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
	IL6012611	A. BUILDING: ______ B. WING ______	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING HOM	940 MAPLE AVENUE HOMEWOOD, IL 60430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint investigations: 2192999/IL133493 2193464/IL134051	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1010h) 300.1030b) 300.1210b) 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 300.1010 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.1030 Medical Emergencies

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.

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.

These Requirements are not meet as evidenced by:

A. Based on observations, interviews, and record reviews, this facility failed to perform a comprehensive respiratory assessment, recognize the need to implement life sustaining interventions, including providing oxygen therapy according to professional standards of practice,

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the comprehensive person centered care plan, and the resident's goals and preferences for a resident with a diagnosis of respiratory failure for 1 resident (R1) out of 3 reviewed for an acute change in respiratory status in a sample of 18. On 5/19/2021, R1 exhibited abnormal vital signs, decreased oxygen saturation levels, increased heart rate, and labored breathing for 43 minutes before EMS (emergency medical services) was notified. This failure resulted in R1 expiring upon arrival to the hospital.

Findings include:

Review of R1's medical record, notes R1 was admitted to this facility on 2/17/2021 after being hospitalized for acute on chronic respiratory failure, and septic shock secondary to urinary tract infection. During R1's hospital stay, R1 was intubated and mechanically ventilated. R1's medical history included chronic respiratory failure and home oxygen therapy. On 4/08/2021, R1 exhibited a change in condition with a temperature of 102.1 degrees Fahrenheit, sweating, and only responsive to painful stimuli. An outside ambulance service was contacted. Upon their arrival, the paramedics noted R1 to have increased heart rate, labored breathing, and an oxygen saturation level of 88% on room air. The paramedics applied supplemental oxygen of 15 liters per minute using a non-rebreather face mask and transported R1 to the hospital. R1 was re-admitted to this facility on 4/23/2021.

During the onsite investigation the following was observed regarding R1's care:
On 05/19/2021 at 11:26am, the emergency cart was observed being pulled into R1's room by V4 (nurse) and V6 (nurse). A rapid response emergency code was paged overhead at

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11:15am for R1 exhibiting respiratory distress. R1 was observed sitting upright in bed. R1's breathing was labored. R1's breathing was audible and sounded gargled. Respirations were deep and chest was rising and falling with great effort. This surveyor did not observe an oxygen tank in R1's room or with the emergency cart.
On 05/19/2021 at 11:30am, V3 (unit manager) was observed looking for oxygen tank and supplies at R1's bedside. V4 (nurse) asked if V3 wanted V4 to call 911 EMS (emergency medical services). V3 responded "yes". V3 requested oxygen tank and oxygen supplies.
On 05/19/2021 at 11:31am, V3 was observed exiting R1's room. R1 was observed lying in bed with head of bed elevated. R1's eyes are open; R1 did not respond to V4's verbal or tactile stimulation.
On 05/19/2021 at 11:33am, V3 was observed returning to R1's room with a portable oxygen tank. V4 was observed setting up the suction equipment and suction R1's mouth. V10 (nurse) was observed entering R1's room to assist with R1.
On 05/19/2021 at 11:35am, V3 stated that R1's oxygen saturation level is 82% on room air. Oxygen at 15 liters via non-rebreather mask applied to R1.
On 05/19/2021 at 11:37am, V3 asked V4 (nurse) and V10 (nurse) if 911 EMS was called. No clear answer was given. V3 exited R1's room to inquire if 911 EMS was called.
On 05/19/2021 at 11:48am, V3 was observed re-entering R1's room and stated that EMS was in route.
On 05/19/2021 at 11:51am, V3 was observed asking V4 how long R1 had been decompensating. V4 stated "it's been about an hour. When I first checked on R1, I noticed something was a bit off during my first

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assessment. I came back 30 minutes later and R1's breathing was increased. I came back 10 minutes after that and R1 was full blown (respiratory distress). I put an oxygen sensor on R1 but could not get a reading".
On 05/19/2021 at 11:55am, EMS paramedics were observed at R1's bedside. V4 informed EMS R1 had been in distress for one hour.

Nursing staff were interviewed about R1's condition and services provided on 05/19/2021 as follows:

On 05/19/2021 at 1:35pm, V6 (nurse) stated that at 11:15am, V4 (nurse) approached V6 and informed V6 that V4 needed help. V6 stated that V4 informed V6 that the emergency cart was needed. V6 stated that V4 and V6 went to R1's room with the cart. V6 stated that the oxygen tank was not with the emergency cart and V6 was instructed by V3 (unit manager) to obtain an oxygen tank. V6 stated that V4 (nurse) went to the oxygen supply room to obtain an oxygen tank, so V6 went to the nurses' station to print forms (face sheet, medication list) for EMS paramedics. Neither V6 nor V4 were observed bringing an oxygen tank to R1's room.

