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	IL6010482	A. BUILDING: _____ B. WING _____	C 05/23/2023

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AVANTARA LIBERTYVILLE	1500 SOUTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

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S 000	Initial Comments Complaint Investigation 2313886/IL159728	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1010 h) 300.1210 b) 300.1220 b)2) 300.3240 a) 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 facility shall obtain and record the physician's	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to identify a resident's significant change in	S9999		

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S9999	Continued From page 2 condition; failed to assess a resident with a significant change in condition; and failed to notify a resident's provider of a change in condition; resulting in delay of potential lifesaving care to 1 of 3 (R2) residents reviewed for death in the sample of 12. The findings include: R2's Admission Record (Face Sheet) showed an admission date of 2/14/23. R2's Face Sheet showed diagnoses to include but not limited to: achalasia (Achalasia is a rare disease in which food passage from the mouth to the stomach is disturbed.), gastric reflux disease, protein-calorie malnutrition, and diabetes. On 5/17/23 at 10:45 AM, V13, R2's Daughter and facility employee, stated R2 was admitted to the facility following a hospital stay. V13 stated R2 was vomiting and not eating at home, which lead to her subsequent hospital admission and having a feeding tube placed. V13 stated her mother was a Full Code (If R2's breathing or heart stopped, lifesaving interventions should be initiated.) R2's History and Physical (H&P), dated 2/15/23, (dictated 2/15/23 at 9:29 AM by V16, Medical Director/R2's physician) showed R2 "...for 5 weeks prior to her admission was experiencing bouts of vomiting, which was worsening. She was experiencing frequent bouts of emesis (vomiting) despite taking [nausea medication]." The H&P showed "She is feeling poorly and that she is nauseated...She is breathing well." The H&P showed, "this is a middle-aged elderly female, currently in no acute distress." R2's Skilled Note from 2/15/23 at 7:25 AM	S9999		

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showed, "Resident has been nauseous and vomiting through shift. Resident on continuous feeding...resident also refused the TB (Tuberculosis) test, stating 'She got the shot...'"

R2's Social Service Note from 2/15/23 at 2:34 PM showed, "...patient was alert and oriented..."

R2's Social Service Note from 2/16/23 at 2:06 PM showed, "...patient cooperated in the evaluation even though she was feeling nauseated..."

R2's 2/17/23 Physician Note (time of visit not indicated. Note was dictated 2/17/23 at 11:40 AM.) "The patient is awake and alert, but continues to have emesis. We changed her feeding to now 18 hours a day to see if that will help better tolerate the feedings." The note stated the emesis was foul smelling.

R2's Skilled Noted from 2/17/23 at 3:03 PM, showed, "pt (patient) extremely lethargic and not responding to external stimuli. [V16, Medical Director/Doctor of Osteopathy/R2's physician] notified. Ordered to hold morphine [for] 6 hours and changed the morphine order to q6h prn (every 6 hours as needed). Orders carried out. Patient stable at this time." (Note authored by V23, Registered Nurse.)

R2's Order Summary Report (Physician Order Sheet, POS) showed an order for Morphine (narcotic pain medication) 10 milligrams per 0.5 milliliters solution and to administer 0.75 milliliters via her feeding tube every 4 hours for pain for 7 days. This order was started on 2/15/23. The POS showed the order was changed to as needed on 2/17/23.

R2's Diagnostic Note from 2/17/23 at 6:59 PM

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showed, "cxr & kub (chest X-ray and kidney, ureter, bladder X-ray) results relayed to [V16.]"

R2's Skilled note from 2/18/23 at 8:24 AM (this note followed R2's 2/17/23 6:59 PM note; no other notes between), showed, "The writer took a report from the night shift nurse saying that pt (patient) wasn't responding, and pt is gurgling. RN (Registered Nurse) check on the pt O2 71 (oxygen saturation 71 percent), put on non-rebreather (mask used to supply high concentrations of oxygen) went up to 76, BP (Blood-pressure) 73/57, T (temperature) 97.5, R 30 (Respiratory Rate 30 breaths per minute) Pt is non-responsive, not reactive to chest rub. Spoke to pt's daughter, explained the situation, pt's condition, okay to send her out. It was explained they take the pt to the closest ED (Emergency Department) at [local area hospital.]" (Note authored by V22, Registered Nurse/RN)

R2's Skilled Note from 2/18/23 at 8:34 AM showed, "Per staff the last time they saw pt responding was last night." (Authored by V22, Registered Nurse/RN)

R2's Skilled note from 2/18/23 at 1:58 PM showed, "Call to [local area hospital] to get updates on pt, pt coded (heart and breathing stopped) at the hospital."

