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
	IL6006605	A. BUILDING: ______ B. WING ______	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	**310 BANBURY ROAD NORTH AURORA, IL 60542**

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S 000	Initial Comments Complaint Survey: 247507/IL174981 & 2475196/IL175106	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1035a)4)5 300.1210b) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 4) procedures detailing staff's responsibility with	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 08/02/24

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respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;

5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

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.

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 observation, interview and record review, the facility failed to initiate CPR (Cardiopulmonary Resuscitation) for a resident (R1) with full code status (attempt CPR). The facility also failed to have a system in place to ensure that Advance Directives are completed timely and available to direct care staff.

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These failures resulted in R1 not receiving CPR and expiring at the facility.

These failures have the potential to affect all residents residing in the facility. The June 29, 2024, Facility Data Sheet showed 96 residents reside at the facility.

Findings include:

1. R1's Admission Record dated 6/27/2024 documents R1 as an 83-year-old with diagnoses that include bipolar disorder, dementia, and schizoaffective disorder.

On June 29, 2024, R1's paper chart included a green Practitioner Order for Life-Sustaining Treatment (POLST) form dated October 3, 2019, and signed by V14 (R1's Physician and facility Medical Director). The POLST included R1's signature and in Box A, the option for "Attempt Resuscitation/CPR (Selecting CPR means Full Treatment...)" was checked.

R1's Clinical Physician Order Report dated 6/29/2024 shows an order dated 5/23/2023 for R1 to be a full code (attempt CPR) but this order was discontinued on 1/8/2024. R1's Order Recap Report 5/01-7/31/2024 does not show a current order for R1's code status.

R1's Electronic Medical Record (EMR) shows a Progress Note dated 6/18/2024 documenting V14 (Medical Director) provided an order for a hospice evaluation due to R1's refusal to eat and failure to thrive.

R1's Hospice Telephone Verbal Order form dated 6/21/2024 shows R1 was admitted to hospice

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with a primary diagnosis of dementia on this date. There is no indication of a code status on this document.

R1's EMR Progress Note completed by V5 (Nurse) on 6/27/2024 from 8:21 PM showed "CNA (Certified Nursing Assistant) has reported to the writer about or around maybe later 5:20 PM that the resident has passed away...No vital and no pulse.

On 7/2/2024 at 12:10 PM V5 (Nurse) stated she was assigned as R1's nurse on 6/27/2024 between 7 AM- 7 PM. V5 stated she was instructed at the beginning of her shift that R1 was on hospice and had a "Do Not Resuscitate (DNR [do not attempt CPR])" order. V5 stated on 6/27/2024, R1 was acting as usual, stayed in bed and ate minimally. V5 stated she works many places as an agency nurse and is not sure what the process is at the facility to verify advanced directives. V5 stated around 4 PM, a nurse from hospice (V9) came into the facility and she and V9 went into R1's room together. V5 stated V9 informed her that R1 was beginning to "transition." V5 stated around 5 PM, R1 was unchanged, and then sometime between 5:30-6pm, a Nursing Assistant (V6) reported to her R1 was no longer breathing. V5 stated she assessed R1 and after taking vitals and confirming R1 was not breathing, she went to find R1's chart and notified V2 (Director of Nursing) that R1 had passed. V5 confirmed she did not notify V2 that she was unable to verify R1's code status and she did not initiate CPR. V5 stated when she entered the room, V1 (Administrator) was present and instructed her to call hospice to clarify her advanced directives, which she did. V5 stated after speaking with V8 (Hospice Nurse), he told V5 he would call her back. V5 stated, "I left

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[R1] with the workers in the back. I was in charge of the patient but [V1] was in charge of me. I waited in the nurse's station as I was instructed to do. I was in the nurse's station until I got a call back. I then had another resident with an issue, so I handled that...I thought [V2 (Director of Nursing)] was with [R1]...Nobody is administering CPR and we are calling hospice, so I assumed she was a DNR. Later, I was told there was a DNR in process but it was not complete. Then I called the paramedics, 911, and assumed the people in the back initiated CPR. I did notify the people in the back that she was a full code. We all came back to the room; paramedics were back there then and were working on her when I got back to the room." V5 confirmed that at the time she discovered R1 had no vital signs, she was still unsure of R1's advanced directives because she was unable to find the chart where the POLST form is supposed to be located.

