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	IL6001374	A. BUILDING: _____ B. WING _____	C 10/01/2021

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S 000	Initial Comments Complaint Investigation 2126946/IL138406	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.620 b) 300.1010 h) 300.1210 b) 300.1210 d)2) 300.1210 d)3) 300.1220 b)10) 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 300.620 Admission, Retention and Discharge Policies b) An individual who needs services that are not readily available in a particular facility, or through arrangement with a qualified outside resource, shall not be admitted to or kept in that facility. The Department defines a "qualified outside source" as one recognized as meeting	S9999	Attachment A Statement of Licensure Violations	

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professional standards for services provided.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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:
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

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S9999	Continued From page 2 resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available. 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 are not met as evidenced by: Based on interview and record review, the facility failed to ensure necessary gastrostomy equipment was available, failed to administer gastrostomy tube feeding per physician order resulting in excess of 600 cc (cubic centimeters) during one shift, failed to notify physician of unavailable equipment, failed to notify physician of a resident change in condition, failed to stop gastrostomy tube feeding when resident began vomiting orally and through tracheostomy, failed to provide emergency assessment of a resident with a gastrostomy feeding tube and respiratory tracheostomy tube who was vomiting both orally and through the trach (tracheostomy), failed to implement necessary tracheostomy suctioning and supplemental oxygen, and failed to follow facility policy and procedure for one (R98) of two residents reviewed for tracheostomy care, and one (R98) of three residents reviewed for gastrostomy care in the sample of 23. These failures resulted in R98 suffering respiratory	S9999		

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distress, being hospitalized with new diagnoses of severe aspiration pneumonia and sepsis, and R98 requiring end of life services.

Findings include:

The Face Sheet for R98, documents R98 was admitted to the facility on 9/20/21 with the following diagnoses: Cerebrovascular Accident (Stroke), Hemiplegia and Hemiparesis, Tracheostomy, Gastrostomy, Occlusion and Stenosis of Carotid Artery, CHF (Congestive Heart Failure), Type 2 Diabetes Mellitus without complications, Essential Hypertension, Stage 2 Chronic Kidney Disease.

On 9/26/21 at 11:00 am, R98 was not in the facility, and the facility's Resident Room Roster, dated 9/25/21, documents R98 is currently in the hospital.

The facility Admission Screening from the local hospital, dated 9/17/21, includes the following documentation: "Reason for admission: L (Left) MCA (middle cerebral artery) stroke M2/3 (Sylvian and Cortical segments of brain) occlusion s/p (status post) tPA (tissue plasminogen activator - given to dissolve the stroke) and emergent thrombectomy (removal of blood clot from artery) 8/11. Intubated due to respiratory failure 8/14. Trach placement 8/16. 8/25 went for trach tube exchange due to bleeding." "Patient is a new trach and peg (gastrostomy feeding tube), patient has right side hemiparesis and is needing a short stay care."

The physician Order Summary Report for R98, documents the following physician orders: 9/20/21 "Nothing by Mouth (NPO) diet," 9/20/21 "Osmolite 1.5 75cc/hr continuous every shift," and

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S9999	Continued From page 4 "trach care every shift." The Progress Notes for R98, dated 9/21/21 at 10:29 pm, documented by V4, LPN, documents "Resident has had 3 large loose stools, telehealth notified, new order for Imodium 2 mg (milligrams) every 6 hours as needed. To give bolus 250cc water and have CMP and CBC lab drawn for tomorrow. (Local laboratory) called and notified of need of services." The Progress Note for R98, dated 9/22/21 at 4:38 am, documented by V4, LPN, documents, "Resident had large tan emesis orally and through trach tube. Skin warm and dry color pale pink. Emesis looks like color and consistency of g-tube feeding. HOB (head of bed) elevated. Bowel sounds present all quads (quadrants). While cleaning resident up resident had 2 more large emesis orally. Communicated with telehealth through I pad, waiting for call back from a provider." The Progress Note for R98, dated 9/22/21 at 5:00 am, documented by V4, LPN, documents "B/P 180/110, pulse 120, resp (respirations) 24, O2 sats 80% room air, temp (temperature) 97, blood sugar 450. No call back from providers, Telehealth called again, DON called, ADON called. No DNR found in chart. Family called, message left. Resident continues to have projectile emesis. No call back from telehealth providers. Resident sent to (local) ER (Emergency room) for eval (evaluation) and treat (treatment)." The Progress Note for R98, dated 9/22/21 at 7:41 am, documented by V4 LPN, documents "(Local) ER called, told resident would be admitted to a Hospital, not sure which one with DX (diagnosis)	S9999		

