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Z 000	COMMENTS ANNUAL FOCUSED CERTIFICATION SURVEY W 122 Client Protections cited	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.1220k) 350.1230b) 350.1230d)2)3) 350.3240a) Section 350.620 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: Section 350.1220 Physician Services k)At the time of an accident, immediate first aid treatment shall be provided by personnel trained	Z9999	**Attachment A** **Statement of Licensure Violations**	

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in medically approved first aid procedures.

Section 350.1230 Nursing Services

b)Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:
d)Direct care personnel shall be trained in, but are not limited to, the following:
2) Basic skills required to meet the health needs and problems of the residents.
3)First aid in the presence of accident or illness.

Section 350.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on record review and interview, the facility neglected to:
1) Ensure that CPR (cardio pulmonary resuscitation) was immediately initiated for 3 of 3 clients found unresponsive (R7 expired 5/9/2020, R8 expired 7/29/2020 and R9 expired 8/10/2020); and
2) Ensure that 911 was immediately called upon discovering 1 of 3 clients (R7) unresponsive with no pulse, no breathing.
Findings include:

The facility's Adult Basic Life Support Training provided to the surveyor on 1/20/2021 was reviewed. Under Steps it includes; "When someone is found unresponsive, tap and shout to see if you can rouse them. If not, yell for help and

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have someone call 911 and grab the AED (automated external defibrillator) in the hallway across from the timeclock (outside the mail room). Also have the nurse verify the DNR (do not resuscitate) status. Start with compressions if no breathing or gasping for breaths. Compressions should be 30, then 2 breaths..."

1) The Incident Investigation of R7's 5/9/2020 incident was reviewed. Under summary of incident, it includes: "On 5/9/2020 it was noted that R7 was unresponsive, 911 was called. R7 was pronounced deceased, her body was released to the funeral home..." Under information gathered it included; "E10 (nurse) states that E2 (Director of Nursing) was called and notified of the incident at 5:36am..."

Further review of the investigation showed an interview with E9 (Direct Support Person) on 5/12/2020. She stated that nurse (E10) called out for her at about 5:30am and told her that she needed her help. E9 stated that she went down to R7's room and noticed that R7 was laying on the floor and E10 was assessing her. E9 stated that E10 freaked out and was in shock. E9 stated that she immediately started on chest compressions. E9 stated that while she did chest compressions, E10 was on her phone and called E2 (Director of Nursing). E9 stated that E10 then told her that she was going to go to the nurses office to call the doctor, call 911 and to get the AED (automated external defibrillator). E9 stated that she does not recall if E10 left her with any instructions on what to do while she stepped away. E9 stated that she stopped doing compressions on R7 because she got tired...E9 stated that she waited until E10 came back to the room a few minutes later and assisted the nurses again..."

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E10's interviewed on 5/12/2020 was reviewed. It includes; "E10 stated that on 5/9/2020, she was passing meds (medications) and when she got to R7's room she noted that R7 was laying on the floor on her right side and did not have her oxygen on. E10 stated that she assessed her and called out to E9 so she can assist her. E10 stated that when she assessed R7, she noticed R7 was still warm. E10 stated that she believed R7 was already deceased but she is no one to be making that call. She stated that she had her handheld phone on her so she immediately called E2 to notify her... E10 stated that E9 immediately started compressions when she got to the room. E10 stated that she then went to the nurses office because she needed to call E11 (Medical Doctor) to notify her of what was going on. E10 stated that since she did not have E11's phone number, she needed to go back to the nurse office to get the work phone, call 911 and to also get the AED..."

Further review of the investigations showed that according to the review of the video surveillance E10 left R7's room at 5:38am and did return to the room until 5:57am...