On 7/3/2024 at 7:47 AM, V4 (Nurse) stated he overheard a Nursing Assistant report to V5 that R1 "doesn't look good." V5 requested V4's assistance with obtaining a blood pressure cuff and pulse oximeter which V4 stated he provided to V5, then went to attend to another resident. V4 stated at some point after this interaction he took a call from an unknown hospice nurse who reported to V4 that he was in the process of changing R1's full code status to a DNR. V4 stated this unknown hospice nurse was frustrated as to why the POLST form had not been completed. V4 could not indicate when he became aware that R1 had passed and was a full code. V4 stated he did not perform CPR at any time during this incident.

On 7/2/2024 at 12:47 PM, V3 (Nurse) stated that around 7 PM on 6/27/2024, she saw V5 in the

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hallway and she asked for help, stating "it is an emergency." V3 stated she ran down the hallway and asked what was going on, and V5 responded, "Apparently we were supposed to start CPR two hours ago," and that V5 was instructed to call 911. V3 stated CPR was not started until the paramedics arrived.

On 7/2/2024 at 2:36 PM, V6 (Nursing Assistant) stated he found R1 non-responsive between 5:15-5:20 PM and notified V5. V6 confirmed he did not perform CPR, stating V5 did not give him instructions to perform CPR. V5 stated he was instructed to perform postmortem care for R1, which he did, and completed care with the assistance of V7 (Nursing Assistant). V6 stated about an hour later, the paramedics arrived.

The Reporting Officer statement from the June 27, 2024, local Police Department's preliminary Case Report Summary showed " ...On 6/27/24 at 18:57 [6:57 PM] ...responded ...for deceased patient at [facility address]. Due to some uncertainty, dispatch clarified that this was not an in-progress emergency, rather the patient, [R1] ...had been deceased for some time." This document shows the timeline obtained by the officers during interviews conducted with the witnesses on 6/27/2024 as follows: R1 was discovered deceased between 5:15-5:20 PM by V6 (Nursing Assistant), who then alerted V5 (Nurse). V5 stated to the officer she then spent the time between discovering R1 was deceased up to the time 911 was contacted at 6:57 PM attempting to locate R1's DNR paperwork, contacting hospice, and the state guardian. V2's (Director of Nursing) interview identified her at the facility at approximately 6 PM to pay her respects then she left. V4 (Nurse) stated he became aware of the situation between 6-6:30 PM after

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notification by V5, who had indicated she was in the process of contacting hospice. V8 (Hospice Nurse) reported to the officer that he spoke with V5 at approximately 6:25 PM and advised V5 to call 911 because no DNR was in place. V3's (Nurse) statement to the officer identified she was notified of R1's status at approximately 7 PM. This report shows a hospital physician provided a time of death to the paramedics as 7:20 PM.

On June 29, 2024, at 12:05 PM, V2 (Director of Nursing) stated V5 (Nurse) is an Agency nurse, and she works at the facility a lot. V2 stated V5 notified her that R1 had expired. V2 stated she asked her if hospice had been notified and she said yes. V2 stated CPR was not done. V2 stated that once a resident is admitted to hospice services, hospice takes over. V2 stated the facility still provides standard care. V2 stated if hospice says a resident is a full code, the resident is a full code, adding "R1 was a full code in our chart." V2 stated R1 expired, and CPR was not performed, adding "If a full code, CPR should have been done." V2 re-iterated "if there is no DNR, you initiate CPR."