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S9999	Continued From page 5 of possible aspiration Pneumonia." The Weights and Vitals Summary document for R98, documents R98's vital signs on 9/22/21 at 4:57 am as: Blood Pressure 180/110 Diastolic High of 89 exceeded and Systolic High of 139 exceeded; Pulse 120 bpm (beats per minute) - new onset and High of 100.0 exceeded; Respiration 25 breaths/min (per minute); O2 (oxygen) sats (saturations) at 80% (Trach) Low of 90.0 exceeded." The local Hospital Medical Record for R98, dated 9/22/21, documents "Upon presentation to the (local hospital) (R98) was placed on 3 L (liters) oxygen, labs were significant for a lactic acidosis of 5, leukocytosis of 17... Chest x-ray with right sided middle lobe infiltrate and lower lobe infiltrate indicating aspiration pneumonia... Looks dry, lethargic... Active Problems: ...1. Severe sepsis secondary to Aspiration pneumonia from suspected Gram-negative etiology, this was resulted from patient's vomiting likely related to possible overfeeding verses intolerance to the feed. Leukocytosis, lactic acidosis. 2. Acute respiratory insufficiency secondary to pneumonia. 3. Nausea and vomiting. 4. Old CVA (Cerebrovascular Accident-Stroke) with right-sided hemiparesis, status post trach and PEG (Parenteral enteral gastrostomy)." The local Hospital Discharge Summary for R98, dated 9/24/21, documents "Discharge diagnoses: Principal Problem: Aspiration pneumonia... Active Hospital Problems (include) Aspiration pneumonia from suspected Gram-negative etiology, Severe sepsis, Hyperglycemia...Acute respiratory insufficiency, and Nausea and vomiting." "Hospital Course (findings/results/procedures): ... sent from nursing	S9999		

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facility for evaluation of from hypoxia nausea and vomiting. (R98) was found to have severe sepsis secondary to aspiration pneumonia and acute respiratory insufficiency which was initially treated with IV fluids and Zosyn. Continued to have lactic acidosis. G-tube feeding was discontinued as this was thought to be the cause of aspiration... Patient was accepted for inpatient hospice for further care."

On 9/26/21 at 6:00 am, V4, LPN (Licensed Practical Nurse), stated on 9/21/21 V4 worked from 9:00 pm 9/21/21 through 6:00 am on 9/22/21, and was the nurse who sent R98 to the local hospital on 9/22/21 at 4:30 am. V4 stated (R98) had a new g-tube (gastrostomy- feeding tube) and trach (tracheostomy-artificial airway). V4 stated on 9/21/21 at 10:30 pm, R98 had loose stools. V4 called R98's doctor, got an order for Imodium, a 250cc (cubic centimeter) water bolus, and labs to be done in the morning. V4 stated V4 turned off R98's g-tube, administered the medication and the water bolus through R98's g-tube, and turned (R98's) feeding back on. V4 stated at around 11:30 pm, V5 and V6, CNA's (Certified Nursing Assistants), notified V4 R98 was vomiting from R98's mouth and R98's trach "but his vital signs were good." V4 stated V4 cleaned up (R98), and did not shut off R98's g-tube feeding because R98 had an order for continuous feeding and V4 did not call R98's doctor because V4 was more concerned about stopping R98's diarrhea. V4 stated on 9/22/21 around 4:15 am, V4 went in to give (R98) his morning medications and (R98) was vomiting again from R98's mouth and trach, and R98 had another loose stool. V4 stated V4 cleaned (R98) up, and suctioned the opening of his trach, "I did not do deep suctioning," and called the on-call service for a Physician. V4 stated (R98's) blood

