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	IL6008098	A. BUILDING: _____ B. WING _____	R 12/20/2023

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{S 000}	Initial Comments First Certification Revisit to Annual Survey date July 20, 2023.	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3) 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 300.1210 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.	{S9999}	**Attachment A** Statement of Licensure Violations	

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

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 300.3240 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)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to monitor a resident's respiratory status as ordered for a resident with a history of respiratory failure and mechanical ventilation resulting in death for 1 out of 3 residents (R512) reviewed for respiratory care in the sample of 17.

The findings include:

R512's face sheet showed a 59-year-old female with diagnosis of acute and chronic respiratory failure with hypoxia (low oxygen) and hypercapnia

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{S9999}	Continued From page 2 (high carbon dioxide), obstructive sleep apnea, pneumonia, schizophrenia, bipolar disorder, asthma, hypertension, and morbid obesity. On 12/13/23 at 12:00 PM, V6 (Registered Nurse/RN) said R512's condition was "very fragile", her oxygen saturations dropped easily. V6 said R512's oxygen nasal cannula fell out of her nose frequently and was noncompliant with it at times. On 12/13/23 at 1:15 PM, V10 (Certified Nursing Assistant/CNA) said on 9/28/23 around 8:30 PM, she was passing snacks and found R512 cold and unresponsive to verbalization and touch. V10 said R512's mouth was "bluish". R512 was on laying on her stomach with her arms outstretched over her head face down. V10 said she ran to get help. V10 said it took about 5-6 minutes for her, V7 (Licensed Practical Nurse/LPN) and V9 (CNA) to turn R512 onto her back to start CPR. V10 said V9 started chest compressions. V9 and V10 (CNA) said after they started CPR, V7 told them to call 911. V9 said (and V10 confirmed), V9 tossed her personal cell phone to V7 to call 911. On 12/13/23 at 2:12 PM, V9 (CNA) said on 9/28/23 she was coming down the hall and V10 yelled at her to hurry up, she needed help, and "she" (R512) was not breathing. V9 said she entered R512's room and she tapped on R512's shoulder and did not get a response. V9 said she and V10 ran down the hall to get V7. V9 said it took about five to six minutes to turn R512 onto her back to start CPR (cardiopulmonary resuscitation). V9 said "I know they were not checking on her like they were supposed to. What p****d me off was as soon as everyone showed up (police paramedics), V7 told V8 (CNA) to say she checked on R512 and instructed all of	{S9999}		

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{S9999}	Continued From page 3	{S9999}		

us not to say anything else. "The cops heard me, V8 and V10 arguing". R512's dinner tray was still there, and she would normally eat as soon as it was placed down. R512's dinner tray had not been touched. We were arguing about her tray not being picked up and R512 not being checked. V8 sat at the nurses' desk most of the shift up to that point. R512 was V8's responsibility that shift and she does not allow me or V10 to touch or check on her residents. V9 said she and V10 told the police V8 had not checked on R512 and showed the officer the absence of documentation in the medical record. V9 said "I was praying someone would look at this injustice". V9 said snacks are passed around 8:30 PM so this all happened around 9:00 PM. V9 said V1 (Administrator) texted her to let her know IDPH would be calling her and instructed her to be vague and not tell them everything. V9 sent this surveyor a screenshot of V1's text message sent on 12/13/23 at 2:07 PM which said- IDPH is going to call you about R512's death. Leave it vague, you started compressions, you weren't sure what the time frame was.

On 12/13/23 at 2:46 PM, V1 (Administrator) reviewed R512's monitoring documentation and confirmed there was no evidence to show R512 was checked after 5:45 PM on 9/28/23. Additional evidence of every 15-minute monitoring was requested and not received.

On 12/14/23 at 8:15 AM, V12 (Local Fire Department Lieutenant Paramedic) said he was on the scene at the facility 9/28/23 regarding R512 and "their timeline didn't add up".

On 12/14/23 at 9:40 AM, V11 (RN) said R512's oxygen saturations would drop quickly. V11 said R512 could be fine one second and her oxygen

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{S9999}	Continued From page 4	{S9999}		

could drop the next. That's why she was on 15-minute checks, to make sure her oxygen was kept on. R512 had a lot of hospitalizations related to respiratory failure and had been intubated (placed on mechanical ventilation). She was intubated almost any time we sent her out. The CNAs do the 15-minute checks, and we did hers to prevent her death. "I'm sure she could die if they weren't done". The checks are documented for accountability. The CNAs on night shift prefer to do their own assignments and no one else. It was difficult to work with. That's why I left that shift.

