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S 000	Initial Comments Complaint Investigations 2425952/IL176123 and 2425736/IL175830	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1035 d) 300.1035 h) 300.1210 b) 300.1220 b)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 300.1035 Life-Sustaining Treatments d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record.	S9999		

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h) If no choice is made pursuant to subsection (c) of this Section, and in the absence of any physician's order to the contrary, then the facility's policy with respect to the provision of life-sustaining treatment shall control until and if such a decision is made by the resident, agent, or surrogate in accordance with the requirements of the Health Care Surrogate Act.

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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on record review and interview, the facility failed to formulate Advanced Directives on admission and document current Advanced Directives within the care plan and within the physician's order sheets for five of six residents (R1, R3, R5, R9, and R10) reviewed for advanced directives in the sample of 13. These failures resulted in facility staff failing to provide CPR (Cardiopulmonary Resuscitation) to a resident (R1) with no Advanced Directive, who was found unresponsive in his room. Findings include: The facility's Advance Directives Policy, dated 8-9-22, documents, "Purpose: To provide guidance to staff on the expectation of respecting wishes with regards to Advance Directives and compliance with state and federal regulations. Responsibility: It is the responsibility of the Social Service Department/Administrator to know the regulations/policies and ensure all appropriate staff are aware. Procedure: 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law. 3 If the residents are incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. 6. Prior to or upon admission of a resident, the Social Services	S9999		

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Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 8. If the resident indicated that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. Advance Directive-a written instruction, such as a living will or durable power of attorney for health care, recognized by State law, relating to the provision of healthcare when the individual is incapacitated. Life-Sustaining Treatment-treatment that, based on reasonable medical judgment, sustains an individual's life and without it the individual will die. This includes medications and interventions that are considered life-sustaining, but on those that are considered palliative or comfort measures. 20. The Director of Nursing or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care."

The facility's CPR (Cardiopulomary Resuscitation) policy, dated 5-18-21 documents, "Policy: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support including defibrillation, for victims of sudden cardiac arrest.

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If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. Emergency Procedure: If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR. Instruct a staff member to activate the emergency response system and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic lift support sequence of events. Continue with CPR until emergency medical personnel arrive."

1. R1's Nurse's Notes, dated 7-24-24 at 4:40 PM, and signed by V23 (LPN/Licensed Practical Nurse) document R1 was admitted to the facility on a stretcher via emergency medical transfer on three liter of oxygen being delivered by nasal cannula.

R1's Cumulative Diagnosis Log documents R1's diagnoses are Weakness, Hypertension, Atrial Fibrillation, Cerebrovascular Disease, Diabetes Mellitus Type II, Congestive Heart Failure, Acute Kidney Injury, Atrial Flutter, and Chronic Pain.

R1's IDPH (Illinois Department of Public Health) Practitioner Order for Life-Sustaining Treatment (POLST) Form located within R1's medical record is incomplete and does not indicate R1's Advanced Directives.

R1's Medical Record does not include a baseline plan of care or physician's order that indicates R1's Advanced Directives.

R1's Nurse's Notes, dated 7-26-24 at 12:30 AM, and signed by V30 (Agency Registered

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Nurse/RN) documents R1's oxygen was not on and had to be re-applied.

R1's Nurse's Notes, dated 7-26-24 at 3:15 AM, and signed by V30 documents R1 was found in his room with no heartbeat and was cold to touch. This same note documents a second nurse confirmed R1 was deceased.

R1's Medical Record does not include any documentation of 911 being called or CPR being initiated once R1 was found with no heartbeat.

On 7-28-24 at 9:00 AM, V16 (R1's Family Member) stated, "(R1) always told us he wanted to be brought back (resuscitated) at least three times. It was a shock that (R1) passed away so quickly. (R1) was alert enough to tell the staff if he wanted CPR or not."

On 7-28-24 at 9:20 AM, V24 (Registered Nurse/RN) stated, "On 7-26-24 around 3:00 AM, (V21/Nursing Assistant) got me and said (R1) had passed away and (V30) needed me to verify with (V30) that (R1) had no pulse or respirations. I confirmed with (V30) that (R1) was deceased. No one had performed CPR. (V30) stated (R1) did not have Advanced Directives in his chart and (V30) did not know if (R1) was a full code or DNR. 911 was not called either."

On 7-28-24 at 10:00 AM, V29, Care Plan Coordinator, stated, "(R1's) care plan and medical record did not have Advanced Directives. Since there were no Advanced Directives, (V30) should have performed CPR and called 911 when (R1) was found without a pulse or respirations. The admitting nurse (V22, Licensed Practical Nurse/LPN) admitted (R1) and was responsible for formulating (R1's) Advanced Directives and

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care planning (R1's) Advanced Directives. (V22) did not get (R1's) Advanced Directives completed or care planned."