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pressure was 180/110, pulse 120 bpm (beats per minute), respirations were elevated, his SpO2 (blood oxygen saturations) was only 80%, and blood sugar was high at 450. V4 stated V4 looked in (R98's) chart and noted R98 was a not a DNR (Do Not Resuscitate). V4 stated the on call service couldn't find a doctor to call V4 back, so V4 called V2, DON (Director of Nursing), and told V2, DON, V4 was sending (R98) to the hospital. V4 stated R98's g-tube feeding was almost done; R98 had a continuous feeding order, and V4 did not stop (R98's) g-tube feeding until the EMT (Emergency Medical Transporter) instructed V4 to do so on the way out of the facility with (R98). V4 stated, "My biggest concern was trying to get (R98) to stop throwing up." When asked V4, LPN, why she didn't stop (R98's) g-tube feeding when R98 began vomiting at 11:30 pm, why V4 did not do deep suctioning of R98's trach, and why V4 did not call R98's Physician at 11:30 pm, she stated, "Honestly, I didn't think of shutting his feeding off. I was most concerned about getting him to stop throwing up." V4, LPN, stated (R98) would not be returning to the facility and would be going on Hospice (end of life services).

On 9/26/21 at 6:15 am, V5, Certified Nursing Assistant (CNA), stated V5 and V6, CNAs, worked together the night (R98) was sent to the hospital. V5 stated, "On 9/21/21 at 11:00 pm, (R98) started throwing up, vomit was coming from (R98's) mouth and (R98's) trach, and (V5) reported to (V4 LPN). (V4) came down and looked at (R98) but that was it." V5 CNA stated, "We kept checking on (R98) every hour or so and kept telling (V4, LPN) that (R98) didn't look good, but V4 didn't do anything." V5 CNA stated, "On 9/22/21 at 4:00 am, (R98) started throwing up again, and vomit was still coming out of (R98's) mouth and (R98's) trach." V5 stated she reported

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it to V4, LPN, and V4 ended up sending R98 to the hospital. V5 stated, "(R98's) vital signs were very elevated and (R98) was not doing well." V5 stated, "I even called (V2, DON) after I got home from work and told (V2) that we kept telling (V4 LPN) that (R98) wasn't doing well, and (V4) didn't do anything." V5 also stated, "(V4, LPN) never shut off (R98's) g-tube feeding during the night, and never came into (R98's) room when the EMT came to get (R98)." V5 stated the EMT removed (R98's) feeding bag from the IV pole, laid it on top of (R98) and wheeled (R98) to the Nurses station where V4, LPN, was so V4 could disconnect it.

On 9/26/21 at 6:25 am, V6, CNA, stated, V6 and V5, CNAs, told V4, LPN, each time (R98) had a loose stool and was throwing up, and that R98 wasn't doing well. V6 stated, "I finally told (V4, LPN) she was going to have to do something, that's when (V4) got off the phone with pharmacy and sent (R98) to the hospital." V6, CNA, confirmed R98's g-tube feeding continued to infuse during the night shift and the bag was empty on 9/22/21 at 4:30 am.

On 9/26/21 at 9:00 am and 9:08 am respectively, V15, LPN, and V7, RN (Registered Nurse), stated if a resident with a g-tube and trach is vomiting orally and through the trach, the resident's feeding should be shut off, resident lung sounds should be assessed, resident should be suctioned, and the doctor should be called. On 9/21/21 at 8:15 am, V15 stated V15 checks residual by pulling back enough to see there's feeding in the syringe, and pushes it back through, and doesn't think the residuals are charted in the residents medical record. V15 also stated, "If having trouble reaching a resident's doctor then we are to call (V22, Medical Director)."

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On 9/27/21 at 8:30 am, V2, DON (Director of Nursing), stated V4, LPN, called V2 on 9/22/21 at 4:30 am, and reported R98 was having an emesis from his mouth and trach, and V4 couldn't get a hold of a doctor, and was sending R98 to the hospital. V2 stated (R98) was admitted to the hospital with aspiration pneumonia and discharged from the hospital on Hospice services. V2, DON, stated V2 did not receive any other calls from V4, LPN, during the night, and was unaware R98 had vomited earlier in the shift. V2, DON, stated V4, LPN, should have stopped (R98's) g-tube feeding, performed deep suctioning, and should have notified V2 and (R98's) Physician after (R98's) first episode of vomiting at 11:30 pm on 9/21/22.