On 7/3/2024 at 9:45 AM, V10 (R1's State Guardian) confirmed she was aware of R1's decline and as of 6/27/2024 had been communicating with hospice regarding advanced directives. V10 stated that on 6/27/2024 at 2:05 AM, she received an email from V8 (Hospice Nurse) regarding R1's change in status and concerns that R1's advanced directives at that time showed R1 as a full code. V10 stated she then spoke with the hospice company again on 6/27/2024 at 9:17 AM and reviewed the required process as a State Guardian to consider changing R1's code status. V10 stated the process includes an initial form with supporting

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documentation signed by two doctors. V10 stated once this information is received, a POLST form can be signed by her as a resident's guardian. V10 stated, "I cannot change a resident's status without knowing their wishes."

On 7/2/2024 6:57 PM, V22 (Deputy Coroner) stated an autopsy was planned but it was later decided not to after reviewing R1's comorbidities and speaking with V10 (R1's Guardian) and finding out a DNR was in process but apparently not valid yet because the physician information and signature were not completed. V22 stated, "My concern is nobody started CPR. That is basic nursing. Without a valid DNR order she should have been provided emergency interventions and CPR. I am not sure what they were thinking. I understand there was some confusion but without a valid DNR, she is a full code."

In section "2.1 Admission to Hospice Program" under "Article II: Services to be Provided by Hospice" in the facility's Nursing Facility Hospice Services Agreement, it showed "(c) Hospice shall notify Nursing Facility whether a resident is authorized for admission as a Patient and shall be responsible for obtaining all necessary admission forms, consents, and election statements from the Resident or, where applicable, the Resident's representative." The Article does not refer to hospice being responsible for obtaining a POLST form.

R1's hospice Informed Consents/Election of Benefits Form was stamped and signed by R1's State Guardian and hospice company on June 21, 2024, and it does not mention the completion of a POLST form.

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R1's Circuit Court Letters of Office Guardianship of a Disabled Person dated 9/21/2023 documents R1 as a disabled person totally without capacity per physician and therefore ordered a plenary guardian of person.

2. On 7/2/2024 at 2:13 PM V1 (Administrator) stated advanced directives are initiated at admission. If a resident does not have a POLST in place upon admission, we implement the process and obtain one. POLST forms are obtained by a joint effort between nursing and social services. All residents should have a POLST form in their paper chart and a physician order indicating their code status in the Electronic Medical Record (EMR).

A review of R5-R17, and R19's paper charts on July 3, 2024, did not find a completed POLST form in their chart.

The Admission Record shows R17 admitted to the facility on 11/25/2023. R17's Order Summary Report dated 7/5/2024 did not include an order indicating code status.

The Admission Record shows R10 admitted to the facility on 5/20/2024. R10's Order Summary Report dated 7/5/2024 found an order dated 6/28/2024 for a full code.

The Admission Record shows R16 admitted to the facility on 4/04/2024. R16's Order Summary Report dated 7/5/2024 found an order dated 6/28/2024 for a full code.

The Admission Record shows R5 admitted to the facility on 5/01/2024. R5's Order Summary Report dated 7/5/2024 found an order dated 6/29/2024 for a full code.

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The Admission Record shows R9 admitted to the facility on 5/02/2024. R9's Order Summary Report dated 7/5/2024 found an order dated 6/29/2024 for a full code.

The Admission Record shows R11 admitted to the facility on 5/30/2024. R11's Order Summary Report dated 7/5/2024 found an order dated 6/29/2024 for a full code.

On 7/3/2024 at 12:15 PM, V20 (Social Services) stated the last Social Service Director that was here would review the POLST forms. V20 stated, "We have had a lot of 'hiccups' since transferring to PCC (Electronic Medical Records System) and I do not have access to fix it...We are running into hiccups when we compare the (paper) charts with PCC. It has been an ongoing issue, including the face sheet (Admission Record) not always being accurate..." V20 stated V1 has requested access for Social Services approximately 1-1.5 months prior in order to correct issues identified with inconsistent information in PCC, and access has not been granted as of this date.

