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S 000	Initial Comments Complaint: 2148670/IL140536	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. (B) 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. (Section 3-202.2a of the Act) 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:	S9999		

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S9999	Continued From page 2 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three	S9999		

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S9999	Continued From page 3 months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were NOT MET as evidence by: Based on record review and interview, the facility failed to provide sufficient monitoring and progressive interventions to prevent decannulation (pulling out tracheostomy cannula) for 1 resident (R3) and failed to provide adequate monitoring during capping/weaning off of the ventilator for 1 resident (R4) reviewed for ventilators is a sample of 8. This failure resulted in R3 decannulating 4 times, the last time ending in death, and R4 not being adequately monitored during capping, leading to death. Findings include: 1) R3's Minimum Data Set (MDS), dated 02/07/17, documents that R3 was moderately cognitively impaired. R3's face sheet dated, 11/09/17, documents a diagnosis of Acute and Chronic Respiratory failure, unspecified whether with hypoxia or hypercapnia. R3's care plan, last reviewed/revised 12/21/16, has no documentation regarding R3 having decannulated self on multiple occasions. R3's nurses' notes and respiratory notes were reviewed on 12/07/21 at 9:00 AM, and documents	S9999		

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that R3 decannulating self on four different occasions, 08/11/17, 08/21/17, 08/29/17 and 10/11/17.

On 8/11/17 at 7:30 PM, R3's nurses' notes, documents, "This nurse called into pt. (patient) room by RT (respiratory therapy), r/t (related to) resp. (respiratory) distress. Pt. decannulated self and was hypoxic and confused. Pt. bagged with vs (vital signs) of 167/102, 120, 18, 97.5, 99% bagged."

On 08/11/17 at 7:39 PM, documents "Pt. back to baseline with no signs and symptoms of distress noted at this time. VS of 140/86, 94, 18, 92% on vent. (ventilator). NP (Nurse Practitioner) called and notified of event with NNO's (no new orders) at this time. Will cont. (continue) to monitor pt. close."

R3's respiratory progress notes, dated 08/11/17, documents "Doing alarm checks at (7:30 PM) pt. unresponsive with trach (tracheostomy cannula) out. Other therapist and I reinserted trach and started bagging. Pt has HB (heart beat). Pt started to come back around approximately (7:40 PM) @ (at) (7:43 PM) put back on vent. Sp02 (oxygen saturation) 98%. HR (heart rate)121 and she's responding well. @ (7:48 PM) Sp02 97% HR 88 back on vent. Some blood."

R3's care plan has no documentation of any updated progressive interventions for decannulation on 08/11/17.

On 08/21/17 at 12:30 PM, R3's nurses' notes, documents "Res (resident) had call light on, after knocking and announcing presence, res without response, upon entering room res trach out, res flaccid, color blue lips and nail beds, without

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palpable apical pulse. Respiratory paged to room stat, trach reinserted, res bagged and sx (suctioned) and after 2 min. (Minutes) res color returned to normal, res opening eyes and apical pulse heard with stethoscope, radial pulse palpable. Res pulled up in bed and extra TLC (tender loving care) given and prn (as needed) anxiety med due to res. waving arms and upset because of trach being out."

On 08/21/17 at 12:30 PM, R3's Respiratory progress notes, documents "Pt. found decannulated by RN (Registered Nurse), Pt unresponsive and cyanotic. Trach was re-inserted, bagged with 100% 02 (Oxygen) and Pt became alert and communicating appropriately Sp02 99%." It further documents, "Trach tie system changed to tie that actually ties to trach for the purpose of keeping pt from undoing the Velcro."

R3's care plan has no documentation of any updated progressive interventions for decannulation that occurred on 08/21/17.

On 08/29/17, R3's Respiratory progress notes, documents, "Trach out re-inserted some blood at stoma present. (11:10 PM)."

R3's care plan has no documentation of any updated progressive interventions for decannulation that occurred on 08/29/17.

