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	IL6010144	A. BUILDING: _____ B. WING _____	C 10/27/2021

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S 000	Initial Comments Complaint Investigation: 2177638/IL139258	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.696d) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3) 300.1220b)2) 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 300.696 Infection Control d) The facility shall establish an infection prevention and control program (IPCP) that includes, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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	S9999		

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S9999	Continued From page 2 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: 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 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility neglected to follow policies and procedures for notifying the physician and seeking medical intervention for a resident with a	S9999		

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S9999	Continued From page 3 change in condition, failed to provide the necessary care and services by not identifying and initiating timely emergency care for a resident in a rapidly declining condition for 1 of 3 residents (R1) reviewed for care/neglect and services. R1 had temperatures greater than 104 degrees and the facility failed to communicate with R1's physician for medical evaluation and intervention for a period of 27 hours after R1's condition had changed. This failure resulted in delayed emergency medical intervention being provided as R1 continued to deteriorate until he had cardiac/respiratory arrest. R1 expired on 9/25/21. The findings include: R1's face sheet showed he was a 40-year-old male who was admitted to the facility on 9/20/21 with diagnoses to include but not limited to Encephalopathy, Acute and Chronic Respiratory failure, multiple fractures of ribs, Tracheostomy, Gastrostomy, and Anoxic Brain damage. R1's facility admission assessment dated 9/21/21 showed he was in a comatose state and was dependent upon staff for all cares. R1's 9/21/21 Infectious Disease Note entered by V8 (Infectious Disease Nurse Practitioner) showed, "... Patient is a 40-year-old male who is being consulted by ID (Infectious Disease) for fever... he was reported with a fever of 100.4.... Plan: ... Nursing staff will continue to monitor and will contact ID NP (Infectious Disease Nurse Practitioner) or PCP (Primary Care Provider) for any change in condition. R1's temperature readings on 9/21/21 were documented as ranging between 98.6 and 101.3 degrees.	S9999		

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S9999	Continued From page 4 On 9/24/21, R1's temperature readings were as follows: 7:33 AM-104.5, 7:45 AM-104.5, 11:09 AM-102.6, 11:47 AM-104.7, 3:18 PM-101.3, 6:36 PM-104.0, and 10:51 PM-100.9. R1's medical record did not show any evidence of notification to R1's primary care Physician or Infectious Disease Nurse Practitioner regarding these elevated temperatures. On 9/25/21 the temperature log showed 6:30 AM-102, 8:53 AM-99.9, 10:57 AM-104.5 and 1:18 PM-101.4. R1's general progress note dated 9/25/21 showed, "7:30 AM... resident in bed. Noted resident is warm to touch and resting. Cool compress in place, not in any distress... 8:45 AM vitals checked and recorded. Noted a temp 99.9. Cold compress applied... 10:45 AM, Vitals checked and recorded. Temp 104.5 ... HR (heart rate) 112. PRN (as needed) Tylenol and cold packs applied. Paged [V7 R1's Primary Care Provider] for resident's status (Over 30 hours after R1 started running temperatures exceeding 104 degrees). Waiting for call back... 12:35 PM Respiratory Therapist informed the nurse that resident's heart rate noted 120-130 after suction. Nurse assessed the resident. Resident is not in any distress or pain... 1255 Paged [V7 R1's Primary Care Provider] 1315 (1:15 PM) NOD (Nurse on Duty) checked resident and noted temp of 101.4 and HR (heart rate) 118. Cold Packs applied. 2:15 NOD did rounds and noted resident resting without any distress. 3 PM Paged [V7] and answering service transferred the call to [V7] and he answered (over 4 hours after the first call was made). Informed [V7] about resident's condition and doctor ordered transfer the resident to the ER. 3:05 PM Called [ambulance service] for transportation and [ambulance service] gave ETA (estimated time of arrival) of 90 minutes. 3:10 PM Respiratory Therapist called NOD for	S9999		

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S9999	Continued From page 5 assessment of resident because RT noticed resident's breathing is shallow... NOD assessed noted breathing is shallow called for help... HR 134... RT started ambu bagging with 100% oxygen. 3:15 PM Called 911. 3:23 PM 911 arrived and assessed the resident. Paramedics took over the resident. Paramedics started CPR (Cardiopulmonary Resuscitation) ... Paramedics connected the defibrillator and noted residents HR 147... 3:42 PM Paramedics left the facility with resident..." R1's death certificate showed he expired on 9/25/21 at 4:20 PM. R1's death certificate showed he expired on 9/25/21 at 4:20 PM. From the time of R1's first 104-degree fever until someone at the facility spoke with a physician over 30 hours had elapsed and 4 separate shifts of staff had been assigned to care for R1. R1's 9/25/21 acute care hospital documentation showed R1 arrived to, the emergency department at 4:02PM. The Emergency Department Provider note from 9/25/21 showed, "... Patient presents to the ED (Emergency Department) from the [Long Term Care Facility] in Cardiopulmonary arrest. EMS (Emergency Medical Services) was called for respiratory distress and found the patient without spontaneous respirations, CODE BLUE called on their arrival... EMS states that patient had no respirations or pulses on their arrival. Pulses were regained twice during transfer after 2 rounds of CPR (Cardiopulmonary Resuscitation) ... ED Course: Patient present to the ED after arresting at his care facility. Suspect Respiratory Arrest, possibly due to Pneumonia... Patient pronounced dead at 1620..." On 10/21/21 at 2:52 PM, V2 (Regional Nurse	S9999		

