STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005474	A. BUILDING: _____ B. WING _____	C 10/09/2024

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S 000	Initial Comments Complaint Survey 2448033/IL178856	S 000		
S9999	Final Observations Statement of Licensur 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	S9999		

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

These requirments are not met as evidenced by:

Based on interviews and record reviews the Facility failed to assess, monitor, and perform vital signs for 1 of 3 residents (R2) reviewed for change of condition in the sample of 6. This failure resulted in R2's low oxygen saturation level, hospitalization, and being put on a ventilator, unable to return to the facility.

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Findings include:

On 10/4/2024 at 1:22 PM, V1, Administrator stated, "(R2) was recently sent to the hospital for a change of condition, and when she got to the hospital, she tested positive for COVID, and they admitted her for COVID and pneumonia. (R2) had to go on a ventilator. We do not take any residents with ventilators (vents) so she was going to be sent to another facility that takes vents and will not be returning to us."

R2's Physician Order Sheet (POS) for October 2024 documents a diagnosis of amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, morbid obesity, hypertension, depression, chronic pain, and encounter for screening for COVID-19.

R2's Minimum Data Set (MDS) dated 8/19/2024 documents R2 was cognitively intact for decision making of activities of daily living. She has impairments on both sides of her upper and lower extremities, uses a wheelchair and was dependent on most activities of daily living.

R2's Care Plan: Respiratory: (R2) has potential for difficulty in breathing related COPD acute respiratory, date initiated 11/15/2023. Interventions: Assess respiratory status rate, depth, pattern, skin color. Monitor O2 (oxygen) Sats (saturation). Monitor every shift for shallow respiration, diaphoresis, dyspnea, monitor vital signs and lung sounds, observe for change in breathing pattern. All of the interventions listed were documented with the date initiated of 11/15/2023.

R2's Progress Notes dated 9/25/2024 at 11:35 AM, document "Patient states she is not feeling

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good today and is very worried for her health situation. She reports her health concerns of being short of breath and unable to cough. Therapist notified nursing staff of patient concerns and nursing staff assessed patient."

R2' s Progress Notes dated 9/25/2024 at 6:56 PM, "Resident sent to (ED) (emergency department) via EMS (Emergency Medical Services) with c/o (complaint of) SOB (shortness of breath). O2 sats 79% during MD (Medical Doctor) consultation. MD instructed this nurse to raise O2 concentration to 5 L (liters), O2 sats improved to 91% but LOC remained unaffected. MD (Medical Doctor) instructed this nurse to send resident out due to change of condition. MD stated she would call report into (Hospital)."

On 10/8/2024 at 9:44 PM, V13, Physical Therapist stated he was familiar with (R2), and he remembered she was a total assist, and her ALS (Amyotrophic Lateral Sclerosis) was progressing. "The last time she had any therapy was on 8/30/2024 and she received speech therapy. (R2) did not have any therapy treatment, speech, or physical therapy on 9/25/2024. I am not sure what you are referring to. I have checked our records, and (R2) did not see any therapist on 9/25/2024."

On 10/8/2024 at 10:07 AM, V6, Licensed Practical Nurse (LPN), stated, "I am fairly new in the facility. I am the Wound Nurse. Earlier in the day some staff told me (R2) was having some discomfort and I took (R2's) O2 (oxygen) sats and she was at 96%. I called the Telehealth doctor and sent her out later in the day. I recorded her vital signs in the progress notes and on the (electronic medical charting) under vitals. When I first checked on (R2) she was not in respiratory distress. I remember at that time

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COVID was in the building and I know I did not test her for COVID but did send her out. I did not write the entry for (R2) on 9/25/2024 at 11:35 AM. Someone did come and get me; I believe it was someone from therapy and let me know she was having breathing issues."

On 10/8/2024 at 10:34 AM, V1, Administrator stated, "The only way anyone could write a note for a nurse's note is if they have a password. Once they make a note, they have to enter their password again in order for the note to go through. More than likely, (V6) just forgot she had written the note. I find it hard to believe anyone else has her code. She is fairly new and learning so much stuff."

R2's Electronic vital signs do not document any vital signs were being performed on R2. Oxygen, temperature, and pulse were not documented on her chart, everything was blank after 9/19/2024. No vital signs were documented for 9/25/2024 except for the oxygen levels on 9/25/2024 at 6:56 PM, no other O2 levels were documented when R2 stated she was having shortness of breath on 9/25/2024 at 11:35 AM.

On 10/8/2024 at 1:57 PM, V18, Certified Nursing Assistant (CNA) stated, "I remember (R2), her breathing was very rapid, and you could tell she was off. I immediately went and got the nurse, this was right before lunch, and let her know she was having issues with her breathing and said she did not feel good. If I charted anything, like her vitals it would be in PCC. I can't remember if I charted anything, but I did go and get (V6) and let her know what was going on. Then later that night (R2) was sent out to the hospital. The nurse was (V6, LPN). We can chart and/or the nurse can chart vitals. If we chart anything it will be in the

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(electronic charting system)"

On 10/8/2024 at 1:50 PM, V2, Corporate Nurse/Director of Nursing stated, "I would expect all change of conditions to be charted in the charts and all vitals to either be in the Progress Notes and or (electronic charting system)."

On 10/8/2024 at 2:03 PM, V19, CNA stated, "I remember the day (R2) went out to the hospital because she was not looking good. She could talk and she said she was having issues breathing. This was right before lunch. I remember telling the nurse and then later she was sent out to the hospital. The nurse was (V6), I believe."

R2's Progress Notes dated 9/26/2024 4:18 AM, documents, Note Text: "Resident was sent to (Hospital) for low 02 sats. I called (hospital) and they stated that (R2) is intubated at this time."

On 10/9/2024 at 2:00 PM, V22, Nurse Practitioner stated, "If a resident has a history of ALS and they tell staff they are not feeling well, and they were having issues with breathing I would expect to be notified. If a resident was complaining of SOB, then I would expect to be notified. I would expect the O2 stats to be monitored at least every shift but without knowing the vitals it makes it difficult because if (R2's) vitals were not within normal limits then I would expect to be contacted immediately and sent out. I would expect all vitals to be charted and documented in the patient's chart. If (R2's) oxygen situations were below 90 and I felt she was in distress I would have sent out her sooner to the hospital."

R2's Hospital Notes dated 9/25/2024 documents, "7:00 PM, (R2) is a 58 y.o. (year old) female

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S9999	Continued From page 6 presenting to the ED (emergency department) c/o (complaint of) respiratory distress, EMS (Emergency Medical Services) reports they found the patient in significant respiratory distress. They immediate placed her on a non-rebreather with minor improvement. Impression: 9/26/2024 Patient presented to ED via EMS with respiratory distress, Patient intubated in ED. Plan includes respiratory, infection disease and medical management, isolation, ventilator, IV antibiotics, remdesivir and steroids." The Facility Change in Resident Condition Policy with a review date of September 2024 documents, "It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician, and resident's responsible party of a change on condition. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and the family of the issues and any physician order. The communication with the resident and their responsible party as well as the physician will be documented in the resident medical record, or other appropriate documents." (A)	S9999		