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
	IL6000962	A. BUILDING: ____ B. WING ____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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S 000	Initial Comments Complaint Investigation: 2319294/IL166433	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

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.

This REQUIREMENT is not met as evidenced by:

A. Based on interview and record review, the facility failed to identify, assess, and monitor a resident (R1) with significant respiratory changes. This failure resulted in R1 being hospitalized with acute respiratory failure, septic shock related to urinary tract infection and pneumonia, and suspected hypoxic brain injury. R1 expired in the hospital as a result of his illnesses. This failure applies to 1 of 3 residents reviewed for oxygen therapy in the sample of 6.

B. Based on interview and record review, the facility failed to notify a resident's physician of a change in condition for greater than 24 hours.

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S9999	Continued From page 2	S9999		

This failure resulted in a decline in R1's condition leading to hospitalization for acute hypoxic respiratory failure, sepsis, and suspected hypoxic brain injury. This applies to 1 (R1) of 3 residents reviewed for change in condition in the sample of 6.

The findings include:

R1's electronic face sheet printed on 11/8/23 showed R1 had diagnoses including but not limited to type 2 diabetes, hypertension, and white matter disease.

R1's facility assessment dated 10/13/23 showed R1 had moderate cognitive impairment, did not use oxygen, and had no pulmonary conditions.

R1's physician's orders for November 2023 showed no orders for R1 to receive oxygen.

R1's nursing progress notes dated 11/4/23 12:35PM showed, "Resident has been incontinent all night, refuses to get up to bathroom. Resident refusing to sit up so he can eat breakfast. Assisted with 2 to finish getting him up and to his recliner. Medications given. On his light every 5 min or so asking for different things.... shower, hip hurts, spa bath, etc. Medications taken and resident is in his wheelchair for lunch so he can get out of his room safely. 11/5/23 2:13am Resident lethargic all night, skin pale, grey, Blood pressure 105/ 62, pulse 68, respirations 16, temperature 96.7, pulse oximetry 91% on 2L oxygen via nasal cannula. 11/5/23 1:24PM physician notified of blood glucose of 577. On call physician notified and gave orders to send to emergency room for evaluation." (No physician notification was made regarding R1's condition

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S9999	Continued From page 3	S9999		

change from 11/4/23 at 12:35PM until 11/5/23 at 1:24PM).

R1's internal facility communication notes dated 11/4/23 showed, "Called power of attorney and informed her of his condition today. She said just let her know if things change. She stated that she knows he is depressed and wants to leave here but she knows it is not going to happen. We did start oxygen on him at 2L/minute because we can't get a pulse oximetry on him and looks like he is struggling to breathe...evening medications were crushed and put in pudding, and he did take them. Refused the (nutritional) drink. Would not drink from the straw and did not swallow from a glass." (R1's physician did not acknowledge the communication regarding R1 until 11/5/23 at 6:33PM after R1 had already been sent to the hospital.)

R1's electronic medical records showed no assessment of R1's respiratory status to include lung sounds, respiratory effort, signs of dyspnea, or response to oxygen therapy. R1's last obtained pulse oximetry level and respiratory rate occurred on 11/5/23 at 1:15AM. (Approximately 12 hours prior to R1 being sent to the hospital).

R1's neurological flow sheet dated 11/5/23 at 6:00AM showed, "Pulse oximetry-unable to get."

R1's nursing progress notes for November 2023 showed, "11/5/23 at 2:13AM showed, "Resident lethargic all night, skin pale, grey, blood pressure 105/62, pulse 68, respirations 16, temperature 96.7 and pulse oximetry 91% on 2 liters of oxygen."

R1's emergency medical services (EMS) report

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S9999	Continued From page 4 dated 11/5/23 at 1:33PM showed, ""Dispatched to (facility) for a male resident who is unresponsive. When arrived, patient was found lying in his bed, unresponsive to both painful and verbal stimuli...patient is on 3 liters of oxygen via nasal cannula ...staff stated they are unable to obtain any blood pressure readings ...skin was pale, cool, and clammy. Lung sounds were diminished. Respirations were 10-12/minute and shallow. EMS placed patient onto 6 liters of oxygen, showing 100% oxygenation ...pupils were non-reactive. En-route, EMS warmed patient with no changes noted in condition during transport to (local hospital)." R1's local hospital emergency room physician note dated 11/5/23 showed, " ...Male from local nursing home unresponsive, hypotensive, flaccid with poor oxygenation. Patient was noted yesterday to be unresponsive and brought in today from paramedics ...on 6 liters of oxygen with oxygen saturation 97%, blood pressure 60/30 ...patient placed on Bi pap ...impression and plan: pneumonia, acute urinary tract infection, hypovolemic shock ...condition: critical." R1's critical care physician's note dated 11/6/23 showed, "In the emergency room evaluation he is afebrile. Pulse and respirations are now normal. He is in acute hypoxic respiratory failure-on 6 liters oxygen." R1's internal facility communication notes for November 2023 showed, "11/6/23 9:45AM Update from (local hospital); wanted information prior to emergency room visit. Resident is losing his neurological reflexes. 100% being managed with Bi pap (bi-level positive airway pressure). Critical carbon dioxide levels and all labs abnormal...11/6/23 2:43PM (R1) has passed	S9999		

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S9999	Continued From page 5	S9999		

Continued From page 5

away in the hospital."