Review of the video surveillance report included in the investigation showed the following:
>5:34:15am E10 pushes R7's bedroom door open and goes into her room
>5:34:50am E9 is observed walking down the hall and goes into R7's room
>5:35:38am E9 is observed walking over to another client's room and then goes back to R7's room
>5:36:24am E10 is observed standing next to the medication cart that is located outside of R7's room

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>5:37:43am E9 is observed standing outside R7's room
>5:37:55am E9 walks back inside of R7's room
>5:38:19am E10 goes back to R7's room
>5:38:38am E9 and E10 were observed coming out of R7's room, it appears as if they are talking to each other
>5:38:48am E9 goes into another client's room
>5:38:50am E10 exits blue hallway through the exit door that leads to the backyard
>5:39am E10 goes into Med Office
>5:39:13am E9 is observed walking slowly back into R7's room
>5:41am through 5:57am E9 is observed walking in and out of R7's room. During this time she is also observed going into other client's rooms, checking on them
>5:56am E10 is observed walking towards the east side of the building, it appears she is looking for E15, nurse, but does not find him down the hall
>5:56:42am E15 is seen running to get the AED

Review of this video surveillance timeline showed that E9 was in and out of R7's room from 5:34:50am when R7 was allegedly found unresponsive by E10. E9 didn't stay in R7's room until after she entered the room again at 5:39:13am until she was observed exiting the hallway at 5:58am.

Under conclusion / summary it includes; "Based on the information gathered, it can be concluded that on 5/9/2020 while passing morning medications at approximately 5:34am, E10 discovered R7 unresponsive laying on the floor on her right side. It was noted that R7 was not wearing her oxygen. E10 assessed R7 and noted that she was unresponsive to verbal and tactile stimulation, her skin was warm to touch..." It

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further includes that E10 used her personal hand held phone to call E2 first at 5:36am and then walked over to the medical office to call 911 and E11...The Injury/ Event report completed by E10 showed that she called E2 at 5:36am, E1 (Administrator) at 5:41 am and E11 at 5:43am. The information received from the police through the freedom of information act showed that E10 called 911 at 5:54am.

E1, Administrator, was interviewed on 1/20/2021 at 11:02am. E1 stated, "It was okay for the nurse to leave the staff performing CPR if she needed to get other information." Surveyor asked E1 why the staff who had to stop CPR didn't call for help. E1 answered, "At that time, we had COVID cases and we didn't allow any staff going from one wing to another." E1 added, "During the night shift only one staff works in every wing." Surveyor asked in case of emergency, can staff call for help. E1 answered, "The nurse could have called the other nurse to help E9 with the CPR while she was calling 911." Surveyor asked why E10 left R7's room when she had the handheld phone with her and she could have called 911 then. E1 answered, "I am not sure, what E10 was thinking at that point."

2) R8's incident of 7/29/2020 investigation was reviewed. Under summary of incident it include; ""On 7/29/2020 staff found R8 unresponsive in the bathroom. CPR (cardio pulmonary resuscitation) was initiated and 911 was called. R8 was pronounced expired at 10:18pm..."

E12 (Direct Support Person)'s interview dated 7/30/2020 was reviewed. It includes; "...E12 stated that on that particular day R8 did not eat his dinner. E12 stated that the nurses were made aware. E12 stated that R8 also had about three

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bowel movements and they were a bit loose and color brown. E12 stated that at approximately 9:30am, R8 had a bowel movement in bed and E12 cleaned R8 up. E12 stated that he then had R8 sit on the shower chair so he can continue to have bowel movement...E12 stated that he cleaned up R8's bowel movement in his room and then went to change other clients in the suite next door. E12 stated that he then went back to check on R8 and he was making his normal vocal noises. E12 stated that after 2-3 minutes that he last checked on R8, E13 (Direct Support Person) went into R8's room to put some laundry away. E12 stated that E13 called out for him because R8 didn't seem right. E12 stated that R8 did not look himself, so he then ran over to the nurses office to inform the nurses of what was going on. E12 stated that the nurses then shortly arrived to R8's room with the AED. E12 stated that since R8 was in the bathroom on the shower chair with his safety belt on, he and E14 (nurse) lowered R8 to the floor. E12 stated that E14 then began CPR..."

The internal incident investigation form completed by E12 on 7/29/2020 was reviewed. Under please described the incident, it includes; "...Two minutes later another staff was putting away clothes and seen him unresponsive. I ran to get the nurses." Under what was your response, it includes; "Went to get the nurse and we lowered him to the ground and they began CPR."

