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
	IL6007918	A. BUILDING: ______ B. WING ______	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaint investigation 2291005/IL143256 2291344/IL143678	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 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, 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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.

These requirements were not met as evidenced

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by:

Based on observation, interview and record review, the facility failed to have a physician order to remove newly placed sutures holding the inner/outer tracheostomy tube stable for one resident (R6). The facility also failed to activate 911 emergency services and monitor one vent dependent resident (R17) who was in respiratory distress. Additionally, the facility failed to ensure a ventilator was set up and ready for use at the time of (R17) admission. This failure affected 2 of 4 residents (R6, R17) reviewed for respiratory services. These failures resulted R6 experiencing respiratory distress, the facility staff removing R6's inner/outer cannulas and were unable to correctly replace the cannula back in place for R6. R6 became cyanotic (blue), 911 activated and R6 expired upon arrival to the local hospital, and the failure resulted in R17 experiencing respiratory distress, using accessory muscles to breathe and expiring at the facility without assistance.

Findings include:

1. R6 was admitted to the facility on 12/9/21 with a diagnosis of acute and chronic respiratory failure, asthma, heart failure, dependence on ventilator, tracheostomy status, anxiety and personal history of sudden cardiac arrest.

R6 preadmission paperwork dated 12/6/21 under operative report: Creation of tracheostomy.

R6's respiratory therapy assessment dated 12/10/21 at 6:05 AM documents: inner cannula changed; under suctioning: medium clear thick secretions; under lung sounds: diminished in

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bilateral upper and lower lungs.

R6's respiratory therapy assessment dated 12/10/21 at 8:47 AM documents: Under secretions: medium thick yellow secretions, under lung sounds: rhonchi in bilateral upper and lower lungs.

On 3/10/22 at 2:53 PM, V24 (RT) who was assigned respiratory therapist to R6 on 12/10/21, said she performed suctioning on R6 around 9:00 AM with no concerns. V24 said around 9:30 AM, V28 (wound care) reported R6 tracheostomy dressing had not been cleaned for a while. V24 said trach site, "looked nasty. It was crusty and had dried blood around it." V24 said R6 had maybe 4 -5 stitches around tracheostomy site. V24 said she cut all the stitches and cleaned the area.

On 3/11/22 at 11:26 AM, V28 (wound care nurse) said that a female respiratory therapist identified as V24 requested scissors from him to cut a resident's sutures. He stated that he asked if this was okay to do and RT replied yes.

R6's physician orders do not document any orders for suture removal.

On 3/10/22 at 2:53 PM, V24 (RT) who was assigned respiratory therapist to R6 on 12/10/21, said she heard ventilator alarms in R6's room and R6 was having a hard time breathing. V24 said she attempted to suction R6 but was unable to pass the suctioning catheter through. V24 said called for help and respiratory staff attempted to utilize ambu bag over R6's tracheostomy site but unable to compress the ambu bag. (Ambu bag- is a hand-held device commonly used to provide positive pressure ventilation to patients who are

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S9999	Continued From page 4 not breathing or not breathing adequately.) V24 said staff took both inner and outer cannulas out of R6 and replaced with a new one. R6 oxygen level was decreasing, vent pressure was high and R6 was using accessory muscles to breathe. Staff attempted to bag R6 via mouth but unsuccessful. V24 said there was no rise and fall of R6's chest. 911 arrived and took over. V24 said she did not see a mucous plug. On 3/9/22 at 2:05 PM, V17 (nurse) was assigned to R6 on 12/10/21 said she saw R6 about an hour before rapid response with no concerns. V17 said she responded to rapid response. Respiratory therapist thought she had a mucus plug and attempting to suction her. One staff pulled out the outer cannula and replaced it but it was not in place because R6's face turned blue and swollen. R6 ambulance report dated 12/10/21 documents: dispatched at 12:54 pm and at patient at 1:00 pm. Narrative documents: patient was observed in bed in supine position accompanied by nursing home staff. Staff informed crew that patient had a mucous plug in her tracheostomy tube that they were having a hard time clearing. Staff also informed crew that the RT pulled tracheostomy tube out, suctioned and replaced it with a new one in an effort to clear the mucous plug. Patient was unresponsive but had pulse. Pulse oxygen saturation was at 15 liters per minute at 47 %. Patient was being provided ventilations via BVM (bag valve mask) by nursing home staff but there was resistance and crew did not note any chest rise or fall. Patient was also being suctioned and her face was blue and extremely swollen. Per staff patient face was not swollen prior to the insertion of new tracheostomy tube, patient continued not being able to be ventilated via new tracheostomy tube at 1:17 PM the resident went	S9999		