On 6/4/2021 at 12:20pm, this surveyor observed V30 (director of maintenance) measure the distance between R1's room and this facility's oxygen supply room. R1's room is noted to be 289 feet from this facility's oxygen supply room.

On 05/19/2021 at 2:00pm, V4 (nurse) stated that during V4's rounds at 8:30am this morning, R1 was okay, a little rhonchi (coarse breath sounds), slight cough, V4 tried to get R1 to cough, R1 not able to effectively cough. V4 stated that V4 requested V11 (central supply room staff) to

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deliver a suction machine on the next delivery round. V4 stated that V4 returned at 10:30am, R1's lungs sounded a lot moister. V4 stated that V4 elevated R1's head of bed a little more and tried to get R1 to cough. V4 stated that no other assessments were done. V4 stated that V4 returned to R1's room 30 minutes later and R1 was in (respiratory) distress. At 11:00am, R1's breathing more labored becoming diaphoretic, unable to obtain accurate oxygen saturation level with pulse oximetry, fleeting reading of 86%. V4 stated that V4 informed V3 (unit manager) of situation and then asked another nurse (V6) for assistance. V4 stated that V4 did not recall what time V4 notified V6 and V3. V4 stated that V4 got the emergency cart and brought it to R1's room. V4 stated that the oxygen tank was not with the emergency cart. V4 stated that the emergency cart is checked daily by nursing. V4 stated that the suction machine, portable defibrillator, back board, and a full oxygen tank should be present with the emergency cart. V4 stated that at approximately 11:32am, V4 set up the suction machine and suctioned R1's mouth. V4 stated that V4 tried to obtain oxygen saturation level on left index finger, then applied oxygen. V4 stated that at approximately 11:34am, the highest oxygen saturation level was 86% on 15 liters of oxygen and R1's heart rate was 128 beats/minute. V4 stated that the suction machine V4 requested was not delivered prior to the onset of this event.

On 05/20/2021 at 9:20am, V2 DON (acting director of nursing) stated that when a resident exhibits a sudden change in condition, the nurse should remain at the resident's bedside and shout out for assistance as well as shout out for a rapid response or code to be called. V2 stated that each emergency cart is checked daily by the nurse. V2 stated that the nurse is expected to

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make sure oxygen, portable defibrillator, resuscitative bag, back board, and suction machine are present and functioning properly. V2 stated that there is a form on top of the emergency cart that the nurse signs and documents the cart's lock number. V2 stated that if a nurse takes equipment off emergency cart, the nurse is expected to replace before leaves building for day.

On 05/20/2021 at 10:35am, V11 (central supply room staff) stated that V11 is responsible for ordering and stocking supplies on nursing units. V11 stated that V11 received a call from V4 (nurse) between 11:00am and 11:15am requesting a suction machine. V11 stated that V11 brought V4 suction machine to the nurses' station, heard code paged overhead. V11 stated that V11 brought suction machine to R1's room. V11 stated that V11 was not sure which resident needed the suction machine in R1's room and therefore left the suction machine at nurses' station.

On 05/21/2021 at 9:18am, V3 RN (registered nurse/unit manager) stated that at approximately 11:15am, just prior to the rapid response emergency code called, V4 (nurse) informed V3 that R1 may have to be sent out to the hospital for respiratory distress. V3 stated that this facility's protocol is to inform the unit manager of any changes in resident's condition. The unit manager is responsible for investigating the situation and assessing the resident immediately. V3 stated that V3 expects the nurse to obtain oxygen supplies and oxygen tank when a resident initially exhibits any breathing difficulties. V3 stated that V3 expected V4 (nurse) to remain at R1's bedside, apply oxygen and continue to obtain an oxygen saturation level with the pulse

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S9999	Continued From page 7 oximeter, and then shout out for a rapid response to get additional staff assistance at 11:00am on 5/19/2021. V3 stated that on 5/19/2021, V4 (nurse) did not inform V3 that R1 was exhibiting respiratory distress until 11:15am. V3 stated that upon entering R1's room, V3 noted R1 with audible coarse breath sounds. V3 stated that V3 did not see any oxygen supplies or an oxygen tank in R1's room. V3 stated that R1's blood pressure was low, R1 had a lot of generalized swelling, and V3 had difficulty obtaining R1's oxygen saturation level on room air. V3 stated that R1's heart rate was 94 beats/minute at that time. V3 stated that V3 knew R1 was in acute distress just by looking at R1. V3 stated that 911 EMS should have been called immediately. V3 stated that V4 brought the emergency cart to R1's room, but the oxygen tank was missing. V3 stated that V3 instructed V4 to obtain an oxygen tank. V3 stated that V3 asked for nurse to check R1's code status. V3 stated that when V3 asked if 911 EMS was called, V3 got no response from V4 or V10 in R1's room. V3 stated that V3 left R1's room to inquire. V3 stated that a nurse at the nurses' station informed V3 that EMS was in route; V3 returned to R1's bedside. V3 stated that EMS arrived about 10 minutes later and took over the care for R1. V3 stated that when bringing the emergency cart, the nurse is expected to do a quick check and ensure suction machine, oxygen tank, resuscitative bag, and defibrillator are present. On 6/2/2021 at 3:00pm, V19 (nurse manager) stated that V19 is unable to find a policy regarding oxygen therapy. V19 stated that this facility follows a Care Path for symptoms of SOB (shortness of breath). Care path reviewed with V19. If resident exhibits difficulty or labored breathing, the nurse should obtain the resident's	S9999		