On 7/2/2024 at 1:20 PM, V21 (Social Service Director) stated she began employment at the facility June 3, 2024. When asked what her role is in the initiation of advanced directives, V21 responded with, "I would think that I should be involved in advanced directives and code status initiation and changes."

On 7/3/2024 at 11:35 AM, V2 (Director of Nursing) stated the facility process for the completion of POLST forms is that V14 (Medical Director) comes in every Thursday, so if a POLST form needs to be signed, we let him know when he comes in. V2 stated Social Services will try to

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get POLST forms done as soon as possible and in an acceptable amount of time. V2 further stated that if it is an emergency, the facility will fax the POLST form to V14, but if not an emergency, it can be held until Thursdays. V2 stated that in early May, an audit of POLST forms was done and updated.

On 7/3/2024 at 1:05 PM, V1 (Administrator) stated that she was aware a recent audit was done by V2 and V25 (Assistant Director of Nursing) in May. V1 stated that physician orders are entered into the EMR by Nursing and Social Service does not have access to make changes. V2 confirmed inconsistent information related to advanced directives has been an ongoing issue at the facility since PCC was initiated last June. V1 stated she has asked the facility corporate office to give additional access to some staff and she has also requested the ability to scan documents into PCC.

The Advanced Directive Policy dated 9/27/2017 documents the following:

The Patient Self Determination Act states that individuals have the right to make their own decisions, and to formulate advance directives to serve as decisions when the individual is incapacitated. It is the policy of this facility to honor resident's wishes as expressed in advanced directives regarding medically indicated treatments whenever possible. This facility shall take all steps necessary to comply with state and federal legislation relating to advance directives.

Procedure:
1. At the time of admission each resident, POA (Power of Attorney), guardian or responsible party shall be given written information regarding

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resident rights and advance directive. At this time, each resident /responsible party will be requested to furnish this facility with copies of all existing advance directives.

2. The day of admission to this facility, the Social Service Designee, Administrator or designee at admission shall meet with the resident/responsible party to review existing advance directives.

3. After confirming the accuracy of provided documents with the resident/responsible party, the document will be sent for appropriate signatures. No order for "No Code" or "DNR" shall be effective until the Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form is signed by resident/responsible party and physician order is received and documented.

4. Any decision made by the resident shall be indicated in the chart in the manner easily understood by all staff. Advance directives specifying full code/Attempt Resuscitation/CPR, or the absence of determination shall be recorded as a "Full Code". Those residents indicating "Do Not Attempt Resuscitation/DNR" shall be recorded as a "DNR". Code status shall also be recorded on the resident's Physician Order Sheet.

6. In cases where a legal guardian has been appointed by the court, and the resident is without decisional making capabilities or a qualifying condition, the guardian must seek court authorization for consent for a DNR. Until this consent is obtained, the resident shall be considered without advance directives.

8. Any advance directive will be reviewed quarterly with the interdisciplinary team and the

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resident/responsible party. Advance directives may be reviewed more frequently as condition warrants.

9. Implementation of a code is as follows:

i) Direct and Non-Direct care staff upon finding a resident non-responsive shall remain with that resident as is possible while signaling for assistance.

ii) The nurse shall be summoned to respond, and upon review of chart documents determine code status.

iii) The nurse shall evaluate the code status and notify appropriate staff for task assignment. If CPR is indicated only certified personnel shall administer CPR.

iv) Activation of the Emergency Medical System shall be initiated, or the ambulance service notified. The physician shall also be notified to inform him/her of the resident condition.

v) Upon completion of notifications and necessary paperwork, the nurse shall relieve those performing CPR. The appropriate certified staff will continue until the emergency medical team arrives and takes over.

vi) The emergency medical team trained in advanced life support shall then assume charge of the situation. The nurse shall follow the direction on the emergency medical team, until transport of the resident out of the facility.

10. Once CPR is initiated in this facility, the staff trained in CPR shall continue until:

i) The resident is revived.

ii) The emergency medical team has arrived and assumed care

iii) The physician gives an order to stop CPR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING: ______ B. WING ______	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

(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 13 (A)	S9999		