On 10/11/17 at 3:30 PM, R3's nurses' notes documents "CNA (Certified Nursing Assistant), called nurse to pt. room. Pt. found with trach out and no pulse. Code blue was initiated. RT (Respiratory Therapist) put trach back in with ease. Alarm did not sound after trach removal."

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On 10/11/17 at 3:35 PM, R3's nurses' notes, documents RT noted no pulse, pt. unresponsive, CPR (Cardiopulmonary resuscitation) initiated and 911 alerted of emergency."
On 10/11/17 at 3:37 PM, R3's nurses' notes, documents "No HR, CPR continued, compressions done by RN."
On 10/11/17 at 3:43 PM, R3's nurses' notes, documents "First responders arrived on scene."
On 10/11/17 at 3:45 PM, R3's nurses' notes, documents "First responders applied AED (Automated external defibrillator), no shock advised, CPR continued."
On 10/11/17 at 3:50 PM, R3's nurses' notes, documents Local EMS (Emergency Medical Services) arrived."
On 10/11/17 at 4:00 PM, R3's nurses' notes, documents "EMS team states faint pulse is noted."
On 10/11/17 at 4:03 PM, R3's nurses' notes, documents "pt. loaded onto local EMS stretcher."
On 10/11/17 at 4:06 PM, R3's nurses' notes, documents "pt. left facility with local EMS, emergency transport to nearest hospital."
On 10/11/17 at 3:30 PM, Respiratory progress notes, documents, "Called to room stat. Upon entering room pt looked blue. I grabbed ambu bag and started to bag pt. That's when I saw trach was out . I put trach back in and began bagging on 15 LPM (liters per minute) and nursing started chest compressions CPR continued til EMS took over and continued CPR."

On 11/24/21 at 10:15 AM, V5, Respiratory Therapy (RT) , stated that the residents that use a vent (Ventilator) have an alarm on it that is directly hooked up to the call light system.

On 11/24/21 at 10:30 AM, V4, Respiratory Director, stated that the alarm should sound when

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the trach is out. She stated that there is a red light that comes on above the door and it will sound off "Attention Ventilator Staff." V4 stated that if someone has pulled their trach out multiple times, that they will secure the trach with a trach tie, and they will incorporate it into that resident's care plan. She also stated that she would check on the resident more often.

On 12/07/21 at 12:35 PM, V3, RT, stated that if a resident pulls a trach out, the ventilator will alarm due to loss of pressure. V3 stated that she would move the circuit out of reach of the resident, so they could not reach it to pull it out. She stated that she would explain to the resident that it will hurt if it is pulled, and that is your way to breathe.

On 12/07/21 at 1:35 PM, V9, CNA, stated that when someone pulls their trach out, there is an alarm that sounds on the vent itself, one above the door and then there is an alarm that states "Attention ventilator staff" that will sound also. V9 stated that "I would reposition the resident so it would be harder for them to reach and check on them on a regular basis to make sure they aren't trying to pull out their trach."

On 12/07/21 at 1:40 PM, V10, CNA, stated that there is an alarm that will sound when someone pulls a tracheostomy out. She stated that the light goes off over the door that's red, and then there is an alarm on the vent that will sound also. She stated that she would check on the resident more frequently, 15 minute checks.

On 12/08/21 at 11:45 AM, V4, Repiratory Director, stated that some of the different interventions they would use are the different ties, closer monitoring and then request mittens. She stated that with educating R3, you had to be direct with

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her, due to her intellectual disabilities. V4 stated that they went to different ties for R3, but she was still able to remove the trach. V4 stated that she would expect the new interventions would be added to the care plan. V4 stated that "Yes, I would expect respiratory staff to notify the doctor that they had to re-insert the trach, and that yes, I would expect it to be documented that they had called the doctor or the Nurse Practitioner."

On 12/08/21 at 1:30 PM, V2, Director of Nursing (DON), stated that some of the interventions that she would put into place would be, to do more frequent checks and to move the individual closer to the nurses station.

On 12/09/21 at 9:35 AM, Requested from V1, Administrator, any further investigation notes, monitoring documentation or care plans regarding R3. V1 stated that he did not think there was anymore, but he would check.