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vital signs; if heart rate more than 100 beats/minute, oxygen saturation level less than 90%, physician should be notified. Evaluate signs/symptoms for immediate notification: cough, abnormal lung sounds, notify physician. V19 stated that the care path can be reviewed from any computer within this facility and it should be utilized when a resident is exhibiting a change in medical condition.

On 6/3/2021 at 8:15am, V2 DON presented this facility's oxygen administration policy. V2 stated that the first lines of the policy note it is appropriate for nursing to administer oxygen immediately and then notify the resident's physician for orders.
On 6/3/2021 at 9:10am, V29 NP (nurse practitioner) stated that V29 expects nursing staff to apply oxygen immediately for any resident exhibiting signs/symptoms of respiratory distress, such as difficulty breathing, labored breathing, increased respirations, decreased oxygen saturation level, and then contact V29 or the physician for further orders.

Review of R1's respiratory surveillance documentation, dated 4/30/21 - 5/19/21 at 3:02am, noted R1 did not exhibit a cough or shortness of breath, and R1's lungs sounds were clear in all lobes on auscultation.

There is no documentation noted in R1's medical record of R1 having a history of requiring oral suctioning via a suction machine at any time during R1's stay at this facility.

Review of R1's care plan, dated 2/18/2021, notes R1 has altered respiratory status related to chronic respiratory failure and COPD (chronic obstructive pulmonary disease). Interventions

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identified include: monitor for changes in orientation, increased restlessness, and air hunger; monitor for signs/symptoms of respiratory distress and report to physician: increased respirations, decreased pulse oximetry, increased heart rate, diaphoresis, and accessory muscle usage; monitor/report abnormal breathing patterns to physician: increased rate, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, and nasal flaring; position R1 with proper body alignment for optimal breathing pattern; and provide oxygen as ordered.

Review of R1's altered cardiovascular status care plan, dated 2/18/2021, notes monitor/report to physician changes in lung sounds and edema. Notify physician of any abnormal vital signs.

Review of R1's progress notes, dated 5/19/2021, notes the following:
At 3:02am, noted R1's lung sounds, right and left lobes clear.
At 8:46am, V4 RN (registered nurse) noted lung sounds, right and left upper lobes with rhonchi (coarse breath sounds), right and left lower lobes diminished.
At 12:20pm, V4 noted at 10:30am, R1 with more rhonchi than on first assessment this morning, awake and responsive.
At 12:25pm, V4 noted at 11:00am, R1's breathing more labored becoming diaphoretic, unable to obtain accurate oxygen saturation level with pulse oximetry, fleeting reading of 86%.
At 12:32pm, V4 noted at 11:10am, vital signs: blood pressure 102/87, heart rate 124 beats/minute, respirations 30/minute, still unable to get accurate oxygen saturation level.

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Review of the EMS (emergency medical services) report, dated 5/19/2021, noted EMS was notified at 11:44am. The EMS unit was in route to this facility at 11:45am. The EMS unit arrived on scene at 11:51am and were at R1's bedside at 11:52am. EMS assessment noted R1's breathing labored, rapid, and shallow, mental status was unresponsive. Initial vital signs taken at 11:53am: blood pressure 180/104, heart rate 106 beats/minute, respirations 36/minute, oxygen saturation level on 15 liters of oxygen was 85%. Summary noted EMS dispatched for a resident having difficulty breathing. Upon arrival, R1 was unresponsive and in respiratory distress on 15 liters/minute oxygen via non-rebreather mask. Staff stated R1 had been in current condition for approximately one hour. R1 was diaphoretic and coarse breath sounds were heard bilaterally. The local hospital was alerted to R1's critical condition. While in route to the hospital, R1 began gurgling and mouth was suctioned, no improvement in R1's overall condition. Upon arrival to the hospital, R1 stopped breathing. Hospital staff took over the care of R1.
Review of the hospital records, dated 5/19/2021, noted R1 was pronounced expired at 12:19pm on 5/19/2021.