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S9999	Continued From page 5 into cardiac arrest. On 3/11/22 at 1:52 PM, V8 (pulmonologist) said staff should not have removed R6's sutures from new tracheostomy site. Tracheostomy sutures are typically removed seven to ten days post operation because the area needs time to heal. If the sutures are removed too early it can cause an air leak, which can lead to subcutaneous emphysema (occurs when air gets into tissue under the skin caused from rib fracture, lung wound or esophageal trauma). On 03/25/22 at 11:45 AM, V8 said he never gave any orders to remove R6's sutures. On 3/11/22 at 1:52 PM, V8 said it is not recommended to remove new tracheostomy outer cannula and he would not even remove new tracheostomy outer cannula because there could be post-surgical complications and resident should be sent to hospital right away. It is recommended to wait a month before changing a new tracheostomy out, even if mucous plug suspected because the tracheostomy site can close in seconds and patient will not have an airway. Staff should have maintained airway and called 911. Ventilator patient in distress may display rapid respiratory rate or decreased oxygen saturation. If patient turns cyanotic (blue), it indicates they are not getting any oxygen. R6's hospital record dated 12/10/21 document: Per report patient had mucous plug in her trach. Staff at long term care facility changed trach out, patient coded. Subcutaneous emphysema tracking across neck and chest. Patient arrives without tracheostomy in place. R6's death certificate dated 12/10/21 documents under cause chronic respiratory failure and congestive heart failure.	S9999		

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S9999	Continued From page 6 Facility policy titled Tracheostomy Care version 03/19/15 documents: It is the policy of this facility that residents with tracheostomies receive routine care to maintain a patent airway that aseptic technique is used during dressing changes until the tracheostomy is healed and a physician order is obtained for tracheostomy care. Facility policy titled: Tracheostomy Emergent Management version 03/19/15 documents: It is the policy of this facility to prevent airway obstruction and if an obstruction occurs, to correct the airway obstruction quickly as possible in a safe and effective way in accordance with applicable rules and regulations and the standard of care. According to Respiratory Care August 2010, Volume 55 number 8 titled: When to Change a Tracheostomy tube documents: Conventional practice recommends changing the tube 7-14 days following the placement. A surgically placed tracheostomy tube can include creation of cartilaginous flap, and the tube is secured to the neck by placing sutures through the flanges to the skin in addition to the tracheostomy ties. Stay sutures are usually placed to facilitate opening the stoma in the event of accidental decannulations and can be lifesaving in the event of a decannulation occurring in an obese patient with increased neck circumference. All sutures are usually removed at time of first tube change. It is important to remember first tube change can be associated with risk. Patient with increased neck circumference or elevated body mass index are at increased risk of having the tube placed into false passage in the anterior mediastinum. If this happens the patient can develop massive subcutaneous emphysema and cardiac arrest. 2. R17 was readmitted to the facility on 2/4/22	S9999		

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with a diagnosis respiratory failure, atrial fibrillation, dependence on ventilator status, anxiety, tracheostomy status, end stage renal disease and epilepsy.