On 12/09/21 at 10:44 AM, V12, MDS Coordinator, stated that V1 had asked her to look for anymore documentation on R3 regarding monitoring, care plan, nurses notes and investigations. She stated that she was unable to find addition documentation.

The facility's Re-insert Displaced Tracheostomy Tube Policy and Procedure, dated 11/02/18, documents, "Policy: Re-insert displaced tracheostomy to to provide immediate airway after displaced tracheostomy tube. Responsibility: Obtain and maintain patent airway in long term tracheostomy patient." It further documents, "Procedure: 1. Immediately re-insert tracheostomy tube into stoma if stoma is greater than four weeks old. 2. After re-insertion assess patient for patent airway and adequate ventilation

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with equal breath sounds, heart rate, and respiratory rate." It also documents "Hazard of Dislodged Tracheostomy: 1. Threatened airway."

2) R4's Minimum Data Set (MDS), dated 01/28/19, documents that R4 was cognitively intact.

R4's face sheet, with an admission date of 12/27/18, documents diagnosis of Acute and chronic respiratory failure, unspecified with hypoxia or hypercapnia, Dependence on respirator (ventilator) status.

R4's care plan, dated 12/27/18, was the admission care plan. No other care plan was available.
On 12/09/21 at 9:40 AM, Requested R4's care plan from V1, Administrator. V1 stated that the baseline care plan done on admission is the only one that was available.

On 01/28/19 at 1:50 PM, R4's Respiratory progress notes document, "Begin capping trial. Noted rapid desaturation (97% down mid 70's) within < (less than) 5 min (minutes) on NC (nasal cannula). 02 sats (oxygen saturation) up to mid 90's after cap removal."
On 01/31/19 at 5:28 PM, R4's Respiratory progress notes document, "Capped with NC at 4 LPM (Liters per minute) 100%, HR (Heart rate) 91, RR (respiration rate) 20, BS (breath sounds) course, Tol. (tolerated) well with encouragement to smell the roses and blow out the candles."
On 01/31/19 at 5:40 PM, R4's Respiratory progress notes document, "Sat (saturation) 96% , HR 85 pt. (Patient) tol ok."
On 01/31/19 at 5:45 PM, R4's Respiratory progress notes document, "Sat 97%, HR 89, pt

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ok."
On 01/31/19 at 5:50 PM, R4's Respiratory progress notes document, "Came to check on pt and pt was blue with head hanging down. I immediately called for help as I uncapped pt." Respiratory progress note, further states, "I tried to arouse pt without success. Help arrived and we put H2O (water) in cuff and bagged pt for 10 minutes with pulse ox (pulse oximeter) on finger. Pt never came back."

On 01/31/19 at 6 PM, R4's Nurses Notes, document, "At 6 PM RT (Respiratory Therapist) called for help from resident's room. Upon arrival resident was unresponsive with no obtainable vital signs. Resident has a DNR (Do not resuscitate) order in place so CPR (Cardiopulmonary resuscitation) was not initiated @ (at) this time. Resident was then transferred from W/C (wheelchair) to bed."

On 11/24/21 at 10:15 AM, V5, RT, stated that residents that are being weaned off the ventilator are monitored continuously with the pulse ox (oximeter) machine.

On 11/24/21 at 10:30 AM, V4, Respiratory Director, stated that they will continuously monitor someone who is being weaned off the ventilator with a pulse ox machine. V4 stated that all respiratory staff carry a portable pulse oximeter and that they will check the resident and report any abnormal findings to the nurse or nurse practitioner, such as mental status changes.

On 12/07/21 at 12:35 PM, V3, RT, stated that when the staff cap a trach (tracheostomy), it is just a cap that goes over the end of the trach. She stated that when they cap someone, they are on a continuous pulse ox monitor. She stated that

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if the resident's Sp02 (oxygen saturation) goes below 90-92%, it will sound an alarm. V3 stated "I would stay with the resident for the first 10 to 15 minutes since that is the time their anxiety is at it's highest."

