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	IL6006795	A. BUILDING: _____ B. WING _____	C 02/01/2022

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OAK PARK OASIS	625 NORTH HARLEM OAK PARK, IL 60302

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S 000	Initial Comments Complaint 2290435/IL142525	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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, but not limited to, the presence of incipient or	S9999	**Attachment A** **Statement of Licensure Violations**	

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manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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S9999	Continued From page 2 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 interview and record review the facility 1) failed to conduct a comprehensive assessment and accurately notify the physician of an acute decline of a resident's condition, 2) failed to immediately activate 911 emergency services for an unresponsive resident. This affected 1 (R1) resident reviewed for provision of care. These failures resulted in delayed treatment and delayed notification emergency transport services being activated for R1 who was transported to the local hospital and required intubation (mechancial respiratory assistance). Findings Include: R1 face facility face sheet shows R1 has diagnosis of emphysema, chronic obstructive pulmonary disease, hypertensive heart disease, dysphagia, acute kidney failure, mental and behavior disorders, atherosclerotic heart disease, anemia, atrial fibrillation, hypothyroidism, hyperparathyroidism, hypercalcemia, dementia, schizophrenia, Parkinson disease, insomnia, cerebral infraction, GERD, osteoarthritis, calculus of kidney, bradycardia, aphasia, abnormal weight loss, vitamin D deficiency, contusion of knee, solitary pulmonary nodule, unspecified head injury, fracture nasal bones, unspecified fall. R1 medical transportation report dated 01/11/22 shows in-part, narrative in summary, crew 92 dispatched to (nursing home name) for the	S9999		

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S9999	Continued From page 3 unresponsive resident. Requested closest hospital is (hospital name) at 5 minutes. Per dispatch, facility accepted 60-90 minutes ETA, fall the other day, 155/108, 95 p, 18 Rr, 99Ra(room air). Responded immediately code 3, 18 minutes to scene. Upon arrival delay to door due to inability access ramp due to cars in the way on one-way road. We entered facility and waited for the elevator to take us to the second floor, we were directed down the hall to room, where we found the approximately 135 lb (pound) 83 year old male in the bed in supine and sleeping. Patient was unresponsive to verbal, eyes opened to sternal rub, no verbal response. Palpable carotid approximately 50, breathing spontaneously unlabored, snoring respirations. Patient's nurse entered room and informed us that since this morning, patient has "not been himself". We asked for a last known normal and time for unresponsiveness, unable to obtain, Nurse said she got there today. No DNR paperwork given, unknown code status per paperwork and nurse. ALS assessment performed by paramedic, patient eyes opened to sternal rub, no verbal response, and flex to pain. Airway patent, nurse took a nasal swab for patient prior to our departure. Noted blood on end of swab, snoring respiration. Breathing was spontaneous and non-labored with clear lung sounds and symmetrical chest rise. Radial pulses not present, palpable carotid at a bradycardia rate and regular. Skin parameters cool and dry, no pallor or cyanosis. Abdomen soft and non-tender. No JVD, trachea midline. Pupils equal and reactive to light. No signs of trauma on or around head, neck, chest. Patient has no known allergies and a history of COPD, anemia, dementia, hypothyroidism, GERD, bradycardia. Initial vital signs obtained, 57/41, 50hr, 14R, 87RA, 138BS, 12 lead ECG obtained, sinus bradycardia with	S9999		

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bigeminal PACs at rate of 44. Patient was moved to stretcher via two man lift and was secured x5 in semi-fowlers. We successfully established 20g IV in patient left forearm WO (wide open). We administered 0.5mg Atropine IV, heart rate increased to 62. We placed patient on 2LPM via nasal cannula, 93%. Patient was moved to ambulance for transport and continuation of ALS care. Hospital contacted prior to departure, no orders given for intervention. Patient was transported code 3 to hospital, 3 minutes to destination. Patient was continuously monitored while in-route, final vital signs 57/35, 45 HR, 15R, 94%, 3LPM. At destination, we moved patient to ER 6 where care and report were given to Nurse. We returned to ambulance to clean and return to service. No incidents or injuries. All time approximate. End of narrative. DC.

R1's run report shows the dispatch was notified at 2:44p.m, the paramedics were on the scene at 3:04p.m and at the patient bedside at 3:09pm, 1.5 hours after V3 said she called for transportation.

R1 emergency room records dated 01/11/22 shows diagnosis unresponsive, hypotension and hypothermia, R1 was intubated at 4:44p.m in the emergency room.

