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S 000	Initial Comments Investigation of Complaint 1870655/IL99918	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1030a)2) 3001030b) 3001030c) 300.1210b) 300.1210c) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:

2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.

c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements.

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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.1220 Supervision of Nursing

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S9999	Continued From page 2 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to initiate CPR (cardiopulmonary resuscitation) on a resident designated as a full code for R1, significantly delayed the implementation of CPR for R2 due to inadequate information about R2's code status, failed to follow the facility's policy for advanced directives and maintaining individual resident code status and failed to have a system in place so staff could promptly determine the code status of a resident. The facility also failed to ensure that staff had current healthcare provider CPR certificates for staff on duty, failed to ensure that staff was knowledgeable about assessing a	S9999		

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resident that codes and failed to ensure that facility crash carts were stocked with needed equipment.

The findings include:

The Facility Data Sheet dated February 13, 2018 indicates that 72 residents resided in the facility at the time of the survey.

1. Facility documentation showed R1 sustained a fall at the facility on January 29, 2018 at 2:30 AM. At 3:00 AM, R1 was screaming and requested to have her bed adjusted by V10 (RN-Registered Nurse). At 3:30 AM, V10 administered Ativan (sedative) to R1 due to screaming and agitation. At 6:30 AM, V10 faxed information regarding R1's fall to V18 (Physician/Medical Director).

V4's (RN-Registered Nurse) documentation dated January 29, 2018 at 7:40 AM shows: "Writer was notified to report to [R1's room]. [R1] was repositioned by staff for her breakfast but extremities are cold, but moaning when repositioned. Pulse noted at right arm, fingernail color within [R1's] norm, and the staff stayed with the resident and writer called 911 with report. Sternal rub was done and 911 crew came and take over. CPR done by 911 crew. 8:15 AM, 911 crew informed writer that the time of death was 8:15 AM. Son was informed of what had happened. MD informed. [V2] DON (Director of Nursing) aware and administrator notified."

R1's undated face sheet shows R1 was a 63-year old resident, admitted to the facility in November 2016 with multiple diagnosis including weakness, epilepsy, diabetes, other cerebrovascular disease, history of falling, hypertension, major

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depressive disorder, and high cholesterol. R1's Illinois Statutory Short Form Power of Attorney for Healthcare, signed by R1 on November 21, 2016 shows R1 initialed the following statement: "I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures."

On February 13, 2018 at 12:32 PM, V4 said, "I started work at 6:00 AM on January 29, 2018. [V10] reported to me that [R1] had a fall during the night but there were no problems. I checked her after report and she was okay. They gave her Xanax (sedative) during the night. She was sleeping when I saw her. I checked her two times. I told [V7] (CNA-Certified Nursing Assistant) to check on her more often. At 7:40 AM, [V7] delivered the room tray to [R1]. They called me to go to the room because she was cold on her lower extremities when they tried to boost her. She moaned when they boosted her, but I went and called 911 because something didn't seem right. I called 911 and told them she's cold but still responsive. I didn't check her vitals at 7:40 AM when I went in the room. I did not check a blood pressure or a pulse oximeter, and I did not document a pulse rate. Another nurse [V5] (RN) came about 10 minutes after. I never started CPR (cardiopulmonary resuscitation). Right before they came she deteriorated but we didn't start CPR. She was a full code. The paramedics started CPR when they got here."
On February 15 2018 at 12:51 PM, V4 said, "I did a sternal rub on [R1]. I thought she was still alive. I did not apply oxygen to her. We are supposed to start oxygen."

On February 13, 2018 at 12:59 PM, V5 (RN) said,

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"I was here doing paperwork. My CNA called me and said [V4] wanted me. He was on the phone with 911. I went to find the room where the problem was, but I didn't know what room it was. I saw a CNA with a resident. She was cleaning her. The resident appeared sleepy. I did not check to see if [R1] was breathing. We usually call a code blue when something like this happens and someone does paperwork, but we did not call a code blue that day. I did not know her code status. She was unresponsive when I got there. I thought I felt a faint pulse on her wrist but I didn't assess her breathing."

On February 13, 2018 at 1:37 PM, V7 (CNA) said, "I did rounds and [R1] appeared asleep. The nurse notified me she had a fall and she should be checked frequently. I was calling her name and she wasn't responding. I cleaned her up before the paramedics arrived. She wasn't saying anything at all. I rubbed her chest and there was no response. I grabbed her wrist and there was no pulse. We are all CPR certified. I went and grabbed the nurse and I stepped aside. When I was trained on CPR they said you should start chest compressions, but I'm not sure how often to do breaths. I never started CPR on her."