E13's statement dated 7/30/2020 was reviewed. E13 stated that at approximately 9:30pm, she was putting clothes away. She went to R8's room and was putting some clothes away in his closet. When she passed by the washroom, she said R8's nickname but he didn't respond. E13 stated that she then saw that R8 was sitting in the toilet not moving, his eyes and mouth were wide open

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and he was drooling a bit. E13 stated that R8 didn't look like himself so she called out for E12. E13 stated that E12 looked at R8 and then he went to get the nurse. E13 stated that she found E16 (Direct Support Person) down the hall and told her about R8 being unresponsive. E13 stated that E16 walked over to the nearest phone and paged for the nurses, from the phone that is located in the exercise room..."

E17's (nurse) interview dated 7/31/2020 was reviewed. E17 stated that she was in the nurse office when E12 came over and said "I think R8 passed away." E17 stated that she immediately went to get the AED (automated external defibrillator) and ran over to R8's room. E17 stated that when she got to R8's room, he was in the bathroom sitting on a shower chair with his seatbelt on. E17 stated that R8 was pale. She and E12 then carried R8 off the shower chair and laid him on the floor and she immediately began CPR..."

Review of the video surveillance report included in the investigation showed the following:
> 9:37pm E13 goes in through R8's room. It appears that she is going to put some clothes away.
> 9:37:36pm E13 looks out the green hallway and it appears that she is calling out for the other staff that are working down the hall
> 9:37:40pm E12 is seen coming out of R57's room and he appears to be rushing into R8's room.
> 9:37:44pm E12 and E13 walk down the green hallway. E12 is observed walking to alert the nurses of what is going on
> 9:38pm E16 is observed speed walking to the exercise room.
> 9:40:44pn E12, E13 and E16 were observed

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standing outside R8's room > 9:41pm E17 and E18 are observed running over to R8's room. It appears E17 has the AED and E18 is holding the oxygen tank.

Under conclusion / summary it includes; "...Based on the information gathered in this investigation, it was revealed that direct support persons waited for the arrival of the nurse to start CPR..."

E1, Administrator, was interviewed on 1/20/2021 at 11:02 am. E1 stated, "Staff should have checked for pulse and breathing and started CPR if needed."

3) An incident investigation involving R9 dated 8/10/2020 was reviewed. Under summary of incident, it includes; "On 8/10/2020, staff found R9 unresponsive during night shift rounds, in bed. CPR (cardio pulmonary resuscitation) was initiated and 911 was called. R9 was pronounced expired at 4:10am..."

E19 (Direct Support Person)'s interview on 8/10/2020 was reviewed. It includes; "E21 stated at around 3:30am, she went to complete her next set of rounds. E21 noticed R9 was not snuggled under her blankets like usual and when she went closer to check on her, she said something about R9 didn't look right so she went to get a co-worker, E20 (Direct Support Person) to help her...Once E20 arrived, E20 said R9 was unresponsive, E19 should get the nurse and AED (automated external defibrillator)..."

E20 (Direct Support Person)'s interview on 8/10/2020 was reviewed. It includes; "E20 confirmed she was not assigned to work with R9 but was called by E19 to assist her. E20 stated that once she arrived to R9's room, she believed

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R9 had passed and told E19 this, E20 stated that E19 ran down the hall to call the nurses then went to get the nurses from what she could see from R9's room. E20 stated that E19 and E21 (nurse) returned with the AED and E19 called 911...E20 stated that she did not think she should start (CPR), but she should wait for the nurse and AED since R9 did not have any responses to them..."

E21's interview dated 8/10/2020 was reviewed. It includes; " E21 stated at approximately 3:30am, E19 came to the nurses office and stated R9 didn't look right and thinks she died, to come to R9's bedroom and bring the AED. E21 stated that she had E19 call 911, she saw E20 was waiting at R9's room, and she went into the bedroom to assess R9. E21 reported that R9 had what appeared to be vomit on her gown and was not responding to stimuli. E21 stated she was applying compressions and put the AED chest pads on..."

Under conclusion / summary it includes; "...Based on the information gathered it can be concluded that staff did not begin to administer CPR until the nurse arrives to R9's room at approximately 3:41am at which time she started compressions and placed AED chest pads on R9."

E1, Administrator, was interviewed on 1/20/2021 at 11:02am. E1 verified that staff did not immediately start CPR on R9 when she was found unresponsive on 8/10/2020.
(A)