Change in R1's condition on 4/8/2021:
On 5/27/2021 at 12:00pm, V24 LPN stated that the protocol for a change in resident's condition, the nurse performs an assessment, full set of vital signs, neurological check, and notifies physician. V24's documentation on 4/8/21 at 2:45pm was reviewed with V24. V24 stated that upon completion of R1's assessment, V24 checked R1's code status. V24 stated that R1 was DNR (do not resuscitate) with selective treatment, but was unable to locate DNR form in R1's medical chart at the nurses' station. V24

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stated that V24 paged the nurse practitioner to inform her V24 was going to send R1 out to the hospital. V24 stated that V24 called 911 EMS (emergency medical services). V24 stated that V24 stayed at R1's bedside until paramedics arrived. V24 stated that V24 obtained vital signs with V24's assessment; no further vital signs were obtained. V24 stated that V24 did not apply oxygen to R1.

Review of R1's medical notes R1 was admitted to this facility on 2/17/2021.
Review of R1's POS (physician order sheet), dated 2/18/2021, notes R1 is a full code.
Review of R1's POS, dated 5/3/2021, notes R1 is DNR.
Review of R1's DNR form, dated 5/3/2021, notes R1 is DNR with selective treatment, including oxygen therapy.
Review of R1's progress notes, dated 4/8/2021, notes the following:
At 10:12am, V24 LPN (licensed practical nurse) noted R1 with temperature of 101.6. Acetaminophen was given.
At 1:15pm, V24 LPN noted R1's temperature went down to 99.5.
At 2:45pm, V24 LPN noted R1's temperature back up to 102.1, diaphoretic, only responsive to painful stimuli.
At 3:38pm, V25 NP (nurse practitioner) noted V25 received a call from V24 at 3:30pm stating R1 has mental status changes and temperature of 101.4 and V24 was sending R1 out to hospital now. V13 (attending physician) notified.
At 4:24pm, V26 LPN noted R1's family made aware that R1 was transferred to the hospital per outside ambulance service to the local hospital due to increased heart rate, altered mental status, and elevated temperature. R1 admitted with fever, sepsis, dehydration, and elevated troponin

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(type of protein found in the muscles of the heart; this protein is released into the blood when the heart muscle becomes damaged).

There is no documentation found noting V24 called 911 EMS for R1's transport to hospital on 4/8/2021.
Review of the outside ambulance service run sheet, dated 4/8/2021, noted dispatch was notified on 4/8/21 at 3:16pm. The outside ambulance service was in route at 3:23pm and arrived at R1's bedside at 3:39pm. Initial vital signs: blood pressure 110/60, heart rate 135 beats/minute, respirations 35/minute, oxygen saturation level 88% on room air. R1's breathing noted to be labored. Paramedics placed oxygen at 15 liters/minute via non-rebreather mask. Oxygen saturation level improved to 99% with supplemental oxygen. The outside ambulance service transported R1 to the hospital at 4:11pm and arrived at 4:20pm. R1's care transferred to the hospital staff.

Review of this facility's emergency management policy, revised 11/2013, notes the following is documented in the resident's progress notes after a resident emergency event: resident status, time medical emergency identified and type of emergency care initiated, evaluation of resident's level of consciousness, circulation, airway, and breathing, verification of resident's code status, occurrence and time code called, time and person contacting EMS, step by step description of care provided, physician notification, response received, and orders obtained ,family notification and response received, EMS arrival and transfer of care, and time and resident status upon transfer from facility.
Review of this facility's oxygen administration policy, updated 07/2017, notes during a

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respiratory emergency, it is appropriate for nursing to administer oxygen immediately and obtain physician's order after resident is stabilized or transferred. It notes to assess resident's respiratory status, breathing patterns and pulse oximeter reading. Record in the resident's progress notes date and time oxygen was initiated, condition necessitating oxygen use, respiratory status related to oxygen use, type of delivery, device used and flow rate of oxygen and any assessments or interventions.

Review of this facility's care path for symptoms of shortness of breath, dated 2014, notes symptoms of shortness of breath include: difficult or labored breathing that is out of proportion to the resident's level of physical activity; any new complaint of shortness of breath. Obtain vital signs, including: temperature, blood pressure, heart rate, respirations, and oxygen saturation level. If heart rate is greater than 100 beats/minute, respiratory rate is greater than 28/minute, oxygen saturation level is less than 90%, or accessory muscle breathing, notify physician. If resident exhibits cough with or without sputum production, abnormal lung sounds (such as rhonchi), swelling, change in mental status, cardiovascular symptoms, or other respiratory symptoms, notify the physician immediately.

Review of this facility's change in condition policy, dated 11/2016, notes a facility must immediately inform the resident's physician and the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status.

