| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>2221081/IL143358 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610 a)<br>300.1210 b)<br>300.1210 d) 2) 3)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>and shall be practiced on a 24-hour, seven-day-a-week basis:<br>2) All treatments and procedures shall be administered as ordered by the physician.<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>A. Based on interview and record review, the facility failed to identify and respond to the change in condition for one resident (R1) of three residents reviewed for change in condition. This failure resulted in a lack of adequate oxygenation for over two hours with subsequent diagnosis of Hypoxia upon arrival at the hospital.<br><br>B. Based on interview and record review, the facility failed to provide oxygen therapy and failed to assess respiratory status for one resident (R1) of three residents reviewed for oxygen therapy. This failure resulted in a lack of adequate oxygenation for over two hours with subsequent diagnosis of Hypoxia upon arrival at the hospital.<br><br>Findings include:<br><br>Physician Order Sheet indicates R1 was admitted to the facility 1/11/22 with the following diagnoses: Recent Lumbar Fracture, Diabetes Mellitus, Cardiac Pacemaker, Protein-Calorie Malnutrition, Malignant Neoplasm of Lung, Acute Kidney Failure, and Dementia with Behavioral | S9999 | | |

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| S9999 | Continued From page 2<br>Disturbance<br><br>Progress Note dated 1/20/22 at 9:28am indicates R1's oxygen saturation level was "noted to be 86-87%" at that time (while working with therapy). This note indicates R1 was placed on 2L (liters) of oxygen and oxygen saturation level increased to 95%.<br><br>Progress Note on 1/21/22 at 1:26pm indicates staff notified Physician - via fax - of R1's decreased oxygen saturation levels and (as needed) oxygen placement. Note indicates a request was made for oxygen administration "as needed with parameters." No physician orders for oxygen administration were found or presented to initiate oxygen therapy for R1 prior to 1/29/22.<br><br>Fax request dated 1/21/22 at 1:45pm indicates V7 (Physician/Medical Director) was notified of R1's oxygen saturation level on 1/20/22 and that oxygen was placed (at that time) on R1 at "2L as needed." Request was made to obtain orders for oxygen 2L (as needed) with parameters. Note included that R1 has a history of lung cancer. Requested was approved by V7 (Physician) and sent back to the facility on 1/21/22 at 2:17pm.<br><br>No Physician orders were found or presented to initiate oxygen therapy for R1 until 1/29/22.<br><br>Weights and Vitals Summary dated 1/11/22 to 1/28/22 indicates on 1/28/22 at 9:39pm, R1's oxygen saturation level was 80% on oxygen via nasal cannula.<br><br>R1's Care Plan did not address Oxygen therapy or low oxygen saturation levels.<br><br>Nurse Progress Note dated 1/29/22 at 1:00am | S9999 | | |

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indicates "Noted at (12:00am) during cares that resident (R1) is unresponsive to any physical or verbal stimuli. (R1) has not opened (R1's) eyes, no verbal or physical response; blood pressure 155/44, pulse 75 and irregular, respirations 20 - labored pursed lips; SPO2 (oxygen saturation level) 80% on Room Air; temperature 98 (oral)." Note indicates PCP (Primary Care Physician) paged and notified of decline; order for (as needed) oxygen use. Applied (oxygen) at 3L per nasal cannula and SPO2 89%. "Will allow body to adjust and bump to 4L per nasal cannula if needed. POA (Power of Attorney) notified of deterioration and will call this nurse back to decide if family wants to send R1 to ED (Emergency Department) for evaluation or keep at facility and keep comfortable."

On 2/9/22 at 2:45pm V2 (Interim Director of Nursing) and V3 (ADON/Assistant Director of Nursing) stated that only emergency oxygen therapy can be administered without an order. V2 and V3 stated that oxygen should not be administered without a Physician's order that includes flow rate and parameters. V2 stated that she was aware a request was made to get oxygen orders on 1/20/22 but was not aware the order did not get transcribed.

On 2/9/22 at 3:04pm V4 (Licensed Practical Nurse/LPN) stated that (on 1/29/22 at 12:00am) R1 didn't look right and R1's oxygen saturation level was "low." V4 stated there was an oxygen concentrator in R1's room but when she went to check R1's orders there wasn't an oxygen order. V4 stated that she notified R1's Physician at that time and obtained order "Oxygen at 2 - 4L per minute via NC (nasal cannula) as needed to keep (oxygen saturation) at 90% or above."

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On 2/9/22 at 3:10pm V4 (Licensed Practical Nurse/LPN) stated that she did not receive any information about R1 during shift report that indicated R1 was wasn't doing well or that R1's SPO2 earlier in the evening was 80%.