On 7-28-24, V6 (Assistant Director of Nursing/ADON) stated, "(V30) should have done CPR when she found (R1) had died."

On 7-28-24 at 10:20 AM, V23 (LPN) stated, "When (R1) was admitted on 7-24-24, the hospital nurse gave me report and told me (R1) was a full code. I did not know it was my responsibility as a floor nurse to do (R1's) Advanced Directives or care plan. I did not complete (R1's) advanced directives or care plan. (V30) should have done CPR when she found (R1) deceased since there were no Advanced Directives in the chart. If there is not an order for a resident to be a DNR, the nurse should always perform CPR no matter what. (R1) was alert and orientated enough to make his own decisions."

On 7-30-24 at 4:55 PM, V21 (CNA/Certified Nursing Assistant) stated, "On 7-26-24, (R2) came out of (R1's) room around 3:00 AM, and said the room and (R1) was really cold. I had saw (sic) (R1) around 12:30 AM and he had taken his oxygen off. When I went into (R1's) room he had no pulse or respirations. I immediately got (V30) and (V30) had confirmed that (R1) had passed away. No one performed CPR or called 911. I do not have access to (R1's) chart, so I did not know if (R1) was a full code or DNR. I figured that was up to the nurse to decide."

On 8-2-24 at 11:20 AM, V30 (Agency RN) stated, "(R2) had gotten (sic) (V20) and said her and (R1's) room was freezing because of the air being on high and (R1) was cold. (V20, Certified

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Nursing Assistant/CNA) came and got me around 3:00 AM (7-26-24) and said (R1) was cold and she thought (R1) had died. I went into (R1's) room and he had no pulse or respirations and was cold to touch. (R1) had been taking his oxygen off that night. I had put (R1's) oxygen back on around 12:30 AM. Every time (R1) took his oxygen off, his pulse ox (oximetry) would go down to 70 to 80 percent. I did not see (R1) again after 12:30 AM until (V20) found (R1) deceased. I looked in the chart and (R1) did not have Advanced Directives or a care plan to show whether or not (R1) was a DNR or full code. I did not do CPR as (R1) was gone and did not have Advanced Directives. I have no idea how long (R1) had been gone. I did not call 911. I had another nurse (V24) come down and verify with me that (R1) had passed away. I called the family and (R1) was transported to the funeral home later on. When I found (R1) he was cold, but I did not notice rigor mortis setting in yet. I could still move (R1's) extremities and (R1's) mouth was shut. (R1) was not stiff and I did not notice any blood pooling. It was very frustrating and a "hot mess" at the facility. When (V24) came down, (V24) told me that she though (R1) was ready to go (die) and that is why I did not do CPR. If I knew (R1) was a full code I would have performed CPR."

2. R3's Admission Record documents R3 was admitted on 7-23-24.

R3's POLST Form, dated 7-29-24, documents, "Do Not Attempt Resuscitation/DNR) if (R3) has no pulse."

R3's Physician's Order Sheets and Baseline Care plan, dated 7-23-24 through 7-29-24, do not include R3's Advanced Directives choice of DNR.

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3. R5's POLST Form, dated 3-24 -24, documents, "Do Not Attempt Resuscitation/DNR) if (R5) has no pulse."

R5's Physician's Order Sheets, dated 6-16-24 through 7-15-24, document, "Code Status: Full Code."

R5's Care Plan, dated 10-12-23 through 7-8-24 (date of R5's death), documents, "Resident has chosen Advanced Directives. Resident chooses to be a full code in the event of cardiac arrest."

4. R9's Admission Record documents R9 was admitted on 7-1-24.

R9's POLST Form, dated 7-2-24, documents, "Full Code. Attempt CPR if no pulse."

R9's current Care Plan does include R9's Advanced Directives of R9's wishes to be a full code.

5. R10's Admission Record documents R10 was admitted on 7-24-24.

R10's IDPH POLST Form located within R10's medical record is incomplete and does not indicate R10's Advanced Directives.

R10's Baseline Care plan, dated 7-24-24 through 7-29-24, does not include R10's Advanced Directives.

On 7-30-24 at 1:00 PM, V13 (Social Service Director/SSD) stated, "I have never had anything to do with the resident's Advanced Directives. I have never been responsible for making sure the residents have Advanced Directives."

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On 7-30-24 at 2:00 PM, V1 (Administrator) confirmed R3's care plan and physician's order sheets do not document R3's Advanced Directives, R9's care plan does not include R9's Advanced Directives, and R10 has not had Advanced Directives formulated or documented in R10's medical record.

On 8-1-24 at 11:42 AM, V6 (Assistant Director of Nursing/ADON) verified R5's Care Plan was not updated with R5's DNR Advanced Directives.