R1's hospital discharge summary dated 11/6/23 showed, "Patient was admitted with unresponsiveness, diagnosed with septic shock due to urinary tract infection and pneumonia. Patient also has acute hypoxic respiratory failure, acute kidney injury, and hypernatremia ...patient was unresponsive for about 48 hours ...family opted for comfort measures. Patient expired."

On 11/8/23 at 11:29AM, V5 (Licensed Practical Nurse/LPN) stated, "I remember on Saturday (11/5/23), we had to put oxygen on (R1) because his breathing looked like he was struggling. I couldn't get an oxygen saturation level on him. I'm sure I assessed his lung sounds but I don't remember what they sounded like. I guess if you can't see them in his chart then I didn't document them. I remember sending a secure message through our internal communication system to the physician but now I don't recall him ever getting back to me. I didn't call any other physician in regard to (R1's) status. When we place a resident on oxygen, we should be doing a full respiratory assessment to include lung sounds, ease of breathing, and their response to the oxygen. We also have to notify the physician, which I did, he just didn't get back to me. It's hard to believe that (R1) passed away so quickly. He was completely fine on Friday (11/4/23). We should notify a resident's physician of any condition change noted, so basically, it's anything abnormal for them we should be letting the physician know."

On 11/8/23 at 1:44PM, V10 (Certified Nursing Assistant/CNA) stated, "I worked with (R1) on Friday night (11/3/23) and I remember he was incontinent which was unusual for him. He was

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S9999	Continued From page 6	S9999		

normally pretty independent and just need cues and reminders. He ambulated independently with a walker and took himself to the bathroom. When I came back on Saturday (11/4/23), the report I got was that (R1) was actively dying and was to receive comfort care measures. I remember trying to give him a shake for dinner and he couldn't even drink it out of the straw. In my opinion his change in condition started on Friday because I specifically remember it being the day, he got an x-ray." (R1 did receive an x-ray of his hip on 11/3/23).

On 11/8/23 at 2:02PM, V12 (R1's physician) stated, "I was notified of (R1's) change in condition on 11/5/23. I was not on call over the weekend so the nurse should have called the on-call number. I never work on the weekends so I'm not sure why they even sent me the message. The nurses are responsible for notifying a resident's physician if the resident is experiencing any change in condition such as increased incontinence, lethargy, oxygen implementation, skin color changes, etc. Had the nurse notified the on-call physician as soon as she noticed respiratory changes, we could have ordered labs, imaging, or even sent him to the local emergency room with this significant of a decline. There's no reason why the nurse couldn't have reached out to another physician when I wasn't responding to her messages. Perhaps there could have been a different outcome for this resident if she had followed the proper protocol. I can't confirm that, but we all know early intervention is the best way to achieve a positive outcome."

On 11/8/23 at 2:17PM, V2 (Director of Nursing) stated, "I would expect the nurse to call the on-call physician for any skin color changes,

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S9999	Continued From page 7	S9999		

respiratory changes, implementation of oxygen, low blood pressure. Any deviation from the resident's baseline should be reported to the physician and all the nurses know that. All the nurses also know that they are to call the on-call physician number for (V12) because he doesn't take calls on the weekends. I can't say for sure that the nurse not calling the physician contributed to his decline in condition but there definitely could have been some interventions implemented sooner had she followed the on-call protocol."

On 11/8/23 at 2:28PM, V11 (Restorative CNA) stated, "Saturday morning (11/4/23) I went into (R1's) room to get him up for the day and he said his hip hurt. I told the nurse, and she gave him Tylenol. I stood him up to get him ready to transfer and he wanted to lay back down so I helped him reposition in bed. I came back around 10am I went back to get him up for lunch and he was unstable with the transfer, so I used a wheelchair to take him to the dining room and he was fed at the assisted table. Usually, he is independent, but something seemed off about him that day. Staff in the dining room told me he refused lunch, so I took him back to his room to lay him down and he was starting to drool and couldn't stand. I asked another CNA to help me transfer him and then I told the nurse (V5 Licensed Practical Nurse/LPN) that I wasn't able to obtain any vitals on him, so she came in and put oxygen on him and checked on him. I don't know what else she did because I left the room after that."

On 11/14/23 at 10:15AM, V2 stated, "I would expect the nurse to do a respiratory assessment on any resident newly placed on oxygen or having a change in condition. A pulse oximetry does not

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S9999	Continued From page 8	S9999		

give enough detail into a resident's respiratory status or tell you lung sounds. This was an unfortunate situation, and I would expect more from my nurses."

On 11/14/23 at 12:51PM, V5 (LPN) stated, "A respiratory assessment should be completed to get a baseline of the resident's respiratory status when they are placed on oxygen so that we can continue reassessing and notify the physician of any changes. Residents that are currently on oxygen get their pulse oximetry reading checked every shift, but we don't do any other respiratory assessment on them if they are stable. If we are unable to get a pulse oximetry reading, we would try to warm the resident's hands, take off nail polish and if I still couldn't get a reading, I would notify the physician."

The facility's undated policy titled, "Oxygen" showed, "There must be a physician's order for oxygen use which includes the route and liter flow or specific oxygen concentration, and how long the oxygen is to be administered...1. When the nurse initiates oxygen therapy for a resident, she must: transcribe the physician's order in the resident's chart, document the event in the 24-hour report, place resident on hot rack (every shift) charting..."

The facility's policy titled, "Notification of Changes" dated 10/19 showed, "The facility will inform the resident; consult with the resident's physician; and notify, consistent with their authority, the resident's representative when there is: (B) A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications. (C) A need to alter

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S9999	Continued From page 9 treatment significantly that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment." "AA"	S9999		