R2's local area hospital records showed, "[R2] is a 78 year old female who presents to the ED from [the facility] for being unresponsive when staff went to wake her up from sleep at 8 am. Last known well 11 pm when she went to bed. Per EMS (Emergency Medical Services) she was GCS 3 (Glasgow Coma Scale - A test to indicate consciousness. A score of 3 indicates she did not open her eyes to pain of verbal stimuli; she

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S9999	Continued From page 5 was non-verbal; and her motor function did not respond to painful stimulus.) They attempted intubation (oral airway) but she vomited and aspirated (went into her lungs.)" The hospital records showed, "Patient had CT (CAT scan) brain no bleed. After return she became bradycardic (slow heart rate) and pulseless. CPR (Cardio Pulmonary Resuscitation, chest compressions and breathing assistance)...CPR continued for [greater than] 30 minutes. No ROSC (return of spontaneous circulation)...Patient expired at 10:43 AM." R2's vital signs were documented as follows: * 2/14/23 (Admission) Blood pressure 167/94; O2 saturation 96 percent (only documentation of O2 saturation) *2/15/23 at 3:50 PM Blood pressure 210/101 *2/16/23 at 6:42 PM Blood pressure 146/75 *R2's physician note on 2/17/23 show vital signs that reflect blood pressure, pulse, and respiratory rate that was taken by the facility staff and documented on 2/16/23 at 6:43 PM *2/17/23 at 1:39 PM Blood pressure 99/61 (a change of more than 45 points from her previous systolic pressure and the lowest documented blood pressure during her admission at that time.) *2/18/23 at 8:24 AM (per progress note) Blood-pressure 73/57; Temperature 97.5 Fahrenheit; Respiratory rate 30; O2 saturation 71 percent; after non-rebreather mask applied (mask used to supply high concentrations of oxygen) O2 saturation went up to 76 percent On 5/17/23 at 10:45 AM, V13, R2's daughter and facility employee, stated she saw her mother every day of R2's stay, except 2/18/23. V13 stated her mother started to decline on 2/16/23. V13 said R2 started to become lethargic and "out of it" on 2/16/23. V13 said on 2/17/23 sometime	S9999		

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shortly after 10:30 AM, she went to see her mother. V13 stated her mother had a bowel movement so she, herself, changed R2. V13 said when she provided the care, "She couldn't move, she couldn't talk, she couldn't do anything, and it was like there was nothing there ...When I cleaned her up there was no response from her at all, no acknowledgement at all from her that I was doing anything to her. I asked the nurses what was her vitals and no one could tell me that, and I believe they couldn't tell me that because no one was doing them. The nursing staff didn't seem concerned about her declining state. [V23] thought it was maybe the morphine, but other than that they had no idea why (she was declining). I thought my mom needed to be sent out and maybe I should have made them send her out, but they were nurses so I thought they would do that if they thought it was necessary. There was no change in my Mom's condition through the day of the 17th. The last time I saw her was around 7:30 PM. I saw the CNA (Certified Nursing Assistant) once or twice the first day, and the second day to do vitals but that was all." V13 said, "I think the nurses should have recognized she was declining and sent her out. I assumed that the nurses were tracking her decline and they would make the appropriate decisions." V13 said, "Every single day it was a different nurse, there was no continuity between the nursing staff."

On 5/17/23 at 11:35 AM, V14, R2's Daughter, stated the first time she saw her mother at the facility was on 2/17/23, between the hours of 3:00 PM to 6:00 PM. V14 said, "I went to see her and I was wondering what the foul smell in the room was. Then the nurse came in and I was also asking her what was that funny sound in her room, and the nurse said she is okay. I kept

