STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004766	A. BUILDING: _____ B. WING _____	C 05/11/2022

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S 000	Initial Comments Complaint Investigation 2273224/IL146214	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)1)3) 300.3210t) 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, but not limited to, the presence of incipient or manifest	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. Section 300.3210 General t) The facility shall ensure that residents are not	S9999		

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S9999	Continued From page 2 subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. 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 requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from neglect when it did not have the structures and processes in place to ensure a newly admitted resident was assigned to the care of a nurse. This failure resulted in R1 residing at the facility for 18 hours without receiving glucose monitoring and scheduled insulin, sustaining a blood sugar reading greater than 600 mg/dL (milligram per deciliter), not receiving scheduled medications, including antihypertensives, diuretic medication, cardiac medications, and scheduled nursing staff denying responsibility for the care of the resident. This applies to 1 of 3 residents (R1) reviewed for improper nursing in the sample of 5. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on January 21, 2022 at 5:45 PM and expired at the facility on January 22, 2022 at 1:09 PM. R1 had multiple diagnoses including metabolic encephalopathy, UTI (Urinary Tract Infection), respiratory failure, diabetes, hypertension, history of TIA (Transient Ischemic	S9999		

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S9999	Continued From page 3 Attack), heart failure, major depressive disorder, history of venous thrombosis, anxiety, schizophrenia, heart disease, morbid obesity, old myocardial infarction, pneumonitis, and abnormal gait. R1's MDS (Minimum Data Set) was not completed at the time R1 expired at the facility due to the resident residing at the facility for less than 24 hours. On January 22, 2022 at 5:30 PM, V7 (RN-Registered Nurse) documented the following regarding R1: "8:30 AM - call light on, resident awake, asking for her tray reassured 10:00 AM - resident awake and verbally responsive skin warm dry respiration unlabored, O2 on via nasal cannula 12:10 PM - resident due for [glucose check], noted resident not responding to verbal and tactile stimuli, vitals not appreciated BP (Blood Pressure) 0/0, PR (Pulse Rate) 0, RR (Respiratory Rate) 0, no rise and fall of chest noted, Code Blue called, CPR (Cardio-Pulmonary Resuscitation) initiated, 911 notified by another staff. CPR continued. 12:20 PM - 911 paramedics arrived and took over CPR. 13:03 PM (1:03 PM) - Resident expired pronounced by [local fire department] paramedics." The local fire department paramedic documentation for R1 dated January 22, 2022 shows at 12:38 PM, paramedics assessed R1 with no blood pressure, no pulse, or respirations. R1's blood glucose reading on the paramedic glucometer read as "high." Paramedic documentation continues to show: "Crew called to	S9999		

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the nursing home for the person not breathing (R1). Upon arrival found crew on scene providing manual CPR. Patient was last seen normal by staff at 10:30 this morning with no medical complaints. Staff found the patient not breathing and pulseless, began CPR and called 911. [Crew] has been on scene for approximately 2-3 minutes prior to [second crew], and obtained an asystole rhythm on the monitor, and has begun obtaining an ET (Endotracheal Tube) 7.0. Patient has no signs of trauma, and no signs of obvious death. Patient is still warm to the touch. Crew places patient on the [automated cardiopulmonary resuscitation device] for continuous CPR, and we obtain the intubation and IO (Intra-Osseous) IV. Crew hangs fluids at wide open. We administer Epi 1:10,000 as directed, with regular pulse checks. Patient remains in asystole except for one pulse check, which was PEA (Pulseless Electrical Activity). Patient's next pulse check returned back to asystole. Crew contacts medical control with full progress report. [Local hospital] confirms to terminate resuscitation attempts in the field at 13:06 (1:06 PM)."

On April 28, 2022 at 8:49 AM, V9 (Paramedic) said, "If we get a blood sugar reading of "high" on our glucometer, it means the blood sugar is over 600 [mg/dL]. All of our glucometers are the same on all of our frontline equipment."

The State of Illinois, Certificate of Death Worksheet, dated January 24, 2022 shows R1 expired at the facility on January 22, 2022 at 1:09 PM due to an "acute MI" (Myocardial Infarction). The death certificate is signed by V4 (Physician).