On 2/10/22 at 11:30am V5 (LPN) stated that at 7:30pm (on 1/28/22) she received report from the previous nurse, counted narcotics then made brief rounds to check on her assigned residents. V5 stated that she just briefly looked in on each resident to make sure "they weren't on the floor and were still breathing." V5 stated that R1 was in bed and the lights were off in the room. V5 could not recall whether R1 was wearing oxygen. V5 stated that after her "rounds" she went over to another resident unit and spent the rest of the evening - from approximately 8:00pm to 10:30pm - passing medications on that unit. V5 stated she did not go back to R1's unit until after 11:00pm when she was helping V4 (LPN) make calls regarding transfer of R1 to the hospital. V5 stated that the residents on R1's unit are monitored by one CNA (Certified Nurse Assistant) while the nurses primarily stay at the main nurses station. V5 stated she would have assessed R1 if she had known R1's SPO2 was only 80%.

On 2/9/22 at 12:30pm V6 (Certified Nurse Assistant/CNA) stated she started her shift (on 1/28/22) at 6:00pm and that R1 was in bed when she made her first rounds. V6 stated that later in the shift she took R1's vitals and R1's SPO2 was 80% with oxygen. V6 stated that R1 was breathing "ok" but knew that 80% was a low reading so she called the main nurses' station and reported R1's oxygen level to "whoever the nurse was that answered the phone." V6 stated that "the nurse" told her R1 should be "Ok" as long as R1 had oxygen on. V6 stated, "I should've

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| S9999 | Continued From page 5<br>insisted a nurse come down to look at (R1)." V6 stated that when V4 (LPN) came on at 11:00pm, she didn't like how R1 looked and wanted to send R1 to the hospital.<br><br>No assessments or documentation was found or presented to indicate R1 had been assessed/monitored between 9:39pm on 1/28/22 when SPO2 was documented as 80% on oxygen and 12:00am on 1/29/22 when R1's SPO2 was documented at 80% on Room Air.<br><br>On 2/10/22 at 1:30pm V7 (Physician/Medical Director) stated that 80% oxygen saturation is significantly low and should receive immediate treatment. V7 stated for someone who does not normally have a low saturation level - like with a chronic condition - a low oxygen saturation indicates a change in condition. V7 stated that he should have been notified on 1/28/22 when R1's SPO2 was found to be 80%. V7 stated that the brain is not getting enough oxygen at 80% and R1 would have been hypoxic.<br><br>Hospital Records dated 1/29/22 indicates R1 arrived at the hospital via EMS (Emergency Medical Services) at 2:47am (on that date).<br>Hospital Emergency Department Decision Making Note dated 1/29/22 indicates R1 was found by facility nursing staff at 11:00pm with AMS (Altered Mental Status) and was noted to be hypoglycemic and hypoxic en route to the hospital. Note indicates R1 "Hypoxic - requiring 5L (liters) oxygen via nasal cannula for O2 (oxygen) SAT (saturation) greater than 90%."<br>Hospital records dated 1/29/22 indicates R1's "Primary Encounter" diagnosis was Respiratory Insufficiency.<br><br>Emergency Department Notes dated 2/1/22 at | S9999 | | |

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| S9999 | Continued From page 6<br>10:32am indicates R1 was seen and examined on 1/29/22 with increasingly altered mental status for two hours prior to EMS being called.<br><br>Facility Policy/Change In Condition Procedure dated 9/21/20 documents:<br>"The following guidelines will be utilized as appropriate to each situation and change in condition:<br>Full assessment by nursing staff including but not limited to:<br>a. Full vitals (temperature, pulse, respirations, blood pressure and SPO2)<br>b. Level of consciousness;<br>c. Respiratory status including lung sounds;<br>d. Abdomen including last bowel movement and urine properties;<br>e. Functional status<br>f. Pain<br>g. Glucometer test if diabetic or decrease in level of consciousness. Notify Physician and give assessment information."<br><br>Facility Policy/Oxygen Administration and Storage dated 11/5/20 documents: "Emergency Oxygen Administration. It is the nurse's responsibility to provide emergency administration of oxygen when it is necessary for the care of the resident. As a guideline, a beginning flow rate of 2L/minute and adjust according to oxygen saturation levels which should be kept above 90% unless otherwise ordered by a Physician. Pulse Oximetry: Residents who have oxygen orders should have oxygen saturation levels measured by Oximetry. The Physician should be notified of any concerns identified with oxygen titration needs so the Physician may determine a need to change the order to best meet the resident's oxygen needs. Procedure: | S9999 | | |

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| S9999 | Continued From page 7<br>1. In cases of emergency oxygen may be administered as a nursing intervention until a Physician order may be obtained.<br>16. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following:<br>a. Signs or symptoms of cyanosis (i.e., blue tone to skin and mucus membranes);<br>b. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion);<br>c. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing);<br>d. Vital signs;<br>e. Lung sounds<br>f. Arterial blood gases and oxygen saturation, if applicable.<br><br>"A" | S9999 | | |