R17 ambulance run report dated 2/4/22 documents at destination at 5:30 PM. Under Vital Signs at 5:28 PM documents : Blood pressure 148/86, Pulse 120, Respirations 14 mechanically assisted, Oxygen saturation at 100 percent.

R17's Respiratory therapy assessment dated 2/4/22 at 6:39 PM documents under vital signs: Pulse 126, respirations 26 and oxygen saturation at 100%. Under description of breathing; rapid breathing with use of accessory muscles. Patient is resting comfortably.

R17's nursing progress notes dated 2/4/22 at 7:30 PM documents: Patient was transferred from local hospital. Vitals signs; Blood pressure 143/88, Respirations 24, Pulse 120, oxygenation saturation 99% via vent/tracheostomy. Family made aware and verbalize "She is now do not resituate and I want her to have enteral feeding while I process her hospice paperwork."

R17's respiratory flow sheet dated 2/4/22 8:30 PM with lock date 2/5/22 7:20 AM documents by V18 (RT): Under vital signs pulse 120 beats per minute; respirations 36; oxygenation saturation 98% via ventilator. Under notes documents: Patient in respiratory distress, labored breathing, accessory muscle use. Nursing is aware of patient condition.

On 3/10/22 at 2:53 PM, V24 (RT) who was the assigned respiratory therapist for R17 upon admission, said R17 arrived in distress and V24 administered a breathing treatment and

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repositioned resident which calmed R17. V24 said at the end of her shift (7pm), R17 was "calm."

R17's medical record did not document any respiratory treatments administered to R17 on 2/4/22.

On 3/10/22 at 11:49 AM, V18 (RT) who was assigned respiratory therapist to R17 from 7pm-7am said, R17 was in respiratory distress. She had an elevated respiratory rate and labored breathing. V18 said he informed the nurse, performed suctioning, and administered a breathing treatment. V18 said, R17 respiratory rate started to decrease and she appeared "calm."

R17's medical record did not document any respiratory notes after 2/4/22 at 8:30 PM. R17's medication administration record or respiratory treatment record did not document any respiratory treatments or medications administered to R17.

R17's progress notes dated 2/4/22 at 09:09 PM by V25 (nurse) documents: Resident received in the room lethargic and breathing with accessory muscle, head of bed elevated, reposition and comfort care provided. Family made aware. Will continue to monitor.

On 3/10/22 at 3:59 PM, V25 (Nurse) who was assigned to R17 on 2/4/22 said R17 arrived to the facility not in good condition, with no report or notice from the transferring hospital. R17's whole body appeared swollen, respiratory rate was rapid and abnormal around 28 breaths per minute. V25 said, "R17 was fighting the ventilator." V25 said he notified V33 (MD) that R17's condition had

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deteriorated from previous stay at this facility and R17 had Do Not Resituate (DNR) orders. V25 said R17 was transitioning. When V25 was asked to clarify what transitioning meant, V25 said an increase in respirations, use of accessory muscles to breath and elevated blood pressure. V25 said R17's vent alarms kept going off and R17's blood pressure was high. V25 said he administered a blood pressure medication and R17 appeared "to calm down". On 3/17/22 at 4:08 PM, V25 was asked to clarify what comfort care was provided to R17 per his progress note on 2/4/22 at 9:09 PM. V25 said it was not hospice comfort care. Staff changed her linen and incontinence product. V25 said the Respiratory therapist never informed him that R17 was in respiratory distress. V25 said it is not abnormal for a vent patient to have an elevated respiratory rate. V25 said they did not call 911 because R17 is a do not resuscitate. V25 said that a do not resuscitate status is hospice.

R17's medication administration record dated February 2022 did not document any medications given. R17's February 2022 physician order sheet did not document any active medication orders. R17 last documented blood pressure was at 7:30 PM 143/88. There were no documented nursing assessments to reassess R17's status. R17's Hospital discharge dated 2/4/22 documents: Lisinopril next dose due 2/5/22.