B. Based on observations, interviews, and record reviews, this facility failed to follow its policy and procedures and ensure the required oxygen

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equipment was readily available on the emergency cart when a rapid response code was called for one resident (R1) out of three reviewed for acute change in respiratory status in a sample of 22. This failure resulted in an additional 7-minute delay in R1 receiving supplemental oxygen for an oxygen saturation level of 82%. R1 expired on 5/19/2021 at 12:19pm upon arriving at the local hospital.

Findings include:

On 05/19/2021 at 11:26am, the emergency cart was observed being pulled into R1's room by V4 (nurse). A rapid response emergency code was paged overhead at 11:15am for R1 exhibiting respiratory distress. R1 was observed sitting upright in bed. R1's breathing was labored. R1's breathing was audible and sounded gargled. Respirations were deep and chest was rising and falling with great effort. This surveyor did not observe an oxygen tank in R1's room or with the emergency cart.

On 05/19/2021 at 11:30am, V3 (unit manager) was observed looking for oxygen tank and supplies at R1's bedside. V4 (nurse) asked if V3 wanted V4 to call 911 EMS (emergency medical services). V3 responded "yes". V3 requested oxygen tank and oxygen supplies.

On 05/19/2021 at 11:31am, V3 was observed exiting R1's room. R1 was observed lying in bed with head of bed elevated. R1's eyes are open; R1 did not respond to V4's verbal or tactile stimulation.

On 05/19/2021 at 11:33am, V3 was observed returning to R1's room with a portable oxygen tank.

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S9999	Continued From page 15 On 05/19/2021 at 11:35am, V3 stated that R1's oxygen saturation level is 82% on room air. Oxygen at 15 liters via non-rebreather mask applied to R1. On 05/19/2021 at 1:35pm, V6 (nurse) stated that at 11:15am, V4 (nurse) approached V6 and informed V6 that V4 needed help. V6 stated that V4 informed V6 that the emergency cart was needed. V6 stated that V4 and V6 went to R1's room with the emergency cart. V6 stated that the oxygen tank was not with the emergency cart and V6 was instructed to obtain an oxygen tank. On 5/27/2021 at 2:00pm, V6 verified V6's signature on the emergency cart check sheet and acknowledged that V6 checked the emergency cart on 5/19/2021. V6 stated that V6 checked the emergency cart within the first hour of starting V6's shift that day. V6 stated that by signing this form, the nurse has made sure the lock is intact and the number on the lock matches the number documented the previous day. V6 stated that V6 observed the suction machine and resuscitative bag were present. V6 stated that V6 is unsure if the oxygen tank was with the emergency cart. On 5/19/2021 at 2:00pm, V4 RN (registered nurse) stated that the emergency cart is checked daily. V4 stated that this task is assigned on the day's assignment sheet. V4 stated that a suction machine, portable defibrillator, back board, resuscitative bag, and portable oxygen tank are stored with the emergency cart. V4 stated that the nurse is expected to make sure all of this equipment is present, the oxygen tank is full, and the lock is secured. On 5/20/2021 at 9:20am, V2 DON (acting director of nursing) stated that there are three emergency	S9999		

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carts; one on each nursing unit. V2 stated that the emergency cart is checked daily. V2 stated that the nurse is expected to make sure the portable oxygen tank is full, portable defibrillator, resuscitative bag, and suction machine are functioning properly. V2 stated that by signing the form on the cart, the nurse has made sure that all required equipment is present and ready for use.

On 5/21/2021 at 9:18am, V3 (unit manager) stated that on 5/19/2021 V4 (nurse) informed V3 that R1 was exhibiting respiratory distress. V3 stated that upon entering R1's room, V3 noted R1 with audible coarse breath sounds. V3 stated that V3 did not see any oxygen supplies or an oxygen tank in R1's room. V3 stated that V4 brought the emergency cart into R1's room. V3 stated that the oxygen tank was missing from the emergency cart and V3 requested V4 obtain oxygen equipment. V3 stated that the nurse working on the night shift is expected to sign the form and ensure the required equipment is with the emergency response cart. V3 stated that if the cart is not checked on night shift, then it will be checked by the day shift nurse. V3 stated that the emergency response cart is brought to all emergent situations. V3 stated that when bringing the emergency response cart, the nurse is expected to do a quick check for portable defibrillator, full oxygen tank, suction machine, resuscitative bag, and backboard are present.

On 5/25/2021 at 12:30pm, V19 (unit manager) stated that the emergency response cart is checked by the night shift nurse after verifying all of the required equipment is present and the lock is secured.

Review of this facility's emergency management

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policy, revised 11/2013, related to emergency cart maintenance, notes the cart is secured with a numbered break-away lock. Use an emergency cart check sheet and signature log form daily to verify the contents of the cart, the licensed nurse verifies that all equipment and care items listed on the emergency cart checklist are present on the top, back, and sides of the cart; and ensures the break-away lock is intact and the number on lock is unchanged from the previous check.