R1 progress notes dated 1/11/22 at 3:00pm completed by V3 (Nurse), shows in-part resident noted in bed unresponsive but breathing and moving. Attempted to give resident his medication and he refused. Refused to eat breakfast and lunch and DON notified. T 97.8 P 90 R 18 B/P 155/108 O2 sat 99% RA (room air). V4 notified. MD ordered resident to be sent to ER. Ambulance picked up resident via EMTs x2. Rapid Covid test Negative (-).

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S9999	Continued From page 5 On 1/27/2022 at 11:58am V3 (Nurse) said on 1/11/22 she was the nurse responsible for R1's care. V3 said she got report that morning that R1 was on 72 hour charting post a fall occurrence, and the nurse did not report that R1 had any injuries from the fall. V3 said when she did her morning rounds, just at the start of her shift (7:00AM) R1 was observed resting in bed, her goal was to make sure the resident was breathing and R1 was, and so she finished rounding on the other residents. V3 said around 8 AM/something (unsure of time) she did a set of vitals on R1 because she noticed R1 was not being himself and she wanted to medicate R1. V3 said R1 was just sleeping and R1 was a resident that would have sitting up at the bedside in his wheelchair, would communicate with her, and eat his meals. V3 said R1's blood pressures were running in the 130's, but she's not sure. V3 said she did not document the vitals because R1 did not have an order for vital sign assessment. V3 stated around 9:40am the aide reported to her that R1 was not eating his breakfast, and the tray was just sitting at the bedside. V3 made an attempt to feed R1, but R1 would hold his lips tight and go back to sleep. V3 said R1 even made a fist at her to get away which was not R1's usual behavior. V3 contacted V4(Physician) and V4 gave orders to send R1 to a local hospital for evaluation. V3 called the ambulance service and they said ETA (estimated time of arrival) of 1 hour. V3 said the ambulance arrived sooner than the time they gave. V3 then said R1 did not eat lunch. Then V3 stated R1 was still at the facility during lunch time. Later V3 said she called the ambulance for transportation after lunch. Asked if V3 completed any other assessments on R1 while she was waiting for the ambulance to arrive? V3 responded she did not complete any other assessments on R1 besides completing a rapid	S9999		

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covid test on R1. V3 said there was no one in the room monitoring R1 while awaiting the ambulance service. R1's progress notes were reviewed with V3, V3 stated the vital signs that were documented at 3:00pm were the vital signs that she assessed at 9:40a.m that morning. V3 said she documented everything all together at 3:00pm. V3 said she doesn't remember the time that the physician gave the orders to send R1 to the hospital. V3 said R1 remained very sleepy, but would open his eyes and then close them when his name was called. V3 said she did not give a report to the hospital nurse because in emergency situation the paramedics usually give the hospital the information. V3 said she did give the report when she called the ambulance service and when the EMTs arrived to the facility she informed them that R1 was not himself and very sleepy. V3 said R1 was unresponsive since that morning. V3 stated she did not do any neurological checks on R1, and she doesn't know what R1's code status was on 01/11/22. V3 said she does not remember what she told the physician during the phone call, she just remembers that the physician gave orders to send R1 to the hospital. On 02/01/22 at 10:08a.m, during a follow up interview V3 stated the second set of vitals was taken at 1:45p.m, just before she called the paramedics. V3 checked on R1 several times from 8:30am to 1:45p.m. V3 would go into R1's room to make sure R1 was breathing and check R1's oxygen saturation. V3 did not document any of her observations of R1. V3 stated that a blood pressure of 155/108 was not a normal blood pressure for R1, but R1 was breathing and, he was okay. V3 stated she usually documents everything at the end of the shift, based on her memory of the events. V3 said it was not at 9:40 AM when she contacted the physician, the

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physician was called around lunch time at 1:45p.m. V3 informed the physician that R1 was not himself, she reviewed the vitals with the physician and the physician said to send R1 to the hospital for evaluation. There were no orders to send R1 out via 911, but V3 understood to send R1 out immediately. V3 said she did not assess R1's vitals again because the paramedics had arrived. V3 said V2 (Director of Nursing) came to the unit to try and feed R1 his lunch. V2 informed V3 to monitor R1, meaning to check R1's vitals and monitor for changes every 5 minutes, "she guessed". V3 said she did not complete a full set of vital signs on R1 every 5 minutes, because she did not have time due to the paramedics arriving. V3 said she does not remember reporting to the medical transportation company that R1 was unresponsive. V3's progress note was reviewed with V3, and V3 stated she may have used the term of unresponsive wrong because R1 would open his eyes, and fall back asleep. R1 "just" would not respond back when she tried to talk to him, and would not eat his food, or take his medication. R1 was not sitting up in bed as he usually does.