On 9/28/21 at 9:28 am, V4, LPN, stated V4 hung a 1,000 ml (milliliter) new bottle of feeding around 10:30 pm on 9/21/21 because (R98's) bottle was empty. V4 stated (R98's) pump was set to infuse at a rate of 75 cc per hour. V4 stated V4 checked g-tube placement and residual by pulling back on the syringe until V4 saw some feeding come into the syringe, and then pushed the feeding back in. V4 stated V4 does not know how much residual there was because V4 did not measure it. V4 stated, "We do not chart residual, it's just something we do." V4 stated there was about 50 ml of feeding left in (R98's) bottle of feeding when the ambulance came to get him. When asked how a 1,000 ml of feeding infused between 10:30 pm and 4:30 am she stated, "I don't know." V4 stated, "I ran the pump at 75 cc/hr, like the nurse I followed told me in report." When asked if she checked the order, V4, LPN, did not answer, and stated the g-tube pump was set at 75 cc/hr (hour). When questioned about which pump was used, V4, LPN, stated, "Well, I hung the bottle by

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gravity." When asked why she originally said it was on a pump, V4 stated, "Because we should have had a pump, but it never came in." When questioned how V4 infused 75 cc/hr per gravity, V4, LPN, did not answer. When asked why V4 didn't stop the feeding when R98 began vomiting orally and from his trach on 9/21/22 at 11:30 pm, V4 stated, "I didn't think about it." When asked about suctioning R98, V4 stated V4 did not do deep suctioning but went down 4 or 5 centimeters to suction with the long thin suctioning tube. V4 stated V4 did not suction R98 at 11:30 pm when R98 first vomited and stated, "I just suctioned once in the morning." V4 stated V2, DON, was aware there was not a g-tube feeding pump in the facility for R98 at the time he was admitted to the facility, and his g-tube feeding was being infused by gravity, and V3, LPN QA (Quality Assurance) Nurse, told V4 in report to run (R98's) g-tube feeding by gravity. V4 also stated V4 did not report to V2, DON, or R98's Physician when R98 began vomiting on 9/21/21 at 11:30 pm.

On 9/28/21 at 10:00 am, V2, DON, stated R98 was admitted on 9/20/21, in the late afternoon and that is when V2 was made aware there was no g-tube pump for R98 in the facility. V2 stated one was ordered, and V11, R98's PCP (Primary Care Physician), was notified. V2, DON, stated the nurses are to check placement and residual per policy. V2 stated V2 is unsure if this charted in the residents medical record as V2 just started working at the facility on 9/20/21. V2, DON, stated V16, Admissions Coordinator, got the referral from the hospital portal, and V13, MDS (Minimum Data Set) Coordinator, reviewed R98's admission screening, and gave the ok to admit R98.

On 9/28/21 at 10:05 am, V3, LPN, QA and ICP (Infection Control Preventionist) Nurse, stated V3

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relieved V15, LPN, and worked the floor from 6:00 pm to 10:00 pm on 9/21/21, and R98's feeding was being done by gravity because there was not a g-tube feeding pump available for (R98). V3 stated V3 calculated the rate of infusion by counting the feeding drops for 15 seconds and multiplied times four, until V3 reached what would be considered 75 cc's an hour, and V3 cannot recall the exact number of drops used. V3 stated there was already a g-tube feeding bag hanging when V3 came in, and V3 did not have to hang any new feeding for (R98) during V3's four hour shift. V3 stated a 1,000 ml plastic bottle of feeding would be opened and poured into a plastic bag because the facility didn't have any spike sets for the plastic bottles during the time (R98) was in the facility. V3 stated V3 gave nursing report to V4, LPN, and told V4 what the nurses were doing. V3 also stated (R98) did have one loose stool, V3 performed deep suctioning once, and there were no complications with (R98's) g-tube or trach during V3's four hour shift. V3, LPN, also stated V16, Admissions Coordinator, did not tell anyone (R98) had a g-tube and trach so no one knew until (R98) was admitted on 9/20/21. V3 stated V3 was on vacation the week of (R98's) screening for admission, and V3 didn't come back to work until Monday 9/21/21, the day (R98) was admitted. V3 stated the facility does not chart residuals for residents with g-tubes. V3 confirmed there is no documentation of R98's g-tube feeding being infused by gravity, drops calculated, or (R98's) Physician being notified. V3 stated, "(R98's) doctor should have been notified at the time of his admission to the facility, and the residual and placement checks for g-tubes should be on the residents MAR (Medication Administration Record) and/or TAR (Treatment Administration Record)." V3 stated, :The g-tube feeding pump