(A)

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300.610a)
300.1010h)
300.1210b)
300.1210d)2)
300.1210d)5)

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 300.1010 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

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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.

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.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection,

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and prevent new pressure sores from developing.

These requirements are not meet as evidenced by:

Based on interviews and record reviews, the facility failed to assess for circulation and identify the signs of altered neurovascular status to include decrease in sensation, increase in complaints of pain and discoloration of toes, failed to consistently and accurately assess and monitor a resident's clinical condition, implement interventions that are consistent with a resident's needs, goals, and professional standards of practice, evaluate the effectiveness of the interventions to prevent a pressure ulcer from developing and/or worsening and failed to implement interventions to prevent or reduce the risk of skin breakdown for 1 of 3 residents (R5) reviewed for splint/cast neurovascular assessments. The facility also failed to follow their policy and procedures for monitoring vital signs at least every 4-8 hours for 1 of 3 residents (R12) reviewed for vital signs after admission. This failure resulted in R5 developing a gangrene wound to the top right foot area, right lateral foot and right heel requiring surgical interventions and above the knee amputation.

Findings include:

On 5/21/2021 at 11:00am, V16 (wound care nurse) V16 stated that R5's right leg was contracted. V16 stated that R5 developed a pressure ulcer to right posterior knee. V16 stated that these wounds were a result of R5's posterior mold splint rubbing R5's posterior leg. V16 stated that wound healing was complicated due to R5's posterior mold splint. V16 stated that a

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hydrocolloid dressing was applied to R5's posterior right knee wound to provide extra cushioning to this wound. V16 stated that the wound care team does not routinely monitor residents with a cast or posterior mold unless they are notified of a wound. V16 stated that the resident's nurse is responsible for monitoring resident's skin for any changes. This surveyor reviewed a wound care photograph of R5's left heel taken on 5/4/2021. This photograph noted discoloration (reddened and purple areas) to R5's right toes. V16 stated that V16 was not aware of any concerns related to R5's right toes. V16 stated that wound care staff shouldassess and monitor any reddened areas..

On 5/21/2021 at 2:00pm, V35 (orthopedic surgeon) stated that V35 was not made aware of R5's right posterior knee wound or of any changes in R5's neurovascular status to right lower leg prior to R5's appointment on 5/18/2021.

On 5/25/2021 at 2:15pm, V23 NP (wound care nurse practitioner) stated that R5's posterior mold on right lower leg rubbed against R5's posterior knee due to right leg contracture. V23 stated that V23 thinks wound care staff placed a hydrocolloid dressing over R5's posterior knee wound to provide cushioning. V23 denied notifying R5's outside orthopedic physician with concerns related to R5's splint and the pressure ulcer to R5's posterior knee. V23 stated that any resident with a splint/cast should have the affected extremity's circulation checked daily. V23 stated that the wound care staff should be checking skin proximal and distal to splint/cast for any circulation issues. V23 stated that V23 can't see wound care staff performing wound care to R5's right posterior knee and not assessing R5's toes for circulation. V23 does not recall observing

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S9999	Continued From page 21 R5's right toes during weekly wound rounds. All assessments should be documented in the resident's medical record. On 6/2/2021 at 10:35am, V25 NP (nurse practitioner) stated that V25 expects the nurse to notify V25 or the physician of any changes in a resident's neurovascular status: pain, swelling, numbness, tingling, or pulses. V25 denied being informed of any changes in the color of R5's toes. On 6/9/2021 at 4:00pm, V32 (medical director) stated that nurse practitioners have standards of care they should be following related to resident care. V32 stated that this facility's wound care staff should have notified V35 (orthopedic surgeon) that the splint was rubbing against R5's posterior knee resulting in skin breakdown. V32 stated that the wound care staff should have implemented interventions to prevent further skin breakdown due to R5's posterior mold splint. V32 stated that the nurse is expected to notify the physician of any changes in the resident's condition. V32 did not respond when questioned regarding this facility's cast care policy for neurovascular assessment, CMS (circulation, motion, sensation) checks. Review of the medical record notes R5 was admitted to this facility on 4/29/2021 with diagnoses including: displaced fracture of the right ankle, anxiety disorder, dysphagia, symbolic dysfunctions, and stroke with hemiplegia affecting right dominant side, major depressive disorder, and history of falling, diabetes, high blood pressure, hyperlipidemia, spinal stenosis, and convulsions. Review of R5's admission note, dated 4/29/2021, notes R5 admitted with redness to posterior knee;	S9999		

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no open areas identified.

Review of R5's Braden scale, dated 4/29/2021, notes no impairments with sensory perception. R5 is noted at risk for developing pressure ulcers. On 5/6/21, R5's Braden scale notes a change in R5's sensory perception: slight limitation in R5's ability to respond meaningfully to pressure-related discomfort.