On 1/28/22 at 2:01p.m V6 CNA (Certified Nursing Assistant) said she was the aide assigned to R1 on 01/11/22. V6 stated R1 was lethargic and she informed the nurse. R1 did not eat breakfast or lunch when she attempted to feed R1. V6 said R1 could not keep his eyes open he would open his eyes, and then fall back to sleep. V6 said she does not usually work with R1 but the times that she was assigned to R1, R1 was the type of resident that would eat all his meals, sit up at the bedside in a wheelchair, and was awake and alert. V6 said she informed the nurse that R1 was not himself.

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S9999	Continued From page 8 On 01/27/22 at 12:44p.m V2 DON (Director of Nursing) said V3 reported to her that R1 was not himself and would not eat. V2 instructed V3 to call the physician and follow the physician's orders. V2 said she went to R1's room and tried to feed R1, and R1 would hold his mouth tight and not take the food. R1 would open his eyes and then close them. V2 said the physician was notified around lunch time and gave orders to the nurse to send R1 to the hospital for evaluation, and the paramedics arrived around 1:30-2:00pm. V2 said the nurse should use nursing judgement if a resident has a change in condition, and the resident vital signs should be assessed at least every 15 to 30 minutes. The nurse should contact the physician right away when a resident is observed with a change in condition. V2 said she believed R1 was a full code. Request was made to review R1 advance directive for his code status. V2 said R1 did not have an advance directive for his code status. However, when a resident does not have any documentation on file, the facility practice is to treat the resident as a full code which means all life saving measures will be implemented. V2 said a physician order should be carried out right away when a resident has a change in condition. On 2/1/22 V2 said the nurse has to assess the vitals and monitor the resident's condition in order to determine if the resident is experiencing a decline. V2 said the nurse should do neuro checks, check level of consciousness, mental status, and keep monitoring until paramedics arrive. On 01/28/22 at 10:31a.m V4 (Medical Doctor) stated V3 contacted him and informed him that R1 was not himself, and he gave orders to send R1 to local hospital for evaluation. V4 said no one gave him any detailed information on R1's status.	S9999		

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S9999	Continued From page 9 V4 said if he would have known that R1 was presenting in a very sleepy state he would have gave orders for neurological checks while the nurse waited for the ambulance. V4 said he should have been notified immediately when the resident was observed with a change in condition that morning, The nurse should have made an assessment, using nursing judgement and assessed vital signs as appropriate. V4 said a resident that is found to be unresponsive should be sent out 911. On 01/28/22 at 10:19a.m V5 (EMT) said he received the call that R1 was unresponsive. V5 said an unresponsive patient is an emergent situation and that's why they arrived before the hour ETA (expected time of arrival) given. V5 said when they arrived at the facility the nurse said R1 had been like this since this morning, V5 said R1 was observed in the bed, and unresponsive to verbal stimuli. R1 was not able to track with his eyes, R1 was snoring, would open his eyes but then close them. V5 said when he assessed R1's vital signs R1's blood pressure was 57/41, heart rate was 50, respiration was 14, and oxygen saturation level was 87% on room air. R1 was not wearing any oxygen when V5 arrived on the scene. Review of R1's POS (Physician Order Sheet) dated 01/11/22, there was no documented code status. Review of R1's progress notes, vital sign assessments were not documented except for the 3:00p.m vital signs. Facility policy Titled "Physician Orders" dated 6/2017 shows in-part, these guidelines are to ensure that changes in residents status/condition are assessed and physician notification is based on assessment findings and is to be documented	S9999		

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S9999	Continued From page 10 in the medical records. Any orders given by physician are carried out. The nurse should not hesitate to contact physician at any time for problems with orders or needed clarifications. Facility policy Titled "Neurological assessment" dated 03/14 shows in-part, residents will have neurological assessment completed when they have experience a head injury or a change in condition that deems it necessary or per physician order. Neurological assessments will be completed upon a physician order when indicated for a change of residents' condition, after all head injuries and when nursing judgement deems necessary. Observe, assess and document the resident level of consciousness, speech, pupils, and hand grasp and vital signs. Unless otherwise ordered by the physician, neuro checks will be completed along the following schedule: Q (every) 15 minutes times 1 hour, Q30 minutes x2 hours, Q4 hours x 24 hours and then Q shift x 48 hours. Facility policy Tilted "Change in condition physician notification overview guidelines" dated 04/14 shows in-part, these guidelines were developed to ensure that all significant changes in resident stats are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical records. Medical care emergency problems are communicated to attending physician and family immediately (generally within 2 hours or sooner). The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate medical interventions. When contacting the physician the nurse in charge should have the following information and medical record available: age and sex, nature of problem or	S9999		

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S9999	Continued From page 11 complaint with symptoms, signs, and results of current physical assessment, including vital signs and mental status, onset, duration of problems/illness, primary and active diagnoses, review of recent hospitalization, current medications. (A)	S9999		