On 12/07/21 at 1:20 PM, V4 stated that the trach is capped with a red cap that plugs up the trach so that the individual will breathe out of their nose and mouth. V4 stated that before they begin to wean someone off the vent they have a process to do. She stated that first, the individual has to have a Passy Muir Valve (PMV) placed. V4 stated that this allows the individual to vocalize words, and it also lets the individual breathe in through their trach and out their nose. She stated that the individual has to be able to tolerate this all day for 1 to 2 weeks, and are stable with this before they can go onto step 2, the capping process. V4 stated that when someone is first capped they will be placed on continuous pulse ox, then someone will stay in the room with them for the first 10-15 minutes. She stated once the individual is stable and comfortable, respiratory will go and do something else (such as trach care), then they will come back and check on the individual. V4 stated that there is a lot of checking on the first day. V4 stated that R4 had been begging to be capped. V4 stated that she would expect it to be documented in the respiratory notes that R4 was requesting to be capped.

During the record review, there was no documentation regarding R4 being started on a Continuous positive airway pressure (CPAP) machine. There was no documentation regarding R4 being seen by speech pathology and assessed for the Passy Muir speaking valve. There were no labs regarding ABG's (arterial blood gases) being drawn on R4.

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S9999	Continued From page 12 On 12/09/21 at 10:00 AM, Requested from V4 any further documentation for monitoring of R4 while capping trial. V4 stated that she did not have any more documentation for monitoring R4 while capping. V4 stated that she has no documentation showing that R4 was requesting to be capped other than the respiratory notes . On 12/09/21 at 2:07 PM, V11, RT, stated that she would check and make sure that the individual had an order to cap before she would begin the process. V11 stated that they monitor someone who is being capped, she would make sure she stayed with them for a few minutes to make sure they were tolerating it well. V11 stated that the individuals are on continuous pulse ox also. V11 stated that with capping an individual she would check the individual's vital signs- HR, breathing, Sp02, and make sure they were stable and tolerating the capping. V11 stated that she stayed with R4 until she felt comfortable enough to be left. She stated that she made sure that R4's Sp02 was stable, and that she was not in any distress. She stated that she wrote down the time she took her Sp02 and asked how she was doing. V11 stated that R4 was not struggling in any way before she left R4's room. V11 stated that she went into the next room for a few minutes and then she went back to R4's room to check on her. V11 stated that she checked R4's Sp02 and wrote it down and made sure that R4 was ok before she left the room again. V11 stated that she then went 2 rooms over and was there for just a few minutes before she went back to R4's room. She stated that she looked at the clock and wrote down the time and checked R4's Sp02. V11 stated that the last time she checked on R4, V11 stated that she walked in the door and noted that her color was not right and that R4 had her head	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006704	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 down. V11 stated that she had stepped things up with the last individual so she could get back to R4 to make sure she wasn't tired. The Facility's Weaning as Tolerated Guideline Policy and Procedure, dated 11/02/18, documents "Policy: It is the policy of this facility that the Vent Unit will utilize these procedures to wean residents who are ventilator dependent." It further documents "2. Place resident on CPAP. A. Once resident is on CPAP and tolerating well, start decreasing SV (support ventilation) as tolerated to achieve the lowest possible PSV (pressure support ventilation) level maintaining SVT (spontaneous ventilation test) .5ml/kg, and RR (respiratory rate), 25 breath per minute." The policy and procedure further states " C. Once a resident is on CPAP mode with the lowest possible PSV level maintaining SVT.5ml/kg, and RR <25 Breath per minute and tolerating well for a period of 24 hours perform an arterial blood gas analysis (ABG). If ABG's results are within physician acceptable range proceed with step 3." The facility policy and procedure further documents " D. If arterial blood gas analysis (ABG's) results are with physician acceptable range request a consult with speech pathology for the assessment and use of Passy Muir speaking valve. E. If the resident is cognitive able to, speech pathology will be responsible for the in-service and training of the resident in the utilization of the speaking valve. F. Once the resident have tolerated the speaking valve for period of one (1) week a re-assessment will be perform by the pulmonary physician to update the resident care plan and proceed with step 4." (A)	S9999		