(A)

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300.610 a)
300.1210 b)
300.1210 c)
300.1210 d)2)
300.1210 d)3)
300.1210 d)5)
300.1220 b)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

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S9999	Continued From page 10 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. 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on record review, observation, and interview, the facility failed to perform pressure ulcer risk assessments as directed by the facility's policy, failed to perform daily skin checks, failed to develop and implement pressure relieving interventions, failed to develop a pressure ulcer care plan, failed to assess a pressure ulcer weekly, and failed to perform pressure ulcer treatments as directed by the physician for one of two residents (R7) reviewed for pressure ulcer development in the sample of 13. These failures resulted in R7's right and left heel pressure ulcers deteriorating from stage one pressure ulcers to an unstageable pressure ulcer to the right heel and a stage three pressure ulcer to the left heel.

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Findings include:

The facility's Preventative Skin Care policy, dated 01/2018, documents, "It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers. Procedures: 1. All residents will be assessed using the Braden Pressure Ulcer Scale at the time of admission and weekly times four then will be reassessed at least quarterly and/or as needed. 5. Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours. 6. Special mattresses and/or cushions will be used on any resident identified as being at high risk for potential skin breakdown. 7. Pillows and/or bath blankets may be used between two skin surfaces or to slightly elevate bony prominences/pressure areas off the mattress. Pressure relieving devices may be used to protected heels and elbows."

The Pressure Sore Prevention Guidelines policy, dated 01/2018, documents, "Policy: It is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. Responsibility: all nursing staff and the dietary manager. Interventions/Comments for High-Risk residents. Special Mattress/Specify type of mattress on the Care Plan. Daily Skin Checks/follow protocol for coding skin conditions. Interventions/Comments for High or Moderate Risk residents: Turn and reposition every two hours. Turning and positioning may be more often than every two hours for high risk, if indicated.

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Care Plan Entry/Skin risk and appropriate interventions are to be placed on the Care Plan. If despite interventions a pressure ulcer develops, the care plan must reflect updated interventions for healing of ulcers and additional interventions for further prevention of Pressure Ulcers. Interventions/Comments as needed for High or Moderate Risk residents. Positioning Devices/Devices while in chair or in bed as needed to maintain turning. Specify on Care Plan. "Any resident scoring a High or Moderate risk for skin breakdown will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse."

The facility's Skin Condition Monitoring Policy, dated 01/2018, documents, "Policy: It is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. Procedure: 1. Upon notification of a skin lesion, wound, or other skin abnormality, the nurse will assess and document the finding in the nurses' notes and complete a QA (Quality Assurance) for newly acquired skin condition. 2. The nurse will then implement the following procedure: Type of treatment, location of area to be treated, frequency of how often treatment is to be performed, how area is to be cleansed, and stop date, if needed. 4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: Characteristic, size, shape, depth, odor, color, and presence of granulation tissue or necrotic tissue. Treatment and response to treatment. Prevention techniques that are in use for the resident."

The facility's Decubitus Care/Pressure Areas

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policy, dated 01/2018, documents, "Policy: It is the policy of the facility to ensure a proper treatment program has been instituted and is closely monitored to promote the healing of any pressure ulcer. Documentation of the pressure area must occur upon identification and at least once each week on the TAR (Treatment Administration Record) or Wound Documentation Form. The assessment must include characteristics and treatment and response to treatment."

The facility's Turning and Repositioning Program policy, dated 01/2018, documents, "Purpose: To ensure residents at risk for pressure ulcers are turned and positioned per the plan of care in an organized system. Procedure:Turning schedule will occur as indicated by the resident's plan of care."

R7's Braden Scales for Predicting Pressure Ulcer Risk, dated 3-14-24 and 3-27-24, document R7 was at high risk of developing pressure ulcers. These same Braden Scales for Predicting Pressure Ulcer Risks document R7 did not have a pressure relieving cushion to his chair, was not on a turning and repositioning program, was not having his heels floated, did not have elbow or heel protectors, and was not using positioning devices such as pillows, cushions, etc.

R7's Medical Record does not include any further Braden Scales for Predicting Pressure Ulcer Risk Assessments since 3-27-24.

R7's MDS (Minimum Data Set) Assessments, dated 3-27-24 and 5-9-24, document R7 had no pressure ulcers and was at risk for developing pressure ulcers.

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R7's Treatment Administration Records (TARs) and Physician's Order Sheets (POSs) dated 3-16-24 through 7-31-24 document, "Daily skin check. Weekly skin documentation on back of TAR." R7's TARs, dated 3-16-24 through 7-31-24, document R7 did not receive daily skin checks on 24 days during this timeframe. R7's TARs, dated 3-16-24 through 7-31-24, do not include documentation of weekly skin checks being completed weekly except for one time on 4-10-24.