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S9999	Continued From page 12 that was ordered for (R98) arrived at the facility today (9/28/21)." On 9/28/21 at 10:35 am, V16, Admissions Coordinator, stated V16 pulls the resident's history and physical, medication list, and diagnoses from the hospital portal, and then scans and emails all the documents to the Administrator, DON, QA Nurse, MDS Coordinator, and Corporate Nurse. V16 stated, "If approved by financial and nursing then we can admit, and usually V3, LPN/QA/ICP Nurse, gives the clinical ok, but V3 was on vacation." V16 stated V13, MDS Coordinator, ended up giving the clinical approval by email documenting, "Ok clinically and has a lot going on." V16 stated everyone should be reading the screening because V16 is not a Nurse and has to wait for nursing approve before she can admit a resident. On 9/28/21 at 10:45 am, V13, MDS Coordinator, stated V13 did give the ok clinically for (R98) to come to the facility, and did see he had a trach and g-tube. V13 stated, (V3,LPN QA/ICP) is the one who generally orders the supplies, or the DON does if (V3 LPN QA/ICP) is not here." V13 stated there was a interim DON at the time, and V13 stated, "I only accept or deny." V13 stated V13 accepted (R98's) referral a day or two prior to R98 coming, and everyone would have known R98 was coming. V13 also stated, "If I had known we didn't have the supplies I would not have accepted him, until we did." V13 stated V13 does recall V16, Admission Coordinator, asking about supplies for (R98), but doesn't know any more than that. V13 stated, "I was not aware we didn't have a g-tube pump. We usually always have a g-tube pump. I assumed we had the supplies needed because no one said we didn't."	S9999		

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On 9/28/21 at 12:11 pm, V12, EMT (Emergency Medical Transporter), stated V12 entered the facility early morning of 9/22/21, answering the 911 call. V12 stated when V12 entered the facility, V4, LPN, was sitting at the nurses station filling out paperwork. V12 stated V12 asked V4 where the patient was, and V4 told V12 to wait for V4 to complete the paperwork. V12 stated, "I was called to the facility for an emergency situation with a resident vomiting from his trach and mouth and wanted to get to the resident and check his airway." V12 stated one of the CNA's walked V12 down to (R98's) room, and another CNA was already in the room. V12 stated (R98) was lying in bed with the plastic bag of feeding still connected, hanging from an IV pole, without a pump, infusing by gravity, and the feeding bag was empty. (R98) did not have any oxygen on at the time. V12 stated V12 took (R98's) g-tube feeding bag off the IV pole and took it, along with (R98), to the nurses station, and had the nurse disconnect (R98) from the feeding. V12 stated, "The nurse's arrogance and non-emergent attitude concerned me that this resident was not being cared for adequately and was suffocating." V12 stated (R98) was not actively vomiting; however his pharynx was covered with thick tan colored residue, (R98) was in severe respiratory distress, and his SpO2 was only 80%. V12 stated V12 suctioned (R98) and got massive amounts of think, tannish secretions from (R98's) trach. V12 stated V12 put a "non-rebreather mask" (oxygen mask that allows for the delivery of higher concentration of oxygen) on (R98) and the highest he could get (R98's) oxygen level up to was 90%. V12 stated, "This whole situation was concerning to me."

