STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZAHAV OF DES PLAINES	9300 BALLARD ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Complaint Investigations: 2397515/IL164199 2397096/IL163648 2398056/IL164853 2398330/IL165232	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4): 300.610a) 300.690a) 300.1210b) 300.3240a)c) 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. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 progress notes or nurse's notes of that resident. 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to follow its abuse policy to determine how a resident sustained an injury to her right labia. This failure resulted in R15 making an allegation of sexual abuse and the facility unable to identify the perpetrator. R15 was sent to the local hospital where R15 was assessed to have wounds to the right labia and left buttocks. This affected one of three residents (R15) reviewed abuse.	S9999		

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S9999	Continued From page 2 Findings include: On 9/27/23 at 5:43pm, R15 who was assessed to be alert and oriented to person, place and time, stated there was a male CNA (certified nurse aide) who worked the night shift. R15 stated in October 2022, the CNA (unable to recall his name) who was Nigerian, bald, no facial hair, average size with a small pot belly started taking longer and longer to provide peri care. The CNA was spending more time wiping my vagina, labia and clitoris. R15 stated R15 told him to stop and 'no' because R15 didn't like it, but he wouldn't stop. R15 stated in November, right before thanksgiving, the same male CNA was providing incontinence care. He wiped my vagina area for the longest time, wiping in between my labia and touching my clitoris, he turned me on my side because R15 said she had a wound on her buttocks. The male CNA applied cream to her buttock. R15 stated while on my side the male CNA stuck his fingers in my vagina from the back. R15 stated she slammed her thighs together around his wrist. The male CNA's hand was in my vaginal area and his wrist was stuck between my legs. R15 stated, finally, the male CNA climbed on top of her, laying across her horizontally. R15 stated she could not fight the male CNA because he was laying across my chest with my arms bent at the elbows with my hands near my face. R15 stated the male CNA had his hands on each side of my face, stating he loves me and trying to kiss me. R15 stated she told the male CNA she does not love him and dug her nails into his neck on both sides. R15 stated she had long nails and she broke all her nails off. R15 stated she made a police report. R15 stated she reported this incident to the nurse (doesn't recall who/name). R15 stated V66 (former	S9999		

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S9999	Continued From page 3	S9999		

administrator) asked, R15 if R15 really wanted to pursue the case, if R15 had really been sexually assaulted.

Review of R15's hospital record, dated 11/28/22-12/7/22, notes R15 informed hospital staff of an allegation of sexual abuse involving a male staff member prior to R15's admission to the hospital. R15 stated, "After the male staff member changed R15's brief, he rubbed barrier cream all over R15 in a massage like fashion and put his hands between R15's legs". R15 informed the hospital social worker she had fought back and lunged at her attacker with her nails. "An exam was conducted with a chaperone present. Exam on 11/29/22, noted a small healing lesion to R15's right labia vaginalis present. R15 was also noted to have a left buttock skin tear. R15's affect: anxious, upset, mad, angry. Also noted was swelling of genitalia. The social worker notified the former administrator of this facility and the State Surveying Agency of the allegation of sexual abuse. While in hospital, there was concern for homicidal ideations towards the male staff member at this facility, due to being sexually abused at this facility. Psychiatry was consulted due to R15 voicing homicidal ideations towards staff member".

R15's medical record, dated 12/9/22, notes V10 (former social service director) met with R15 to check in following allegations of inappropriate touching. R15 was upset. V10 discussed actions being taken to ensure she feels safe. R15 moved to the first-floor nursing unit and will have female CNAs as much as possible. Staff assisted R15 in reporting this to the police as well. Police took her statement on 12/8/22.

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S9999	Continued From page 4 This facility's abuse prevention policy notes residents have the right to be free from abuse. This facility shall immediately protect residents involved in identified reports of possible abuse. This facility shall implement systems to promptly and aggressively investigate all reports and allegations of abuse and make the necessary changes to prevent future occurrences. This facility shall file accurate and timely investigative reports. Sexual abuse is non-consensual sexual contact of any type with a resident. Documentation in the resident's chart should reflect the resident's physical and emotional status as well as any medical and nursing interventions implemented. (no violation) Statement of Licensure Violations (2 of 4): 300.610a) 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. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 5 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 interviews and record reviews, the facility failed to ensure one resident's airway (R18) was free of any obstruction and failed to perform effective bag-valve to tracheostomy resuscitation by (V54), an uncertified staff during a code blue. This failure resulted in R18's airway being obstructed with suction catheter tubing in her tracheostomy preventing adequate oxygenation for at least 7 minutes until Emergency services arrived when it was removed. This affected one of three residents reviewed for death. Findings include: R18 was admitted to the facility on 7/30/2019 with a diagnosis of cerebral infarction, lack of coordination, repertory failure muscle weakness, atrial fibrillation, hyperlipidemia, anemia, insomnia, dysphagia, dependence on supplemental oxygen, aphonia, tracheostomy history of pulmonary embolism and acute embolism of right lower extremity. R18's brief interview for mental status was 15/15 which indicated cognitively intact. R18's minimum data set under functional ability dated 9/18/23	S9999		

