STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012074	A. BUILDING: _____ B. WING _____	C 08/22/2024

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S 000	Initial Comments Complaint Survey: 2446540/IL176854	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1035a)4 300.1210b) 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 respect to the provision of life-sustaining treatment when a resident has chosen to accept,	S9999		

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

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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to update and have appropriate documentation regarding the Code Status/Advanced Directives for 2 of 3 residents (R3, R4) reviewed for Advanced Directives in the sample of 12. Utilizing the reasonable person concept, R3 made his advanced directive choices clear when updating his directive status in June 2024 to Do No Resuscitate (DNR) status. Due to the facility failure to correctly identify his DNR, R3 experienced life saving measures including intubation and extubation prior to expiring.

The Findings Include:

1. R3's Face Sheet, undated, documents R3 was originally admitted to the facility on 12/15/22 and was discharged to the hospital on 8/16/24 with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Panlobular

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Emphysema, Type 2 Diabetes Mellitus (DM), Malnutrition, Schizophrenia, Hypertension (HTN), Dependence on Supplemental Oxygen, COVID-19, and Deep Vein Thrombosis (DVT).

R3's Care Plan, dated 7/25/24 documents: (5/31/23) R3 Is a FULL CODE, CPR Order: Attempt CPR. Interventions: 5/31/24: Resident is a FULL CODE, Allow opportunity to review and initiate Advanced Directives with the resident and/or appointed health care representative.

R3's Minimum Data Set (MDS), dated 6/19/24, documents R3 had a moderate cognitive impairment and required setup or clean up assistance for most ADLs.

On 8/19/24 at 12:19 PM, V5, Registered Nurse (RN) stated "I was the Emergency Room (ER) Nurse who took care of (R3) when he went to the ER on 8/16/24. (R3) was very hypoxic upon arrival to the hospital with the Fire Department getting an oxygen saturation of 65%. The Emergency Medical Service (EMS) guys told us that the Nurse at the facility who was taking care of (R3) knew nothing about him and stated she was just a temp there working. No one at the facility was able to tell EMS when (R3) was last seen well, or how long he was like that. The facility gave EMS paperwork that indicated (R3) was a Full Code, so we intubated (R3) in attempts to resuscitate him. The facility did not call (R3's) brother, who was also his POA (V6), to let him know they were sending (R3) to the ER, and when (V6) showed up at the facility to see (R3), he was told that (R3) was taken to the hospital. Then (V6) showed up at the ER and saw (R3) intubated, he told us that (R3) was a Do Not Resuscitate (DNR) and that he did not want to be intubated. He told us they signed the appropriate

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paperwork back in June 2024 for that, and he provided that paperwork to the facility, and they should have sent that. The ER Physician had to withdraw care and let R3 pass away."

On 8/19/24 at 12:40 PM, V6, R3's Brother/POA, stated "I went to the facility to check on (R3) on 8/16/24. When I got to the facility, I went to (R3's) room, and he was not there, and his roommate stated that they took (R3) to the hospital. When I asked, it took three different staff members just to tell me which hospital he went to. When I got to the ER, I found out that the hospital had intubated (R3) and they should not have done so because (R3) was a DNR/Do Not Intubate (DNI). The ER Nurse showed me the paperwork from the facility that was sent with (R3) and it did show that (R3) was a Full Code. I signed paperwork in June 2024 with (R3) indicating that (R3) was a DNR and the facility should have had that in his record, but they sent the wrong one. I was not happy because my sister and I had to make the decision to terminate (R3's) care, so they extubated (R3) and let him pass away."

On 8/20/24 at 9:05 AM, V1, Administrator, stated "I was aware that (R3) went to the hospital due to respiratory distress and had passed away in the hospital, but I was not aware of any issues."

On 4/22/24 at 9:25 AM, V16, Social Service Director, stated "It looks like (R3's) POA paperwork that was given to us in June 2024 was scanned into his medical record by the Business Office Manager and that is weird because she shouldn't be the one doing that. I didn't even know that (R3's) family brought in new paperwork. I think this would fall on this facility's communication. (R3's) POLST should have been updated once we received the new POA

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paperwork and we should have sent the new POLST and the POA paperwork with (R3) when he went to the hospital. I feel bad because I heard the family had to make that tough decision to let him go like that."