On 9/28/21 at 12:50 pm, V3, QA/ICP Nurse, stated V3 was "On vacation the week (R98) was

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approved for admission and (R98) came the following Monday, on my first day back from vacation." V3 stated, "(V2, DON) started this day, and the Corporate Nurse came in too." V3 stated V3 had not checked V3's email, so was not aware of (R98's) pending admission. "(V15, LPN) received report from the hospital, and that's when we knew he had a trach and g-tube. (V13, MDS Coordinator) gave the ok clinically but does not normally get supplies." V3 stated if the nurse isn't able to get a hold of the resident's physician, they can call V22, Medical Director. V3 also stated, "The residual and placement checks for g-tubes should be on the resident MAR (Medication Administration Record) and the feeding bag and syringe changes should be on the resident TAR (Treatment Administration Record)."

On 9/28/21 at 1:15 pm, V14, LPN, stated V14 worked on 9/20/21, and charted the initial Nursing Note that R98 had arrived at the facility to help V15, LPN out, who was (R98's) admitting Nurse. V14 stated, "(V15, LPN) got report from the transferring hospital, and we didn't known R98 had a trach until that time. We had respiratory therapist come to ensure we had everything we needed. I think we a had a pump for (R98). I didn't see (R98) and didn't hear we didn't have one."

On 9/28/21 at 1:15 pm, V15, LPN, stated V15 was the nurse that got report for (R98's) admission from the hospital near shift change, which was the first V15 had heard (R98) had a g-tube and a trach. V15 stated there was no g-tube feeding pump in the facility at that time, and (R98) came to the facility without any g-tube feeding, but she was able to get (R98's) feeding changed from Jevity to Osmolite, because that was what the facility had in stock. V15 stated V15

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did not initiate (R98's) g-tube feeding so V15 does not know how it was infusing. V15 stated the facility does not usually give g-tube feeding by gravity, but the facility didn't end up having a g-tube pump for R98's feeding so it was hung by gravity. V15 stated V15 did not call (R98's) doctor regarding R98's feeding being hung by gravity, and is unsure if anyone did.

On 9/28/21 at 12:40 pm, V17, MDS Consultant, stated the residual and placement checks for g-tubes should be documented on the resident MAR (Medication Administration Record).

On 9/28/21 at 2:39 pm, V11, PCP (Primary Care Physician) for R98, stated R98 was admitted to the facility on 9/20/21 and went back out to the hospital on 9/22/21. V11 stated from what V11 can see, the first text came through from on call service on 9/21/21 at 10:49 pm asking for a PRN (as needed order) for Imodium for (R98's) loose stools, and it was given along with follow up order, labs and a flush order. The next text came through at 5:29 am that the facility nurse reported R98 was having emesis from R98's trach and g-tube and was requesting Zofran, and there was no response from the on call physician at that time or at 5:53 am. V11 stated V11 is unsure why the Provider on call did not respond back. At 6:02 am, a text was sent to another on-call physician and at 9:00 am, V2, DON, said (R98) had been discharged to the hospital. V11 stated V4 LPN "absolutely should have shut off R98's feeding after the first emesis at 11:30 pm and notified me." V11 stated V11 was unaware of R98's feeding running by gravity and "that is not ok. I would have changed the order." V11 also stated V11 was never notified that the facility did not have a g-tube feeding pump to infuse (R98's) feeding. When V11 was asked if these actions

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could have caused R98's Aspiration Pneumonia and Sepsis he stated, "Absolutely and I should have been notified."

The facility Enteral Tube Care and Feeding policy and procedure, Revised 11/01/11, documents (Procedure: 1. Verify Physician Orders...Placement Verification: Placement is verified before feedings, flush, or medication administration and PRN (as needed)...Residual Check: Residual is verified prior to each feeding and every 8 hours during feedings and PRN; If intolerance symptoms are noted contact MD (Medical Doctor) for further instruction...2. If aspirate exceeds 60cc (cubic centimeters) , instill contents into irrigation container and continue to aspirate. 3. Note total amount of aspirate: If total amount exceeds 100cc: Re-feed contents to maintain fluid and electrolyte balance. Hold tube feeding and or medication administration. Evaluate for abdominal pain, fullness, nausea, vomiting, or gastric distention. Notify physician for any physical signs and symptoms. Recheck residual in one hour. If residual still exceeds 100cc notify physician... 9. Monitor for signs of aspiration, i.e. temperature > (greater than) 100 degrees F (Fahrenheit), increased respiratory rate, wheezing, cyanosis, GI (gastrointestinal) contents in pulmonary secretions; if noted stop feeding and notify physician... Suggested Documentation: Any unusual observation or resident complaints along with subsequent interventions including physician notification."