Documentation provided by the facility shows V4, V5 and V7 do not have the required CPR certification.

2. V17's (LPN-Licensed Practical Nurse) documentation dated January 31, 2018 at 6:00 AM shows, "At 3:40 AM I was notified by the aide that [R2] was unresponsive. After seeing [R2], I checked the chart to see if the patient was DNR (do not resuscitate). I called 911 and paramedics came to take over CPR." Documentation in the medical record dated January 31, 2018 4:50 AM,

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"Resident pronounced dead at 4:22 AM per paramedics by [local hospital], coroner called with order to release the body, to call them once funeral arrangement is done."

R2's undated face sheet shows R2 was a 45-year old resident, admitted to the facility in September 2009 with multiple diagnoses including early-onset cerebellar ataxia, dysphagia oropharyngeal phase, gastrostomy, and contracture of joints. R2's Illinois Statutory Short Form Power of Attorney for Healthcare, dated March 22, 2012 shows R2's relative initialed the following statement: "I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures."

On February 13, 2018 at 3:09 PM, V17 (LPN) said, "[R2] was normal when I got him at 10:00 PM on 1/30/18. I work from 10:00 PM to 6:00 AM. I checked him a few times and he was sleeping. [V9] (CNA) checked him and told me he was unresponsive around 2:30 AM on January 31, 2018. I checked his pulse and there was none and I checked his breathing, and he wasn't breathing. I had to go check the chart to see his code status at the nurse's station down the hall. He was a full code, so I called 911 and then I went to the room and tried to resuscitate him. The resident assistant was close by and I had her get the nurse. It took me a few minutes to check the chart, and another 2 to 3 minutes to call the paramedics, so it was about 5 minutes later when I started CPR. I'm not sure who is supposed to start CPR on the resident. Someone else could have started CPR but they did not."

On February 13, 2018 at 5:25 PM, V14 (RN) said, "I was working in the back hall. The resident

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assistant came to get me to send me to a patient's room. I did not know what room the resident was in because [V17] was on the phone with [V2] (DON-Director of Nursing) trying to figure out the resident's code status so I did not initially go to the resident's room. We were trying to figure out if [R2] was a full code or not. We were looking at [R2's] chart and we were on the phone for about 5 minutes before 911 was called. They came a couple of minutes later. I went to check [R2] and one of the resident assistants was cleaning him. I checked the pulse and there was none, and I checked the pulse oximeter and there was no reading. [V17] started CPR. No one gave rescue breaths or applied oxygen. I was looking for a [bag valve mask] on the crash cart, but I could not find one. I was going to start CPR on [R2], but then [V17] came into the room. I don't know why [V9] (CNA) was cleaning the resident instead of doing CPR. [V21] (CNA) was not available to help with [R2] during the entire time. She was on her break. The paramedics came and did CPR for quite a while."

Documentation provided by the facility shows V9, V14 and V17 do not have the required CPR certification.

On February 13, 2018 at 2:30 PM, V2 (DON) said, [V17] called me at home in the middle of the night, about 2:00 AM on January 31, 2018. He asked me, aside from the chart, is there anything he needs to check to see if a resident is a full code. He called to say [R2] was unresponsive and he wanted to make sure he was a full code. I told him to call 911. I expect staff to start CPR, call a code blue and have another staff member call 911. I would have expected [V9] to be performing CPR on [R2] if [V9] had CPR certification, not cleaning [R2]. The progress

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notes should show an assessment with vital signs and a code blue record should be filled out to show what was done during the code. That did not happen with [R2]. All nurses are required to have CPR certification. Our ADON (Assistant Director of Nursing) used to track the staff CPR cards, but she has been gone for a couple of months."

During intermittent observations on February 13, 2018 between 10:00 AM and 4:00 PM and February 14, 2018 between 9:15 AM and 11:30 AM, resident medical charts were not labeled with the resident's room number and were not in corresponding labeled cubicles. Charts were also missing from the nurse's station, and nursing staff was not aware of the location of the charts. Multiple interviews were held with staff members, and staff members could not provide consistent answers where the resident code status was located.

On February 13, 2018 at 5:11 PM, V11 (RN) said, "I look in the resident's chart for a DNR paper. If there is no DNR paper, we act as if they are a full code. I think my CPR card is up to date." Facility documentation shows V11 does not have the required CPR certification.

On February 13, 2018 at 5:13 PM, V12 (LPN) said, "I took CPR recently. A label on the side of the chart shows if the resident is a DNR or not. If no label on the side of the chart, then the resident is a full code." The facility did not have documentation to show V12 has the required CPR certification.