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saying what is that noise? It sounded like there was mucous in her throat and the nurse was in her room and the nurse kept acting like everything was normal. My mom was slumped over in bed and we had to pick her up. I opened my mom's eyelid and there was nothing there, she didn't wake up at all; she didn't respond. She was okay when she went in there (2/14/23), and then on Friday (2/17/23) she couldn't respond, then the next day (2/18/23) she was gone. I was like what happened through the night and why did they not check on her? They kept saying she was sleeping. The noise was when she was breathing. It sounded like there was something in her throat. The nurse said the noise when she was breathing was normal because she has a feeding tube. I said it didn't sound normal. It sounded like there was something in her throat. She didn't wake up at all that day when I saw her. When I brought up the sound to the nurse, she did not do any vital signs. The nurse would talk to her and give her insulin. She (the nurse) was talking to her like everything was normal, but she (R2) was not waking up at all or responding to her when she talked to my mom. The last time I saw her was on Feb 11 on her birthday ..." V14 continued, "The nurse said the noise was normal and it was the feeding tube, but I was like how is that the feeding tube, it's when she is breathing, it didn't sound right it sounded like she had so much mucous in her throat." V14 said, "Mom did not respond the entire time I was there. I kept trying to talk to her and I touched her and there was no response. My sister and I lifted her up to reposition her and she was just dead weight; there was no response. I was wondering if she needed to be sent out, but I was going off of what the nurse said, which was she was okay and that my mom was sleeping, but that did not make sense. The next morning, they said they were

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S9999	Continued From page 8 rushing my mom to the hospital and they were doing CPR (Cardio Pulmonary Resussitation) at the hospital, and they said she was gone. All I kept thinking about was the night before and what happened in that short amount of time. I kept thinking something didn't feel right; that she was not waking up and that she was just sleeping didn't make sense. I knew something wasn't right and why didn't they check on her all night until the next morning. They just kept saying she was sleeping, but she wasn't." On 5/17/23 at 12:10 PM, V19, R2's Sister and Power of Attorney (POA), stated, "I didn't get to go and see her I was going to go and see her (R2) on Saturday. That is usually when I do my traveling. I talked to her on the phone on Wednesday (2/15/23); it would have been around 1:00 PM. She was concerned about some bills that needed to be paid, and I told her I was going to take care of her personal business. She sounded her normal self; she was cracking jokes and she was doing well at that time. She said she was feeling fine at that time. She didn't say anything about nausea at that time. I tried to call her Thursday (2/16/23) and she didn't answer, so I called [V13] and asked her why [R2] wasn't answering the phone. [V13] said she wasn't doing well. [V13] said it was like she was going backwards and not doing well. Then the following day she [V13] called me and said her levels had dropped and they were trying to get her levels back up. (Levels) I think she was talking about her blood pressure and stuff like that; like her vital signs. I talked to [V13] on Thursday and Friday. She said on Friday her color did not look good; she looked sick. She said she wasn't alert; she was sleeping. She said she was going to ask the nursing staff to lower that drug she was on for the pain, the morphine, and that they were giving her	S9999		

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S9999	Continued From page 9 too much and only give it to her when she asked for that." The facility's staffing schedule for R2's floor on 2/17/23 showed V23, RN, was scheduled to work from 7:00 AM to 7:00 PM, then V18, Agency RN, was scheduled for from 7:00 PM to 7:00 AM the following morning. The schedule for R2's floor on 2/18/23 showed V22 was scheduled to be R2's day nurse. On 5/17/23 at 9:54 AM, V23 stated she believed 2/17/23 was the only time she had provided care for R2. V23 stated she had received report that R2 was lethargic. V23 stated when she began her shift on 2/17/23, R2 was drowsy, not opening her eyes, and she was not responding to questions. V23 stated she documents all physician communication regarding resident status changes. V23 stated if there was an order to hold morphine for lethargy she would notify the doctor if the lethargy did not improve. V23 stated she would expect a person's lethargy to improve in a couple of hours if morphine was the cause. (R2's record showed no assessment or vital signs following V23's progress note on 2/17/23 at 3:03 PM until the following morning.) On 5/17/23 at 2:23 PM, V18, Agency Registered Nurse, stated she does recall R2, and, to the best of her knowledge, 2/17/23 was her only shift providing care for R2. V18 stated, "She was not responsive to anything around her. As far as I knew, she was not responsive. I was told by the previous nurse that when she came to the facility she had her eyes open ...I was not told that she was ever alert and oriented ...The nurse prior did not tell me she had called the doctor regarding this patient. I don't recall any indication that I should be doing any sort of assessment on this	S9999		