On 4/22/24 at 9:40 AM, V4, VP Clinical Operations, stated "I did my own audit of the facility and found the same issues with some residents having an outdated POLST that did not match other documentation in the medical record. I also saw some resident Care Plans that had conflicting Advance Directives and I fixed those. I did see that (R3) had the two conflicting Advance Directives in his Care Plan, but I was not aware of (R4's) because that was back in May. I would expect the MDS Nurse to make appropriate changes to the Care Plan with updated information when necessary. I would also expect the staff to make sure Nursing has the most up to date information available to them."

R3's POLST, dated 12/17/22, documents R3 was a Full Code.

R3's POA Paperwork, dated 6/19/24, documents R3 and his POA signed indicating R3 did not want lifesaving sustaining treatment.

R3's Physician Order, dated 8/5/24, documents "Advance Directive: Full Code."

R3's Hospital Record - page 2, dated 8/16/24, documents "61-year-old male with a history of COPD, acute respiratory failure with hypoxia, panlobular emphysema, moderate protein calorie malnutrition, type 2 diabetes, hyperlipidemia, hyponatremia, hypoosmolality, electrolyte imbalance, schizophrenia, dysphagia, hypertension, oxygen dependence that was

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brought in by EMS secondary to altered mental status and hypoxia. Upon arrival, EMS noted, patient last known well was last night approximately 9:00 PM, however has not been seen until 10:00 AM this morning, all of the nurses at the facility where traveler's and did not know this patient. They did note that he is normally up and smoking however. Upon arrival, EMS noted patient was altered, not following commands, satting in the mid 60s, unsure of how long this has been going on, improved to the 90s with a non-rebreather. No family is at the bedside."

R3's Hospital Record - page 13, dated 8/16/24, documents "Spoke with the brother (V6) at the bedside, he notes the patient was a DNR and has a very poor quality of life over the last number of days to weeks. He states the signed paperwork is at the facility however the paperwork we initially received has him as a full code. He is going to call his sisters, although he is the POA, to confer and decide the next steps at this time. Brother has opted for extubation and removal of care, comfort measures only. Time of death called, ultrasound confirmed cardiac standstill, brother at the bedside, will page his primary care."

R3's Hospital Record - Page 17, documents "Patient's brother to bedside. Patient's brother states what facility told EMS was not true and patient has been weaker/not normal since Sunday. Patient's brother also states patient is DNR/DNI, brother is POA. ERP (ER Physician) to bedside to discuss POC (plan of care) due to paperwork from facility showing full code."

2. 2. R4's Face Sheet, undated, documents R4 was originally admitted to the facility on 10/21/23 and was discharged on 5/3/24 with diagnosis of

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Metabolic Encephalopathy, Fracture Tibia, Mitral Valve Insufficiency, Adult Failure to Thrive, Malnutrition, Pulmonary Hypertension, Anemia, Hypothyroidism, Cardiomyopathy, Gangrene, HTN, Cellulitis Left Lower Extremity (LLE), Rhabdomyolysis, Peripheral Vascular Disease, Congestive Heart Failure, and Acquired Absence of Right Above Knee Amputation (AKA).

R4's Care Plan, dated 5/6/24, documents (11/7/23) R4 has an Advanced Directives on record. Interventions: Advise resident and/or appointed health care representative to provide copies to the facility of any updated Advanced Directives, Discuss Advanced Directives with the resident and/or appointed health care representative. (11/7/23) R4 is a Full Code. Interventions: Allow opportunity to review and initiate Advanced Directives with the resident and/or appointed health care representative.

R4's MDS, dated 5/3/24, documents R4 had a moderate cognitive impairment and was dependent on staff for all ADLs.

R4's POLST, dated 11/2/23, documents R4 is a Full Code.

R4's POA Paperwork, dated 10/19/23, documents R4 does not want treatments to prolong her life or delay her death, but she does want treatment or care to make her comfortable and to relieve her of pain.

The Facility's "Advanced Directives" Policy, dated 9/2023, documents "The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. 1. The facility

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defines the following in accordance with current OBRA definitions and guidelines: a. Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. b. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated (per §489.100). (2) Durable Power of Attorney for Health Care (i.e., Medical Power of Attorney) - a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated. (3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. 1. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. 3. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical

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S9999	Continued From page 8 record and discussing the resident's wishes in care planning meetings. 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. 7. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. 8. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan. 9. The nurse supervisor is required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of the advance directive or POLST when transfer from the facility via ambulance or other means is made." (A)	S9999		