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 |
|---|---|---|---|
| | IL6003644 | A. BUILDING: ______ B. WING ______ | C 02/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NILES NSG & REHAB CTR | 9777 GREENWOOD NILES, IL 60714 |

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| S 000 | Initial Comments<br><br>Complaint Survey:<br>2291467/IL143852 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)3)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

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 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:

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Based on interview and record review the facility failed to follow their change in condition policy by not calling 911 for a resident with acute change in condition unstable vital signs.
This failure affected 1 resident (R1) reviewed for change in condition.
This failure resulted in a delay in receiving hospital treatment for a resident assessed with unresponsiveness, hypotension, (bloody stool) melena in brief, who required intubation due to inability to protect airway.

Findings include:

On 2-22-22, at 1:15 PM, concerned party said he believes the facility should have called 911 for emergent transfer rather than calling ambulance for ETA transfer of 40 minutes.

On 2-22-22 at 12:16 PM, V2 (DON) said primary nurse was aware of 2 episodes of loose bowel movements, B/P (blood pressure) was 89/57 (lower than base line) and HR was 110 (greater than baseline). R1's vital signs is a critical change in condition. Based on R1's appearance (no signs of distress) The 2 supervisors, felt R1 was stable enough for 40 min ETA transfer to hospital. V2 would prefer to call 911 due to R1's critical change in vital signs.

On 2-18-22 at 2:41 PM, V3 (RN) said nursing supervisor called private ambulance company. In the morning R1 was alert and oriented, vitals stable 110/69, pulse 96, 18, temp 97.6, o2 sat(saturation of oxygen in blood %) 94%, ate 50% for breakfast, refused lunch due to change in condition (after 2:00 PM). R1 B/P 89/51, 117, 18, o2 sat 71% RA (room air) - put on 3 liter (oxygen) - 94%, temp 94 temporal. Notified NP,

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| S9999 | Continued From page 3<br><br>NP gave order to send to hospital. nursing supervisor acknowledged o2 sat 94% on 3 liters and decided to call private ambulance company.<br><br>On 2-22-22 at 10:44 AM, V4 (Nurse Supervisor) said she was not aware of order to send to hospital via 911 or medical transport from NP. V4 was not staff who ordered medical transport. V4 was not aware of 40 minute ETA. V4 is familiar with R1 who appeared stable and per her baseline. V4 was not aware of B\P of 89/51 or HR of 117. If V4 knew these values for R1, V4 would have called 911 for R1 transport.<br><br>On 2-22-22 at 11:16 AM, V5 (Nursing Supervisor) said primary nurse reported R1 had 2-3 loose bowel movements and labs ordered. Change in vitals BP 89/58 and heart rate 110, o2 sat was fluctuating, oxygen nasal applied and was stable at 95% with 3 liters per minute. Primary nurse updated NP who gave orders to send to hospital. V5 ordered medical transport for R1 and received the ETA of 40 minutes. R1 appeared alert and responsive. No distress noted. R1 was stable. 89/58 and 110 is a critical change in condition and requires emergent care. Comparing baseline to new change in vitals, this would warrant emergency ambulance (911).<br><br>On 2-22-22 at 9:42 AM, V8 (NP) said primary nurse updated V8 regarding bowel movement and labs ordered. Primary nurse updated regarding saturation and V8 ordered to send out due to change in condition (desaturation, low oxygen). V8 would have preferred to transfer via 911 due to desaturation. V8 said she did not specifically say transfer via 911 but thought it was assumed due to critical change in condition (oxygen desaturation). | S9999 | | |

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| S9999 | Continued From page 4<br><br>R1's Medical Records document the following vital signs: at 12:30 PM, blood pressure 110/60, heartrate 96, oxygen saturation 96% (room air), at 2:00 PM, blood pressure 89/57, heartrate 110, oxygen saturation 71% (RA) the 94% (3 lpm), at 2:30 PM, blood pressure 89/51, heartrate 117, 94% (3 lpm).<br><br>Ambulance Run Sheet dated 2-17-22 at 3:58 PM, documents blood pressure 83/51, heartrate 104, oxygen saturation 84 (on supplemental oxygen). Run Sheet documents dispatch was notified at 2:32 PM, at scene (facility) at 3:19 PM, and at destination at 4:02 PM. Ambulance Run Sheet documents Chief Complaint-Unresponsive<br><br>R1's Hospital Record (dated 2-17-22) documents Critical Care: 120 minutes of critical care time spent at the bedside performing history, physical, diagnostic evaluation, complex data interpretation, discussion with consultants, creating a diagnostic and therapeutic plan for this critically ill patient at risk for significant or life threatening decompensation and/or imminent organ failure. ED Course: MDM: 76 year old female here for unresponsiveness. R1 is hypotensive, hypoxic. R1 had melena in diaper suspicion for possible upper GI bleed. R1 was emergently intubated due to inability to protect airway. R1 found to be likely in combination of hemorrhagic and septic shock. CT scan suspicious for possible ischemic bowel and possible neoplasm. Labs are significant for leukocytosis to 18.4. VBG shows significant acidosis. ICU has come down to evaluate the patient, they have spoken with brother about the likely outcome. Family member states is ok with transition to comfort care. Decision to withdraw care made due to extremely poor prognosis. R1 was extubated and shortly thereafter developed | S9999 | | |

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| S9999 | Continued From page 5<br><br>asystole. Time of death at 10:49 PM. Condolences given to family.<br><br>Change in Resident's Condition or Status Policy (no date) documents during medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding, and responsiveness 911 will be notified for transport to the hospital.<br><br>Medical Emergency (Code Blue) Policy (revised 12-5-12) documents the licensed nurse will be notified when any resident is determined to be non-responsive and Code Blue will be called.<br><br>(A) | S9999 | | |