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S9999	Continued From page 6	S9999		

Consultant) said the nursing staff is expected to update the resident's physician with any change of condition, an elevated temperature is considered a change of condition. V2 said the nursing staff should have notified R1's physician when his temperature was elevated to 104.5 on 9/24/21 and document notification in the nursing progress notes. V2 said on 9/25/21 when V9 paged the physician to notify him of R1's change of condition he should have waited only 30 minutes to an hour before trying again. V2 stated if a physician is not getting back to nurses, they should contact the medical director of the facility for guidance. They should have kept calling the doctor or called the medical director. V2 said she is unsure why the nurse did not contact the medical director. V2 said depending on the effectiveness of nursing interventions such as giving medications she does not know if they should have notified R1's physician for his temperature of 104.5. V2 said the nurses probably notified the doctor but forgot to document. V2 said the nurse attempted to notify the doctor on 9/25/21 right away.

On 10/22/21 at 10:47AM, V10 said R1 was doing ok on that morning except he had a fever, but around 3PM when he did his rounds, he noticed R1 was breathing shallow, and his heart rate was higher. V10 said he suctioned R1, but he was still breathing shallow. V10 said R1 was taking maybe one breath every 20 seconds. V10 said he called the nurse and started giving R1 breaths with an ambu bag. V10 said the nurse called 911 and when the paramedics arrived, they started CPR. V10 said after some compressions the paramedics found a pulse and took the patient to the hospital.

On 10/22/21 at 11:37 AM, V8 (Infectious Disease

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S9999	Continued From page 7 Nurse Practitioner) said she recalled R1. V8 said she saw R1 when he was admitted to the facility and had noted he was running a temperature of 100.4 degrees. V8 said at the time she saw R1 his labs were normal and R1's fever had subsided before she left the facility that day. V8 said she ordered a PCR test (COVID19 Test) and some more labs for the next day just to be sure. V8 said when R1's elevated temperatures should have been reported to her. When asked about R1's temperatures on 9/24/21 being greater than 104 degrees, V8 said "Nobody told me about that. One, they didn't call me about it and two, if they didn't call me about it, they should have called the primary and sent him out immediately. 104 degrees is too much, it's too high no matter what. Even if it was coming down with Tylenol, they should still have called somebody because he needed to be evaluated. No matter what they should have told somebody. He has a trach (tracheostomy). The fever could have been coming from anywhere. They know to call me. If they had called me when his temperature went up to 104, I would have had them send him right away. I've told them before people on traches can change quickly. A fever of 104 degrees could absolutely cause respiratory distress especially in someone like him with a trach." On 10/22/21 at 2:24 PM, V7 (R1's Primary Care Physician) said, "[R1] was admitted to the facility with a low-grade fever. We always get infectious disease involved with low grade fevers and infectious disease takes care of antibiotics They should have called me or the infectious disease doctor when he spiked the high temperature. When there is a temperature of 104 degrees, the PCP (Primary Care Physician) needs to be contacted. I was not made aware on 9/24/21 that he was running a temperature of 104 degrees or I	S9999		

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S9999	Continued From page 8 would have had them send him to the hospital then." I will tell you when I got a call on 9/25/21) that he spiked to104 degrees, I immediately gave them the orders to send to emergency room. During those 3 to 4 days, he was in the facility there was nothing communicated to me, there were no calls until I got the call that his temperature was 104 degrees. They should have called me or the infectious disease doctor when he spiked the high temperature. When there is a temperature of 104 degrees, the PCP (Primary Care Physician) needs to be contacted. I was not made aware on 9/24/21 that he was running a temperature of 104 degrees or I would have had them send him to the hospital then. There's no excuse for not contacting me with something like that. I answer my calls within minutes." The facility's Abuse and Neglect Policy with review date of May 17, 2021 showed, "... It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect or mistreatment... Types of Abuse... 5. Neglect, (Including medical neglect) ... Neglect is the failure to provide necessary and adequate (medical, personal, or psychological) care. Neglect is the failure to care for a person in a manner which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service..." The facility's policy titled Notification of Change of Condition with revision date of 7/28/21 showed, "... The facility will provide care to residents and	S9999		

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S9999	Continued From page 9 provide notification of resident change in status... Procedures... The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: ... b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) ..." (A)	S9999		