V20) held tracheostomy tube halfway in airway to allow for a patent airway, and ten liter tracheostomy mask applied." R1 was then sent to the emergency department.

On 12/7/20 9:21 AM, V6, Registered Nurse/Care Plan Coordinator (RN/CPC), stated, "(R1) frequently attempted to pull out (R1's) inner

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cannula. We educated him over and over." On 12/7/20 at 9:30 AM, V6, Registered Nurse (RN), stated V6 "sent (R1) to the hospital several times because (R1) removed his tracheostomy tube. (V6) witnessed him loosening the ties and (V6) educated (R1) every time." On 12/7/20 at 10:25 AM, V7, Registered Nurse (RN), stated, "The biggest battle (V7) had with (R1) was (R1) taking out (R1's) inner cannula."

On 12/7/20 at 3:29 PM, V16, Licensed Practical Nurse (LPN), stated V16 found (R1) unresponsive on 11/14/20 at approximately 10:00 AM. "(V6) immediately ran out (of R1's room) to get a more experienced nurse. It took (V19) Registered Nurse (RN) and I (V16) at least five minutes to get back into the room. I don't have emergency training on tracheostomies, just on cleaning and suctioning. (V16) didn't check (R1's) pulse when (V16) found him. (V16's) instinct was to get help."

R1's patient care record from local Ambulance Service, dated 11/14/20, documents, "10:38 AM at (R1's) bedside found nurse giving the patient a nebulizer treatment via (R1's) stoma. Nurse stated she did not know how long (R1) had been without (R1's) trach (tracheostomy tube). Nurse also stated that the (R1) had pulled (R1's) trach out several times this morning. (R1) was pale and mottled, no respirations noted, pupils fixed and dilated. (R1's) extremities were cold to the touch. (Post- mortem blood pooling) noted to R1's lower back." Time of death noted 10:51 AM.

On 12/8/20 at 2:00 PM, V19, Registered Nurse (RN), stated on 11/14/20 at approximately 10:00 AM, V19 was called to R1's room and found R1 with the tracheostomy out. After assessing vital signs, V19 put the cannula back in using the

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obturator. "We cranked up the oxygen, but he was gone."

On 12/7/20 at 10:45 AM, V1, Administrator in Training, stated, "I (V1) don't know what my (V1) expectations (for emergency care) would have been."

On 12/7/20 at 4:00 PM, V12, Medical Director, stated, "(V12) would expect 24/7 (around the clock) observation or four point restraints, which we don't do anymore, for a patient who persistently tried to remove his (tracheostomy)."

On 12/10/20 at 10:23 AM, V12 stated the cause of death for R1 was Myocardial Infarction (heart stopped beating) due to Hypoxic Respiratory Failure (not enough oxygen in the blood) caused by the tracheostomy tube not being in (R1). V12 stated, "I (V12) would expect the facility to follow their policy. That is why they have them."

R1's Death Certificate, dated 11/17/20, documents cause of death as Acute Myocardial Infarction due to or as a consequence of Acute Hypoxic Respiratory Failure, signed by V12, Medical Director.

On 12/7/20 at 10:50 AM, V13, Certified Nursing Assistant (C.N.A.), stated regarding emergency tracheostomy training, "I've (V13)not got training on trachs (tracheostomies) I (V13) would get the nurse."On 12/7/20 at 10:53 AM, V14, Certified Nursing Assistant (C.N.A.), stated regarding emergency tracheostomy training, "I (V14) would get the nurse."
On 12/8/20 at 2:00 PM, V19, Registered Nurse (RN), stated regarding emergency tracheostomy training, "I (V19) have not gotten emergency training (for tracheostomies) at work." On

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S9999	Continued From page 6 12/10/20 at 2:15 PM, V24, Licensed Practical Nurse (LPN), stated, "I (V24) did not receive any emergency training to care for a tracheostomy resident at this facility." On 12/8/20 at 10:30 AM, V2, Director of Nursing (DON), stated V2 trained the staff on the (tracheostomy care) supplies at the bedside. V2 stated in an emergency, V2 would expect the nurse to cover the stoma and oxygenate the area or place a smaller cannula in the tracheostomy. When asked why V2's treatment for emergency care differed from facility policy, V2 would not answer. Facility in-services documented on 11/9/20, 11/10/20, 11/11/20, 11/23/20, 11/24/20 documents education on tracheostomy care, and policies and procedures, but does not document staff were trained on emergency care for residents with tracheostomies. On 12/10/20 at 8:45 AM, V23, Respiratory Therapist (RT), stated V23 set (R1's tracheostomy) up on admission. "I (V23) told them that if they wanted an in-service or needed any help, to call and (V23) would provide it. (V23) never got a call. In the case of an alert and oriented resident complaining of their tracheostomy tube being plugged or pulling it out, (V23) would have expected them to call (RT). (V23's) other homes would have called. I (V23) have seen other places use 24/7(around the clock) sitters to prevent patients from pulling out their trachs (tracheostomy tubes). Anyone caring for the tracheostomy patient should be trained on how to handle an emergency with the emergency equipment at the head of the bed including a (manual breathing bag) and more tracheostomy tubes. They should have done something."	S9999		

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S9999	Continued From page 7 On 12/14/20 at 10:30 AM, V2 stated (Respiratory Care Company) had provided tracheostomy training to the facility staff. V2 was unable to provide documenation of when the training was conducted and what education was provided during the training. On 12/15/20 at 10:30 AM, V22, Customer Service Respiratory Care Company, stated V22 has no record of (Respiratory Care Company) providing education to the facility other than the day R1's tracheostomy was set up when R1 was admitted. On 12/17/20 at 9:46 AM, V1 stated the facility had a tracheostomy policy in place at the time R1 removed R1's tracheostomy tube, and V1 would have expected the nurses to follow the policy when an internal decannulation and extubation occurred. V1 stated the facility's policy documented for emergency tracheostomy decannulation and extubation staff should stay with the resident and call for assistance, use a rubber tipped hemostat to maintain the airway, and suction if needed. V1 stated the facility policy has since been revised to include additional guidance for emergency tracheostomy care. V1 stated V2 had provided staff training on tracheostomy care and suctioning, and the equipment/supplies that should be stored at the bedside. V1 stated the training was only provided to licensed nurses. The facility's Tracheostomy Care policy, revised on 8/20/18, documents, "If outer tube comes out, stay with resident and summon assistance. A rubber tipped hemostat may be used to maintain opening. If necessary, suction the resident through the opening." There was no further documentation regarding emergency response or	S9999		

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