R7's Recertification Hospice Plan of Care, dated 7-19-24, documents, "Noted significant skin breakdown. Skin breakdown is significant and progressing rapidly. Communication with floor nurse was made related to assistance by facility staff in keeping (R7) clean, hydrated, and repositioned. May increase visits if (R7) continues to have skin breakdown."

R7's Hospice Care Coordination Progress Note, dated 6-14-24, documents, "Heels starting to look a little reddish."

R7's Abnormal Skin Report, dated 6-24-24, documents R7's bilateral heels were red.

R7's Physician's Orders and Treatment Administration Records, dated 6-24-24 through 7-31-24, document, "Skin Prep (Preparation) to bilateral heels every shift."

R7's TARs, dated 6-24-24 through 7-31-24, documents R7's physician ordered skin prep treatment every shift to both heels was not completed 82 times within this time frame.

R7's Physician Order, dated 6-18-24, documents, "(R7) to be turned and re-positioned every two

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hours due to skin breakdown. Please document and initial."

R7's Medical Record, dated 6-18-24 through 8-1-24, does not include documentation of R7 being turned and reposition every two hours as ordered by R7's physician.

R7's TARs, dated 7-16-24 through 7-31-24, document, "Apply mepilex to left heel change every three days." R7's TARs, dated 7-16-24 through 7-31-24, document R7's mepilex treatment to the left heel was not completed two times during this timeframe.

R7's Hospice Care Coordination Progress Note, dated 8-1-24, documents, "Right foot heel (pressure wound) continues to decline. Current measurement six cm (centimeters) round and completely covered in eschar (dead tissue/If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/injury). New orders per doctor for right foot (heel) to change dressing daily and to cleanse area, pat dry and apply Santyl (debriding cream) and cover with a four-by-four gauze and wrap with rolled gauze and continue to wear protective boots. Left foot (heel) three cm round and wound bed is pink and beefy (stage three pressure ulcer/full thickness skin loss). Change dressing daily."

The facility's Wound Tracking Reports (used to assess the characteristics and size of wounds weekly), dated 7-1-24 through 7-31-24, do not include R1's wound characteristics or size to the bilateral heels.

R7's Medical Record does not include an assessment of R7's wound characteristics or measurements to R7's bilateral heel pressure

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ulcers since first identified on 6-14-24, except for one assessment of R7's bilateral heel wounds performed by hospice services on 8-1-24.

R7's current Care Plan does not address R7's pressure ulcers to the left or right heels since development on 6-14-24 and does not include pressure relieving interventions.

On 7-27-24 at 10:00 AM, R7 was lying in bed with bilateral heels laying directly on the bed. R7 did not have on heel protecting boots. R7's right heel and left heel did not have dressings, leaving R7's right and left heel pressure ulcers exposed. R7's right heel was golf-ball sized and was covered in eschar. R7's left heel was quarter-sized and beefy red. V22 (Agency LPN/Licensed Practical Nurse) verified R7 did not have a treatment to either heel, did not have on pressure relieving boots, and did not have his heels off-loaded. V22 stated, "I am new here and am not sure what (R7's) treatments are."

On 7-30-24 at 11:45 AM, V3 (R7's Family Member) stated, "I got a call from hospice that (R7's) heels are bleeding and are getting really bad. (V5/Hospice Nurse) would go into assess (R7) and said the staff never had (R7's) heels elevated or heel boots on and a lot of times (R7's) heels were not getting treated. (R7) cannot turn and re-position himself and is always laying on his back. There is no reason (R7's) heels should not be getting treated."

On 7-30-24 at 12:30 PM, V5 (Hospice Nurse) stated, "I took care of (R7) quite a bit. The only time (R7) would get turned and repositioned was when hospice staff would do it. I would find (R7's) heels bleeding and laying directly on the bed without a treatment."

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S9999	Continued From page 18 On 8-2-24 at 2:30 PM, V6 (Assistant Director of Nursing) stated she was unaware of R7 having pressure ulcers to his bilateral heels. V6 verified R7 did not have Braden Scale Pressure Ulcer Assessments completed weekly times four weeks after admission or quarterly, does not have any wound measurements or assessments of R7's bilateral heel wounds within R7's medical record, and has not had treatments to the bilateral heels completed as ordered according to R7's TARs. On 8-2-24 at 3:00 PM, V29 (Care Plan Coordinator) stated, "I was unaware that (R7) had pressure ulcers. (V11/Wound Nurse) never told me about (R7) having pressure ulcers so I never developed a pressure ulcer care plan. I get (V11's) wound report every week and not once was (R7's) heel wounds on the report. There are no weekly heel wound assessments or measurements in (R7's) chart. On 8-5-24 at 8:40 AM, V31 (Hospice Chief Executive Officer) stated, "We (hospice) have weekly meetings about (R7's) cares. I know (R7's) wounds to the heels were caused from pressure or friction. (V5) did have concerns at times. (V5) would find (R7) without his heels off-loaded." (B)	S9999		