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S9999	Continued From page 6 documents one person assists for eating, dressing and personal hygiene. R18's physician order documents R18 is a full code. R18's progress note dated 9/24/23 at 7:40AM documents: 19.00 (700PM): Resident received sleeping in bed with head of the bed elevated 30 degrees and bed in the lowest position. Resident has no signs of pain or distress noted. 21.00 (9:00PM): Resident was alert awake not in distress. All due medications given. Resident kept clean and comfortable.23.00 (11:00PM): continue monitoring, not in distress. Resident kept clean and comfortable Hourly rounds performed, patient not in distress. Approximately 04.45AM writer went into the room to change the tube feeding of the co-resident, she (R18) was breathing normally, not in any kind of distress and looks comfortable. 0500am Certified nursing assistant, CNA was doing ADL for the resident (R18), he went out from the room to get necessary items for the continuation of care, at 0508 resident (R189) found unresponsive, CNA called for help, immediately ran in to the room and patient found unresponsive, code blue called, CPR initiated. At 0509, 911 called immediately. Fire department arrived at 0516 am. 911 came and took over the CPR. During resuscitation 911 removed the suction catheter, from the trach site with the help of respiratory therapist from the facility. R18's fire department run sheet dated 9/24/23 documents: notified at 5:02AM and patient contact at 5:09AM unresponsive, cyanotic. Narrative documents: dispatched to local nursing home for cardiac arrest. R18 found lying supine in bed with nursing home staff performing	S9999		

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S9999	Continued From page 7	S9999		

cardiopulmonary resuscitation, (CPR) with Bag Valve Mask (BVM) via tracheostomy. Upon assessment crew found R18 unresponsive, pulseless, and apneic. R18 was placed on the cardiac monitor via pads with pulseless electrical activity, (PEA) noted. Crew continued CPR with pulse and rhythm check every two minutes. While using BVM to ventilate R18 via tracheostomy crew noted resistance on BVM and was unable to ventilate and deliver breaths to pt. When checking trach crew noted an obstruction inside the trach that appeared to be part of a suction tubing. With assistance of the respiratory therapist, the suction tubing was removed from inside the trach. Crew was then able to effectively deliver ventilations to R18 via BVM with oxygen at 15 and maintain throughout. Approximately 12 minutes into CPR with cardiac monitor, R18 obtained return of spontaneous circulation, (ROSC). Crew had a strong femoral pulse and organized sinus tachycardia rhythm noted. R18 was secured to stretcher and moved to Ambulance. Crew contacted local hospital; no orders given. While crew was attempting to obtained further vital signs and a 12 lead, crew noted rhythm change on the monitor and found R18 to be in cardiac arrest with PEA on the monitor. Crew re-started CPR with BVM and continued at ER. Under arrest etiology: respiratory/asphyxia.

On 9/29/23 at 11:49AM, V50 (EMS) said he was present for the emergency call for R18. V50 said they arrived to R18's room with staff performing cardiopulmonary resuscitation and utilizing bag valve mask to R18's tracheostomy site. V50 said he took over the bag mask valve and was meeting resistance and unable to squeeze the bag valve mask. V50 said they attempted to open airway and inspected R18's tracheostomy and

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S9999	Continued From page 8 observed what appeared like a straw within the tracheostomy. V50 said they requested for respiratory therapist to inspect and she then removed the tracheostomy and pulled out what looked like a suction catheter tubing approximately 5-10 inches long from the resident. The tracheostomy was put back into place and V50 said they were able to utilize the bag valve without any resistance and shortly after R18 had return of spontaneous circulation. On 9/29/23 at 6:23PM, V54 (respiratory therapist, RT) who was identified as the respiratory therapist working with R18 on 9/23/23 7:00pm through 9/24/23 7:00AM, said there were no concerns with R18 prior to code blue. V54 said she responded to the code blue and removed tracheostomy collar and checked the inner cannula and provided suctioning with smaller catheter with minimal white secretions removed. V54 (RT) said she connected bag valve mask (BVM) and administered 100 % oxygen. V54 (RT) said she was able to provide ventilations with no resistance. When V54 (RT) was asked how you ensure the resident is receiving adequate oxygen, V54 said because I could squeeze the bag. V54 was asked if there is anything else you would monitor or look for to ensure resident was receiving adequate oxygenation, V54 said no. V54 was asked if she was able to see the chest rise and V54 said no. V54 said that Emergency services took over the Cardiopulmonary resuscitation. Emergency service called respiratory therapist back into the room and observed suction tubing in her tracheostomy. V54 said she removed the tubing and emergency services left with the resident to the hospital. V54 said she did not remove tracheostomy to remove tubing and pulled it out with her hand. V54 said during a code blue staff should check patients,	S9999		

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provide 100% oxygen, check airway, suction airway. Make sure tracheostomy is not clogged, remove inner cannula and check for mucous plug suction, may put saline, apply 100% oxygen.