R1's hospital discharge medication orders dated January 21, 2022 at 3:52 PM show dietary orders,

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S9999	Continued From page 5 and multiple medications orders, including: Amlodipine (blood pressure and cardiac medication) 5 mg. (Milligrams) orally daily. Carvedilol (blood pressure and cardiac medication) 25 mg. orally twice daily with meals. Clonidine (blood pressure medication) 0.3 mg. orally three times daily. Furosemide (diuretic) 40 mg. orally daily. Glimepiride (anti-diabetic medication) 2 mg. orally every day with breakfast. Hydralazine (blood pressure medication) 100 mg. orally three times a day. Insulin Glargine (diabetes medication) 20 units SQ (Subcutaneously) every day Insulin Glargine (diabetes medication) 14 units SQ at bedtime Sliding scale Insulin Lispro (diabetes medication) SQ four times a day based on blood sugar test results. Lisinopril (blood pressure and cardiac medication) 20 mg. orally daily. Metformin (anti-diabetic medication) 1000 mg. orally twice daily with meals. Warfarin 0.5 mg. orally daily. On April 26, 2022 at 12:14 PM, V2 (DON-Director of Nursing) said, "None of R1's admission orders were entered into the system during the first two	S9999		

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nursing shifts following her admission to the facility. For some reason the resident never got entered into our computer system so the staff could not put in the orders or document anything about this resident. The resident was admitted to the facility on January 21, 2022 around 6:00 PM, and it wasn't until the next day, starting around 10:00 AM when V6 (RN-Registered Nurse/Care Plan Coordinator) was able to get the resident admitted into our computer system and start entering all of the orders. It is my expectation the nurse will do a head-to-toe assessment and vital signs on admission and get all physician orders entered into the system. That did not happen for this resident."

On April 26, 2022 at 12:42 PM, V5 (RN) said, "I received report from the hospital around 4:30 PM on January 21, 2022 for R1. The agency nurse was taking the resident but was not in the facility yet. I did not care for this resident the rest of my shift, which ended around 11:00 PM. The agency nurse did not let me know R1 was not entered into the [EMR] until she left for the night around 11:00 PM. I tried to call a few different people to put her in the system but was not able to follow through with that because I was dealing with other issues. I only took telephone report on this resident. I did not obtain physician orders or care for her the rest of the night."

On April 26, 2022 at 1:40 PM, V14 (Agency Nurse) said, "R1 was not my resident. I was supposed to work on January 21, 2022 from 2:00 PM to 10:00 PM. The resident belonged to V5 (RN), not me. I told V5 I would look over the resident's skin and I would let her know what I saw. That was it. I did not care for the resident the rest of my shift. I did not call the physician to obtain orders. A few days later the DON called

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me and asked me to fill out the admission assessment. I told her I did not take care of this resident and they shouldn't be calling me. Here this resident had been in the building for several shifts, and five days later they are calling me to document on her? They asked me to chart what I saw on the resident. I reached out to a corporate nurse and said that I did not think that was okay because the resident was never mine. The resident fell into my assigned area, but because it was my first time in the building, V5 was going to do her admission."

On April 28, 2022 at 12:29 PM, V11 (Registered Nurse/RN) said, "I started work on January 21, 2022 at 11:00 PM. There were two nurses on the unit: me and an agency nurse. R1 was not on the facility census list. R1 was assigned to the agency nurse. The agency nurse was also working in the COVID unit. The resident had not been entered into the system, and there were no orders put in for her. I did not call the doctor to obtain admission orders, and I did not care for the resident during my entire night shift."

On April 28, 2022 at 2:38 PM, V15 (Agency Nurse) said, I worked at the facility on the night of January 21, 2022 starting at 11:00 PM. I did not care for R1 at all that night. When I work with V11(RN), she makes it very clear she does not want to work on the COVID unit, so I take that unit. The hallway R1 resided in belonged to V11. Every time I come to that facility I ask for a resident census and I do my rounds and see if the resident is actually in the room. The census sheet is always messed up. As an agency nurse, I have never had to put the medication orders into the computer. I would remember if they gave me a resident who needed to have her medications entered. I did not care for R1 that night. I did not

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call the doctor to get admission orders."