On 3/17/22 at 4:08 PM, V25 (nurse) said he administered Lisinopril (blood pressure) medication to R17 on 2/4/22. V25 said any medication administrated should be documented on the resident's medication administration record and unable to recall if he documented medications given.

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On 3/11/22 at 1:03 PM, V33 (MD) said he does not recall being notified of any respiratory distress for R17. V33(MD) said he would expect staff to send resident to the hospital if any sign of distress and inform him of any change in condition.

R17's progress notes dated 2/4/22 at 11:15 PM documents: Resident observed unresponsive. No pulse noted. No Blood pressure. No respiration, Temperature, 95.7, oxygen saturation 97% on trach/vent. Code status: DNR. Writer and staff Nurse called expired @ 11:10 pm. V33 (MD) made aware and Daughter made aware.

On 3/10/22 at 3:59 PM, V25(Nurse) said he saw R17 about an hour before she expired with no concerns. V25 said around 11:00 pm, R17 was observed with no pulse, body was warm.

On 3/10/22 at 11:49 AM, V18 (RT) said he checked on R17 again but unable to recall when. V18 said, later that shift the nurse got him to check on R17. R17 did not have a pulse and was cold.

R17's death certificate dated 2/4/22 documents: chronic respiratory failure.

On 3/10/22 at 2:53 PM, V24 (RT) who was the assigned respiratory therapist for R17 upon admission, said she did not setup the respiratory equipment in R17's room. V24 said the equipment was already set up in the room. V24 said they used ventilator circuit from transporting ambulance to connect R17 to facility ventilator.

R17 ambulance run report dated 2/4/22 documents at destination at 17:30. Crew delayed due to facility not having vent ready.

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R17's Respiratory therapy assessment dated 2/4/22 6:39 PM documents under ventilator serial number 968816.

During the survey on 3/10/22 at 11:00 AM, observation of ventilator number 968816 (R17's ventilator on 2/4/22) with document attached titled: "Defective Equipment" dated 2/9/22. Under description of problem documents: Preventative maintanece is due 1/2022. Preventative maintanece sticker on unit documents due 01/2022 or at 29,602 hours. On 3/15/22 at 2:33 PM, R17s ventilator (968816) hours were at 32,800.8.

Invoice dated 1/15/2020 documents: Ventilator 968816 documents blower replacement due at 30,000 hours. Preventative maintanece due 01/2022 or 29,602 hours.

On 3/16/22 at 11:57 AM, V35 (Ventilator Rep) said recommended ventilator maintenance is every 2 years or about 10,000 hours. Ventilator Machine can be used after maintenance date but it is not recommended due to parts can degrade over time and may cause issues with use. If ventilator was not working properly it would alarm that patient needs were not being met. Staff should conduct a leak test to see any concern with ventilator circuit (airway tubing that connects the ventilator and the patient) or ventilator settings prior to use.

On 3/17/22 at 940 AM, V11 (Respiratory Therapy Director) said staff should check ventilator prior to use and perform leak test with the ventilator circuit that will be used on the patient. A leak test could not have been performed on R17's ventilator because we did not have any ventilator

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S9999	Continued From page 12 circuits at the facility. V11 said that R17's ventilator should not have been used because it was due for preventative maintenance and unsure why is was used on R17. Facility was unable to provide any documentation that any checks were done to R17's ventilator prior to use on R17. Ventilator manual revised March 2013 documents under maintence every 2 years or 10000 hour whichever comes first: replace internal battery, calibrate traducers, replace power board, and replace sounder assembly. A leak test Facility policy titled change in condition dated 6/26/11 documents: During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital. Facility policy titled ventilator set up dated 3/19/15 documents: residents who are ventilator dependent must have ventilation and oxygenation maintained; therefore the equipment must be ready and set up prior to arrival of the resident. Prior to arrival equipment function verified by therapist prior to resident arrival. (AA)	S9999		