On February 13, 2018 at 5:16 PM, V13 (LPN) said, "My CPR certification expires February 22, 2018. We can't work if it is expired. To

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determine a resident's code status, we look in the chart. We look for the pink form. If nothing in the chart, then the resident is automatically a full code."

On February 14, 2018 at 9:06 AM, V15 (RN) said, "I go through the chart to find a resident's DNR paper. If I can't find a resident's chart, I would have to call around the facility to find the chart before I could determine a resident's code status. I have CPR certification, but I don't know when it expires." The facility did not have documentation to show V15 has the required CPR certification.

On February 14, 2018, the facility provided a list of residents in the facility with their code status dated February 11, 2018. Chart audits were done to compare the code status designated on the facility-provided list to the code status in the resident's charts. Some resident charts were not available, and the facility did not have any other means to identify these residents' code status. The following discrepancies between the facility's provided list and resident charts were found:

R4 - The facility provided list shows R4 is a DNR. R4's POLST (Practitioner Orders for Life-Sustaining Treatment) form dated November 9, 2015 shows "attempt resuscitation/CPR" if patient has no pulse and is not breathing.

R5 - The facility provided list shows R5 is a DNR. R5's POLST form dated July 7, 2015 shows attempt resuscitation/CPR. A photocopy of the same form dated July 7, 2015 shows attempt resuscitation/CPR crossed out with the word "VOID" written next to the attempt resuscitation/CPR, and a check mark in the box next to the words "Do Not Attempt Resuscitation/DNR." There are no initials or date

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next to the alterations made on the POLST form. There was no DNR order on R5's POS (physician order sheet).

R6 - The facility list shows R6 is a full code. Facility form in medical record entitled "Responsible Party/Advance Directive Election Review" shows "Code Status Designation: Resident/Responsible Party has chosen: Do not Resuscitate Effective on receipt of signature of Resident/Responsible Party and order by physician." No dates were filled out on the form. V2 (DON) was asked to determine the code status of R6. V2 said, "The code status should be on the face sheet of the residents." V2 was unable to determine R6's code status and enlisted the assistance of V22 (Social Services) and V23 (RN). V22 and V23 were unable to determine R6's code status. V2 said, "The facility face sheet shows [R6] is a full code. R6's POA (Power of Attorney) papers show full code. The Code Status sheet shows DNR (do not resuscitate). I am not sure." The process of determining R6's code status took 10 minutes and 20 seconds to determine. A form found in the medical record shows R6's code status as DNR, which contradicts the sheet provided by the facility. There was no DNR order on R6's POS.

R7 - The facility provided list shows R7 is a DNR. There were no forms in the medical record to show R7 was a DNR. V2 said R7 should be a full code.

R8 - The facility provided list shows R8 is a DNR. There were no forms in the medical record to show R8 was a DNR. V2 said R8 should be a full code.

R9 - The facility provided list shows R9 is a full

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code. Forms in the medical record show R9 is a DNR. V2 confirmed R9 should be a DNR. There was no DNR order on R9's POS.

R10 - The facility provided list shows R10 is a DNR. There were no forms in the medical record to show R10 was a DNR. V2 said R10 should be a full code since no papers were in the medical record.

R11 - The facility provided list shows R11 is a DNR. There were no forms in the medical record to show R11 is a DNR. V2 said R11 should be a full code.

R12 - The facility provided list shows R12 is a DNR. There were no forms in the medical record to show R12 is a DNR. V2 said R12 should be a full code.

R13 - The facility provided list shows R13 is a DNR. R13's DNR papers could not be located in the medical record. R13 did not have a DNR order on the POS.

R14 - The facility provided list shows R14 is a full code. Forms in the medical record show R14 is a DNR. There was no DNR order on R14's POS.

On February 14, 2018 at 11:20 AM, V16 (Assistant Chief Local Fire Department) said, "The fire department personnel would follow the POLST forms in the resident's medical record. If the resident does not have advance directives in the medical record, we would perform CPR. In the case where two forms exist for one resident (R6) with a crossed off resuscitate preference, and DNR written in, we would not honor that form and we would perform CPR. A new form should be made when a resident changes their code