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resident. As agency, I did have access to PCC (Point Click Care/ electronic documentation system) and that is where I would do all of my documentation for her. The day nurse was just saying she had her eyes open and if I recall that was just a few days prior. If I had been aware that she was alert and oriented and the doctor was called regarding her condition that day, I would have been more concerned regarding her condition that night. I, personally, if had known that information, I would have been monitoring her ..." V18 said during the night "I would check on her and talk to her but she did not respond. I tried talking with her, and she would not look at me, turn her head, open her eyes or respond in anyway what-so-ever. I didn't notice anything in particular about her breathing ...If I or the CNA's did any vitals or assessments it would be in [R2's electronic health record] in the vitals tab, or the progress notes, or the MAR/TAR." (medication/treatment administration record. R2's electronic health record showed no documented vital signs or progress notes during V18's shift.) V18 stated, "I was not told any of that information; that she was suspected lethargic due to morphine and that she was alert and oriented a couple of days prior. If I had been told that information, I would have definitely called the doctor; if I didn't get ahold of the doctor I would have called 911 and had her sent out. I don't need a doctor's order to call 911 for a full code resident."

On 5/16/23 at 1:50 PM, V22 stated she cared for R2 when she was admitted (2/14/23), and she was the nurse that had her sent out (2/18/23.) V22 said R2 was alert and oriented on her admission. V22 said, "I came at 7:00 AM and got report from the agency nurse and she said [R2] seemed to be sleeping and unresponsive, so I

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saw [R2] first. She was unresponsive so I sent her out." V22 said the previous nurse was not concerned because, "the order was to stop her morphine and she was still coming down from the morphine. Morphine can affect your breathing; I don't remember if she was on oxygen." V22 stated when a resident is experiencing a change in condition the physician and family are notified and if the physician is not available she would send the resident to the ED.

On 5/18/23 at 2:00 PM, V2, Director of Nursing (DON), stated all assessments and vital signs should be documented. V2 stated when a nurse recognizes a change in condition they should do a "head-to-toe" assessment, vital signs, and then contact the provider. V2 said if a nurse is monitoring a resident for lethargy related to morphine, the nurse should be doing on-going assessments as appropriate to include vital signs. V2 stated morphine affects the respiratory system, which is monitored through respiratory rate assessment and oxygen saturation measurements. V2 stated this monitoring would be passed to the next nurse and should continue. V2 stated nurse-to-nurse hand-off should include physician calls as well as changes in mental status over the previous days. V2 stated this information is important for the nurse to be able to determine if a change in condition has occurred. V2 said gurgling is not a normal sound for a resident on a feeding tube, and it can signify pneumonia or aspiration.

On 5/18/23 at 1:15 PM, V16, Medical Director/Doctor of Osteopathy/R2's physician, stated he remembers R2 "well." V16 stated he recalled seeing R2 2 or 3 times, but he could not recall the time of day he saw her on those visits. V16 stated he does not recall a phone call on

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AVANTARA LIBERTYVILLE	1500 SOUTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

2/17/23 regarding R2's morphine. V16 said if he was called and told she was not responding, he would have ordered her to be sent out. (R2's Skilled Noted from 2/17/23 at 3:03 PM was recited to V16) V16 replied, "Lethargy and not responding to external stimuli is a contradiction." V16 stated if he gave an order to hold morphine because the nurse believed the patient was "narcotized" (under the influence of a narcotic) "I think frequent assessment would be appropriate during that time, and if the nurse told me several hours later they were not improving, they (nurses) are my eyes and ears; I depend on them to give me an accurate description of the patient, if they told me not responsive; I would ask them to send her out." V16 stated he is not always available, and the nurses should be capable to make the decision to send a resident with a significant change in condition to the ED (Emergency Department). V16 said a resident being unresponsive is a significant change in condition and they should be sent out in a timely manner. V16 said the purpose of sending a resident to the ED is the hospital has more medical services available compared to the facility and the services can be provided more quickly. V16 said, "It's possible [R2's] outcome would have been different, if she was sent out sooner; however, it is difficult to say in hind sight."

R2's Care Plan for her feeding tube showed "report signs of aspiration or intolerance of feeding."

R2's Certificate of Death Worksheet showed she passed on 2/18/23. The death certificate showed the immediate cause (Final disease or condition resulting in death) was Myocardial Infarction (MI, Heart attack) with R2's achalasia condition leading the MI and the aspiration being the event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 which initiated the MI. The facility's Notification for Change in Condition policy (revised 7/28/22) showed, "The facility must immediately inform the resident; consult with the resident's physician ...a significant change in the resident's physical, mental, or psychosocial status ..." (AA)	S9999		