On 12/14/23 at 10:11 AM, V7 (LPN) said R512 took her oxygen off "a lot" and was chronically in and out of the hospital for breathing issues. V7 said R512 had been on a "ventilator numerous times". V7 said R512 was on 15-minute checks because of her breathing, oxygen saturations dropping, to make sure she was compliant with the oxygen, and to check on her respiratory status. V7 said if 15-minute checks were not done a resident could "code and die. Anybody can". V7 said the CNAs do the 15-minute checks for R512. V7 was asked how she ensured R512's 15-minute checks were done she said, "I rely on the CNAs to let me know if there are any issues and trust them to do their jobs". V7 said if checks aren't documented they weren't done. V7 said on 9/28/23 at 8:50 PM (when R512 was found unresponsive) was the first time on her shift that she had set eyes on R512 (shift started at 6 PM). V7 said it took about two to three minutes to position R512 on her back to start Cardiopulmonary Resuscitation (CPR) and that was "way too long". "It was frightening and impaired our resuscitation efforts". V7 said R512's dinner tray was still at the bedside.

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{S9999}	Continued From page 5 On 12/14/23 at 12:33 PM, V3 (Medical Director) said he ordered 15-minute checks for R512 to make sure she was stable and had her oxygen on. V3 said due to R512's body habitus, chronic respiratory issues, and diagnosis of obesity hypoventilation syndrome, she was "100% at great risk for respiratory failure". V3 said if R512 was not checked as ordered respiratory and cardiac compromise, hypoxia, and death would be possible. V3 said R512 was not always compliant with her oxygen so it was important to check her frequently. On 12/18/23 at 3:16 PM, V19 (Paramedic) said when he arrived at the facility on 9/28/23 the nurse was at the desk and two CNAs were in the room doing CPR on R512. R512 was "definitely" cyanotic (blue color), and the timeline didn't make sense. We got the call about 9:10 PM and we were told it took a while to get her on her back and they said they did CPR for 10 minutes before calling us. V19 said they had picked R512 up at the facility numerous times for respiratory issues and R512 had been intubated in the past. R512's census report showed hospital leaves 8/18/23-8/22/23 and 9/8/23-9/13/23. R512's discharge summary and orders from her last hospitalization was requested and not received. V2 and V23 (Regional Clinical Director) were unable to find them onsite. R512's physician order sheet showed a 9/15/23 order to titrate oxygen to keep saturations at 88% per nasal cannula every shift related to acute and chronic respiratory failure. Another 9/15/23 order showed to obtain a SPO2 (oxygen saturation level) every shift.	{S9999}		

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{S9999}	Continued From page 6 A facility policy for titrating oxygen was requested and none was received. R512's oxygen saturation checks showed no checks done on 9/25/23 and one check was done on 9/26/23. R512's physician order sheet showed a 9/13/23 order for resident to be checked every 15 minutes and an order for a full code. R512's monitoring document showed R512 was last checked on 9/28/23 at 5:45 PM. Additional resident monitoring documentation was requested and not received. R512's 9/25/23 progress note showed V17 (R512's Son/Power of Attorney) called 911 as he wanted her transferred to a different facility because her oxygen was off, and staff were not doing 15-minute checks. V17 said he was in R512's room for 30 minutes and staff did not check on her. On 12/14/23 at 3:17 PM, V17 confirmed he wanted his mother moved because the staff were not checking on her. R512's 9/28/23 10:52 PM progress note showed at approximately 8:50 PM, staff CNA called for the nurse to examine resident as it looked like she was not breathing. R512 was laying on her belly face down into her breasts. There was no pulse and no oxygen saturation reading. R512's 9/28/23 progress note showed R512's time of death was 9:37 PM. R512's 11/7/23 death certificate showed the cause of death was acute and chronic respiratory failure.	{S9999}		

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The 9/29/23 local fire department report showed staff said they contacted 911 at 9:10 PM after approximately 10 minutes of repositioning the resident and starting CPR. The report showed the crew arrived at the facility on 9/28/23 at 9:15 PM and R512 was cyanotic and without respirations or heartbeat.

The 9/29/23 local police department report showed V17 told police he believed R512 was neglected and not getting the proper treatment at the facility.

R512's care plan showed she was on oxygen and required supplemental oxygenation when sleeping and throughout the day; to monitor for changes in respiratory rate or depth. Observe/document for use of accessory muscles. Notify MD of significant changes.

R512's reactive airway/asthma care plan showed to monitor vital signs every shift and as needed, skin color, pulse oximetry, airway functioning, and degree of restlessness which may indicate hypoxia.

R512"s shortness of breath care plan showed to monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor/document breathing patterns.

R512's 9/20/23 provider note showed she had been in and out of the hospital recently for respiratory distress and was intubated. This note showed the need to monitor R512 very closely and they will keep a close eye on her.

The facility's 10/06 Resident Monitoring Policy showed resident monitoring is done to assist in providing safety to residents that are a potential

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{S9999}	Continued From page 8 threat to self. Document all assessments in the resident medical record. The facility's 3/19 Oxygen Policy showed oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. R512's 9/27/23 nutrition note showed she was 66 inches tall and weighed 512 pounds. "AA"	{S9999}		