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S9999	Continued From page 12 status." On February 14, 2018 at 3:15 PM, V18 (Physician/Medical Director) said, "When they found [R1] without a pulse or breathing, I would have expected them to start CPR right away. I also would have expected them to notify me during the night after she fell, especially when she had the screaming behaviors. If I would have been notified, I probably would have sent her out to the hospital. When someone codes, I would expect the staff member to call 911 and go back to the resident to do CPR. If two people in the facility have CPR certification, I would expect one to notify 911 and the other to start CPR. If there are no papers in the chart to show the resident is a DNR, I would expect the staff to start CPR as soon as they can. Whoever discovers the resident without pulse or breathing should start CPR. All staff needs to be certified in CPR. Online classes are not acceptable. You need to practice on the dummy. If the POLST form is signed and the resident and/or family change their mind about the code status, it is not acceptable to cross anything out. You need to fill out another form and resigned by the physician. The facility should have a process in place for them to perform CPR quickly without delay. They should not be taking time to call the DON to find out the code status. I was not aware of the problems with the code status not being readily available. I wasn't aware of a delay in CPR for [R2]." The facility's undated Advance Directive policy shows: "Policy: The Patient Self Determination Act states that individuals have the right to make their own decisions, and to formulate advance directives to serve as decisions when the individual is incapacitated. It is the policy of this	S9999		

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	IL6008718	A. BUILDING: _____ B. WING _____	C 02/22/2018

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S9999	Continued From page 13	S9999		

facility to honor resident's wishes as expressed in advanced directives regarding medically indicated treatments whenever possible. This facility shall take all steps necessary to comply with state and federal legislation relating to advance directives. Procedure: ...4. Any decision made by the resident shall be indicated in the chart in the manner easily understood by all staff. Advance directives specifying full code/Attempt Resuscitation/CPR, or the absence of determination shall be recorded as a "Full Code." Advance directives specifying "Attempt Resuscitation/CPR" shall be recorded as "Full Code." Those residents indicating "Do Not attempt resuscitation/DNR" but requests limited additional interventions shall be recorded as signifying DNR-DNI (do not intubate) or requests comfort measures only shall be recorded as signifying DNR-Comfort as indicated on the Uniform Do-Not-Resuscitate (DNR) Advance Directive Form. Code status shall also be recorded on the resident's Physician Order Sheet. 7. It is the intent of [the healthcare corporation] to implement the terms of the advanced directive placed in the resident's medical record in accord with the appropriate direction of the Power of Attorney and resident's physician. If a resident communicates a revocation of an advance directive to an employee of this facility, that communication, constituting revocation, shall be noted in the resident's medical record and placed in a central file to avoid any misunderstanding. 8. Any advance directive will be reviewed quarterly with the interdisciplinary team and the resident/responsible party. Advance directives may be reviewed more frequently as condition warrants. 9. Implementation of a code is as follows: i. Direct and Non-Direct care staff upon finding a resident non-responsive shall remain with that resident as is possible while signaling for

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S9999	Continued From page 14	S9999		

assistance. ii. The nurse shall be summoned to respond, and upon review of chart documents determine code status. iii. The nurse shall evaluate the code status and notify appropriate staff for task assignment. If CPR is indicated only certified personnel shall administer CPR. iv. Activation of the Emergency Medical System shall be initiated or the ambulance service notified. The physician shall also be notified to inform him/her of the resident condition. v. Upon completion of notifications and necessary paper work, the nurse shall relieve those performing CPR. The appropriate certified staff will continue until emergency medical team arrives and takes over. ...11. This facility shall provide education to all employees regarding advance directives and the implementation of such. In-servicing of advance directive policy and procedure shall be conducted annually."

On February 13, 2018 at 2:30 PM, V2 (DON) said, "We have a log book in my office to track our employee's CPR certification. Our ADON (Assistant Director of Nursing) used to track the staff CPR cards, but she has been gone for a couple of months and we only recently hired a new ADON. We don't have updated records on the staff CPR certification."

The facility provided a list of all nursing staff which includes CNAs, RAs (resident assistants) and nurses. Of the 54 staff members identified as nursing staff, 43 staff members did not have the required CPR certification documentation.

The facility's Employee Handbook dated July 2017 shows: "Certain positions require certification, continuing education units, registration or licensure. If you fall into this category, please make sure you 1) maintain

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S9999	Continued From page 15 certification, registration or licensure in a current status and 2) provide the facility with copies of your current certificate, registration or licensure for your personnel file. Further, all employees, at their own cost, must be CPR trained and recertified bi-annually. If you do not know where to obtain this training, please see your supervisor." On February 15, 2018 at 9:00 AM, the facility's two crash carts were inspected. The crash carts were open, disorganized, and no logs were present to show regular inspection of the crash carts. One crash cart was inspected with V4 (RN) and V3 (ADON). The crash cart did not have a bag valve mask on the cart. V4 (RN), said, "The crash cart was just used. They probably didn't restock it yet." V4 was asked when the crash cart was used last and V4 replied the crash cart was last used when R2 expired on January 31, 2018. (A)	S9999		