Review of R5's medical record does not note documentation of daily head to toe skin evaluations were performed by a nurse or documented in R5's clinical record.

Review of R5's MAR (medication administration record), dated May 2021, notes R5 received tramadol (pain medication) 50mg (milligrams) oral on 5/5, 5/7, 5/10, 5/11,5/13, 5/14, 5/15 and 5/17 for pain control. R5 also received acetaminophen 325mg two tablets oral every 6 hours for pain.

R5's pain assessment, dated 5/3/2021, notes R5 rated pain at 6 out of 10. R5 with complaints of pain frequently. R5's pain goal is 0 out of 10. Pain described as aching, throbbing, and stiffness. Pain relieving factors include repositioning and medications. Pain negatively affects R5's ADLs (activities of daily living), activities, and sleep.

Review of R5's TAR (treatment administration record), dated May 2021, notes body audit one time a day every 7 days for skin observation. There is no documentation found noting R5's right rear knee, cleanse with normal saline, pat dry, apply medicated ointment and alginate and cover with dry dressing was performed on 5/4 or 5/12, 5/13, or 5/14.

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A photograph taken by the wound care team, dated 5/4/2021, notes R5's left heel in the foreground and R5's right toes in the background. R5's first, second, and fourth toes are reddened and R5's third toe is observed to have purple discoloration.

There is no documentation found in R5's medical record noting discoloration to R5's right toes.

Review of V35's (orthopedic surgeon) follow-up appointment note, dated 5/18/2021, noted on 4/22/2021 R5 presented to the hospital with right ankle fracture due to fall. R5's ankle was reduced, and a well-padded splint was applied. R5 was found to be neurovascular intact with normal sensation and capillary refill less than 2 seconds post-reduction. R5 was not able to flex or extend toes before or after reduction, which apparently is R5's baseline. Right lower leg splint removed, found to be well-padded and appropriately wrapped without significant tension on elastic bandage. Posterior slab extends to 2cm (centimeters) distal to the fibular head, no exposed fiberglass material. Splint removed. There is necrosis (dead) of the skin on the top of R5's right foot, lateral foot, and heel. Pedal pulses faint to non-palpable, sensation is absent. The severity of this problem was discussed with R5 and R5's family member. R5 was transported directly from the outpatient orthopedic clinic to the hospital for further evaluation and treatment.

Review of R5's hospital records, dated 5/18/2021 - 5/24/2021, notes R5's right foot with dusky appearance and cool to the touch. R5's right pedal pulses not palpable. Wound care physician consult note, dated 5/20/2021, notes extensive black eschars (dead tissue) on the right foot on

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the top of foot, posterior heel, extending to distal shin. R5 with gangrenous skin changes of the right foot. Vascular consult, dated 5/20/2021, noted R5 stated R5's wounds to right leg were not present prior to R5's fall. R5 had sensation in R5's right foot prior to the fall, but not since after the fall. Right foot with extensive necrotic (dead) tissue to top of foot and mottled in appearance; ischemia changes noted. On 5/22/2021, a right above the knee amputation was performed.

Photographs of 5's right foot and lower leg taken in the hospital, dated 5/18/2021, notes discoloration to R5's right toes, swelling, and gangrenous wounds to the top of R5's right foot, right lateral foot, and right heel.

Review of R5's alteration in comfort care plan, initiated 5/3/2021, notes interventions including: provide cast care, administer pain medication per physician's orders, notify physician if pain frequency/intensity is worsening or if current analgesia regimen ineffective.

Review of R5's alteration in musculoskeletal status related to right ankle fracture, initiated 4/30/2021, notes interventions including: monitor/report to physician signs/symptoms or complications related to pain, swelling, or decline in mobility.

Review of R5's care plan, dated 4/30/2021, notes R5 is at risk for complications due to musculoskeletal problems related to right ankle fracture and contractures.

Review of R5's at risk for alteration in skin integrity care plan related to impaired mobility, use of cast below knee, dated 4/30/2021, notes observe skin condition with ADL (activities of daily

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING HOM	940 MAPLE AVENUE HOMEWOOD, IL 60430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25 living) care daily, report abnormalities. Review of this facility's cast care policy, updated 02/2017, notes to perform neurovascular assessment (5P's) on casted extremity every 1-2 hours for the first 24 hours. Neurovascular assessment should continue at a minimum every shift. 5P's include: pain; pallor, observe color of tissues distal to cast, no signs of circulatory compromise should be present; pulseless-ness, palpate distal pulses of casted extremity, note presence and strength of pulse, assess capillary refill; paresthesia, assess for numbness/tingling, or abnormal sensations; and paralysis, assess for ability to move toes and extremity. Notify physician of change in condition (odor, drainage, hot spots, decreased circulation, increased pain, etc.). Record in the resident's progress notes the date and time care (neurovascular assessment) was provided, condition of skin, status of circulation, and motion of distal extremity. Report unusual findings from the neurovascular assessment and document in progress note. Review of this facility's skin practice guide, dated 01/2013, notes a comprehensive evaluation of a resident's skin status requires evaluations by the physician, nursing staff, registered dietitian, and rehabilitation team. The Braden scale is used to identify potential levels of risk for pressure ulcer development. Each resident is evaluated on admission or re-admission using this scale. The Braden scale is completed for 4 weeks total (at the time of admission and then weekly for the next three weeks, quarterly, with a significant change and as clinically indicated. A comprehensive skin evaluation is completed upon admission. Daily head to toe skin evaluations are completed by the nurse for any resident with a pressure ulcer and documented in	S9999		