On April 28, 2022 at 9:09 AM, V7 (RN) said, "I worked the day shift on January 22, 2022, starting at 6:00 AM. I came in that morning and R1 was in the building, but not in our computer system. I did not call the NP (Nurse Practitioner) or the doctor to get admission orders. I was working with one other nurse that morning. We did not establish who was going to take care of R1. I guess that's where we dropped the ball. The nurses on the two shifts before us didn't get orders for this resident either, so they dropped the ball too. It wasn't until around noon when I went in to take a blood sugar on R1 that I found her unresponsive and called a code blue. I had not given her any medications that day, checked her vital signs or assessed her."

On April 28, 2022 at 10:19 AM, V12 (LPN-Licensed Practical Nurse) said, "I remember a little about January 22, 2022. I was working the day shift with V7 (RN). I was assigned to the COVID unit. If there was something outside of the COVID unit, then V7 took care of it. I did not call the NP or the physician for admission orders for R1. She was not in the COVID unit, so she was not assigned to me. It is very unusual that no one did her admission on the other shifts. It's a 24-hour facility. Nursing is a 24-hour job."

On April 26, 2022 at 11:20 AM, V6 (Registered Nurse/ RN) said, "Normally when a resident is a new admission or a readmission, the admitting nurse is the one putting in the orders on the day the resident is admitted. I was the Manager on Duty on Saturday, January 22, 2022. I noticed when I came in that morning R1 was admitted the evening before but was never entered into the

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computer system. I looked at her admission paperwork and saw none of her admission orders were put in the system. She missed quite a few of her cardiac medications, blood sugar checks and insulin, because of this delay. If she was admitted on Friday evening, the nursing staff on that shift should have gotten the orders and entered them into the system. Whoever was assigned to that resident should have put everything in on that day. I think because the resident was never entered into our computer system, no one did her admission. I started putting in her orders around 10:00 AM on January 22, 2022. I wasn't even finished putting in all the orders and they called a code blue on her, and the paramedics came. I'm not sure if the nurse notified the doctor, none of her medications had been given."

On April 27, 2022 at 4:24 PM, V10 (NP-Nurse Practitioner) said, "I was on call the weekend R1 was admitted to the facility. No one ever called me for admission orders."

On April 26, 2022 at 2:06 PM, V4 (Physician) said, "It is my expectation that the facility staff administer the medications as ordered and on time. The orders should have been carried through from her discharge from the hospital to her admission at the facility right away. "I signed R1's death certificate and put the cause of death as acute MI (Myocardial Infarction). She had a lot of cardiac issues. She had respiratory failure, morbid obesity, diabetes, you name it. She was bound to have heart disease. As a general statement, if you are supposed to take the medications, then you should be taking them. Missing all of those medications could have contributed to her expiring. It is my expectation the facility staff administer the medications as

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ordered and on time. The orders should have been carried through from her discharge from the hospital to her admission at the facility right away. I would expect them to contact me and let me know she had missed all of those medications. They did not notify me."

On April 26, 2022 at 1:54 PM, V13 (Pharmacist) said, "Can we say any harm was caused by this resident not taking the medications? I cannot say missing all of her medications caused her death. Is there a possibility she walked around with elevated blood pressure? We can pretty much say that happened. Can we say missing her insulin would cause elevated glucose levels? We can say that happened. We do put insulin in the refrigerator at the facility to be used as an emergency until the resident's medications arrive. They could have gotten all of these medications with stat delivery or evening delivery and the resident would not have had to miss her medications if they would have notified us."

The facility's policy entitled; "Medication Reconciliation" dated October 2020 shows:

"Purpose: Verify the resident's current medication regimen upon admission and/or readmission to the facility and provide an updated medication list to the next service provider at the time of discharge/transfer from this facility.

Procedure: At the time of each admission and/or readmission to the facility, the charge nurse will review the list of medications/orders (including prescription and OTC) with the physician or physician extender, noting any discrepancies with the name of the drug, dosage, route, frequency, and reason for administration."

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