The facility's undated Tracheostomy Care Guidelines policy and procedure, documents "I. Scope a. The nurse is responsible for evaluating for proper artificial airway care. b. The nurse directs the unlicensed personnel to: 1) Immediately report any changes in respiratory

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status, level of consciousness, dislodgement of tracheostomy tube, and any abnormal drainage... III. Procedure a. Evaluation 1) Observe for excess secretions, soiled or damp tracheostomy ties, diminished airflow and signs or symptoms of airway obstruction that would require suctioning. 2) Evaluate vital signs, oxygen saturation, lung sounds, and the ability to clear airway. 3) Evaluate understanding of and ability to perform own tracheostomy care. 4) Validate when tracheostomy care was last performed... d. Recording and reporting 10 Record respiratory evaluations before and after care; type and size of tracheostomy tube; frequency and extent of care; type, amount, color, and odor of drainage; resident tolerance and understanding of procedure as applicable."

The facility's Tracheal Suctioning policy and procedure, Effective Date: 8/24/2016, documents "Policy Statement: Tracheal suctioning is a component of bronchial hygiene therapy. It involves the mechanical aspiration of pulmonary secretions from a resident with an artificial airway. Licensed Clinicians with demonstrated competence may provide tracheal suctioning of adults with artificial airways, as ordered by resident's physician... 9. Using sterile-gloved dominant hand, insert catheter into the tracheostomy tube to the predetermined depth. Do not force if any resistance is encountered. 10. Apply intermittent suction by quickly opening and closing suction port, while withdrawing the catheter, using a rotating motion. Entire suctioning procedure shall not exceed 10 seconds in duration. 11. Have the resident take "sigh" breaths two to three times to oxygenate and re-expand the lungs. 12. Assess effectiveness of suctioning. If adventitious sounds are present, you encounter ventilating difficulty

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repeat suctioning. 13. If secretions are tenacious, introduce 1-3 mL (milliliters) of sterile saline solution into the airway. Perform suctioning as described above. 14. The following shall be monitored prior to, during and after suctioning: Breath sounds, oxygen saturation: skin color, pulse oximeter, if available, respiratory rate and pattern, hemodynamic parameters: pulse rate, sputum characteristics: Color, volume, consistency, cough effect. Following suctioning: 15. The resident should be instructed to take several deep breaths (sigh) to re-expand and improve oxygenation status. An Ambu-bag may be needed to facilitate this. 16. Monitor the resident for adverse reactions... Documentation: Heart rate, respiratory rate, breath sounds, color, consistency and amount of sputum, Residents tolerance to the procedure, whether or not sterile saline was instilled to mobilize secretions."

The facility's undated Change in Resident's Condition or Status policy and procedure, documents "Policy: It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status. Procedure: 1. The nurse will notify the resident's attending physician when: ...There is a significant change in the resident's physical, mental or psychological status. There is a need to alter the resident's treatment plan significantly... 2. Unless otherwise instructed by the resident (if the resident is alert and oriented and their own representative) the nurse will notify the resident's representative when: ... There is a significant change in the resident's physical, mental or psychosocial status... It is necessary to transfer the resident to the hospital. 3. A significant change in condition is a decline or improvement in the resident's status that: Will not normally resolve itself without

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S9999	Continued From page 19 intervention by staff or by implementing standard disease related clinical interventions and Impacts more than one area of the resident's health status... 4. Except in medical emergencies, notification will be made within 24 hours of a change occurring in resident's condition or status. During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital. 5. If the resident's physician does not respond to calls of a resident condition status change, the facility Medical Director will be notified to obtain orders and this will be documented. 6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status." (AA)	S9999		