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S9999	Continued From page 26 the resident's clinical record. Upon completing an evaluation, the interdisciplinary team develops a resident specific care plan to include prevention and management interventions with measurable goals. For a change in resident condition, the nurse notifies the physician, wound care team, family or responsible party and documents the findings in the clinical record. The resident's care plan is updated to reflect the resident's current status and care needs. Review of R12's medical record notes R12 was re-admitted to this facility on 3/11/2021 after being hospitalized for urinary tract infection, weakness, and metabolic encephalopathy. On 6/2/2021 at 2:00pm, V2 DON (acting director of nursing) stated that the nurse is expected to perform an admission/re-admission assessment, including head to toe assessment and vital signs. V2 stated that the enhanced measures protocol includes vital sign monitoring every 8 hours. On 6/9/2021 at 2:59pm, V34 RN (registered nurse) stated that on 3/11/21, V34 was assisting R12 onto toilet. V34 stated that when R12 sat on toilet, R12 became unresponsive. V34 stated that V34 called out for assistance. V34 stated that another nurse was in the hallway nearby and came to assist. V34 stated that V34 tried to revive R12 while the other nurse left R12's room to page a rapid response overhead. V34 stated that more staff arrived to assist. R12 was helped into wheelchair and then placed into bed. V34 stated that R12 became responsive and was alert and oriented at baseline. V34 stated that R12 appeared to have a syncopal event. V34 stated that V34 notified R12's physician and was informed to encourage fluids and monitor vital signs. V34 denied obtaining orthostatic (blood	S9999		

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S9999	Continued From page 27	S9999		

pressure and heart rate monitoring sitting, standing, and lying flat in bed) vital signs or receiving a physician order to do so. V34 stated that V34 did not receive any physician order to send R12 to the hospital for further evaluation. V34 stated that a resident's vital signs are monitored every shift and with any change in condition.

Review of R12's progress notes, dated 3/11/2021, notes at 8:18pm R12 requested to go to bathroom, V34 RN assisted R12 to toilet, R12 become unresponsive, assisted R12 back to chair and R12 became responsive, blood pressure 105/52, heart rate 82 beats/minute, respirations 18/minute, oxygen saturation level 96% on room air, assisted back to bed and made comfortable. At 9:04pm, V34 noted R12's physician notified of R12's condition, vital signs: blood pressure 127/73, heart rate 73 beats/minute, oxygen saturation level 96% on room air, respirations 18/minute. Orders given and carried out, R12 in bed resting at present no distress at present.

Review of R12's POS (physician order sheet), dated 3/11/2021, notes an order to push and encourage fluids every shift. On 3/14/2021 at 2:30pm, notes an order for vital signs every shift.

There is no documentation found in R12's medical record noting vital signs were ordered between re-admission to this facility on 3/11/2021 at 4:00pm and 3/14/21 at 2:30pm.

There is no documentation found in R12's medical record noting vital signs were obtained between 3/11/21 at 9:00pm and 3/14/21 at 10:30pm.

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This facility's care path for symptoms of acute mental status change, dated 2014, was reviewed. It notes for new mental status change noted, such as unresponsiveness, obtain vital signs. Evaluate resident for any other signs or symptoms and consider contacting the resident's physician for orders for further evaluation and management, such as chest x-ray, urinalysis, bloodwork, and electrocardiogram. Monitor resident's vital signs, fluid intake/urine output every 4-8 hours.

Review of this facility's enhanced measures and monitoring policy, revised 5/14/21, notes at a minimum of every shift, obtain temperature checks and respiratory assessments on all residents. Complete respiratory surveillance evaluation in the electronic medical record at least every shift for all residents in the facility.

Review of this facility's respiratory surveillance evaluation form notes to document the following: temperature; blood pressure; oxygen saturation level; cough; shortness of breath; lung sounds: right upper lobe, right lower lobe, left upper lobe, left lower lobe; sore throat; chills; congestion/runny nose; fatigue; muscle/body aches; headache; loss of taste; loss of smell; presence of nausea, vomiting, diarrhea; if on airborne respiratory isolation; and any additional notes.

(A)