On 10/4/23 at 2:44PM, V54 (RT) said she did not provide any suctioning care to R18 during her shift because R18 self-suctions. Staff leave the suction catheter unlocked and connected to the suction canister on the wall. V54 said she last saw R18 around 4:30AM sleeping in bed. Around 5:00AM, they called a code blue. V54 said she responded to the code and went to R18's room. V54 said she removed the closed suction catheter that was attached to R18's tracheostomy and did not observe any concern. R18 had secretions around her neck and V54 utilized smaller suction catheter to remove secretions. V54 (RT) said she suctioned within the inner cannula but not deeply and observed a minimal amount of white secretions. V54 said she removed the inner cannula and did not see any obstruction. V54 proceeded to administer 100 % oxygen via bag valve mask. V54 said she could easily squeeze the bag valve mask with no resistance. Emergency services arrived and took over care to R18. Emergency services called us back into the room and told there was tubing within the tracheostomy. V54 was unable to recall if emergency services had removed R18's inner cannula or if she removed the inner cannula, but she said she saw the obstruction and removed a piece of the suction catheter tubing. V54 was unable to estimate the length of the tubing, but said it appeared to be broken off the closed suction system. V54 (RT) denied seeing the tubing prior to Emergency services arrival.

On 10/3/23 at 12:13PM, V55 (respiratory therapist, RT) said was the assigned to the other

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S9999	Continued From page 10 side of R18's unit and was not directly assigned to R18. V55(RT) said V54(RT) said, "She (R18) was not getting oxygen" and asked V55 to obtain an oxygen tank. V55 said he obtained an oxygen tank from the storage room and went back to R18's room where V54 (RT) placed R18 oxygen on tracheostomy site. V55 said emergency services arrived and took over and asked Respiratory therapist to come into the room where they showed them a broken tubing. V55 said it appeared to be part of the suction catheter tubing from the closed suctioning kit. V55 said Emergency services removed the suction catheter tubing from R18. R18's hospital record dated 9/24/23 documents: Patient's presentation is most consistent with cardiac arrest potentially in the setting of hypoxia after an object was left in her trach. Patient placed on the ventilator with good oxygen saturations Patient remains unresponsive to verbal and motor stimuli but pupils are slightly more reactive. Patient also noted on reevaluation to have some blood from her trach does not appear to be actively bleeding and only minimal blood suctioned from the trach. Ear nose and throat, ENT scoped patient at the bedside and noted diffuse tracheal injury but from unclear etiology, potentially frequent suctioning. Urinalysis appears infectious but of unclear clinical significance, however patient started on broad-spectrum antibiotics. CT brain showed cerebral edema consistent with diffuse hypoxic injury. She was fluid resuscitated here. Currently her physical examination shows severe neurologic impairment with fixed and dilated pupils and no gag or corneal reflexes. CT dated 9/24/23 at 11:32 am, document diffuse hypoxic ischemic injury. 9/24/23 11:54AM Flexible tracheoscopy performed at bedside. Tube in good	S9999		

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S9999	Continued From page 11 position without obstruction or foreign body. Tracheal mucosa diffusely excoriated with apparent trauma. Scant miniscule sanguine crusts. Patient with recent cardiac arrest with chronic tracheostomy with tracheitis in a pattern that appears consistent with suction trauma. Neurology determined that patient had extremely poor prognosis for neurological recovery. At 1200 on 9/26, patient was taken off vent/pressor support and expired at 12:31 PM. According to the American heart association, a patent airway is essential to facilitate proper ventilation and oxygenation. Although there is no high-quality evidence favoring one technique over another for establishment and maintenance of a patient's airway, rescuers should be aware of the advantages and disadvantages and maintain proficiency in the skills required to establish an adequate airway. Patients should be monitored constantly to verify airway patency and adequate ventilation and oxygenation. V54 (respiratory therapist) basic life support from the American heart association with an issue date of 8/5/21 and renew by 8/2023. V54 (respiratory therapist) basic life support from the American heart association with an issue date of 10/3/2023 and renew by 10/2025. (AA) Statement of Licensure Violations (3 of 4): 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3210t)	S9999		

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S9999	Continued From page 12 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. 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 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	S9999		

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S9999	Continued From page 13 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the physician of an acute change in condition on 9/18/23 and failed to immediately activate 911 for an acute change in condition. R7 was exhibiting lethargy, blue discoloration to fingertips, slow speech, glazed eyes, and a critically low sodium level. This affected one of three resident (R7) reviewed for change of condition, and emergency management response. This failure resulted in R7 being left unmonitored with a declining clinical status for over 14 minutes. R7 was found unresponsive without pulse/respiration by the local EMS team who initiated lifesaving	S9999		

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S9999	Continued From page 14 interventions to include CPR, however, R7 expired. Findings include: On 9/20/23 at 3:55pm, V17 CNA (certified nurse aide) stated V17 was off 4 days prior to 9/19/23. V17 stated when V17 came in on 9/19/23, R7 did not want to eat and was sleepy. V17 stated R7 refused breakfast and lunch. V17 stated V17 told V34 (nurse) R7 did not look good at about 10:00am and again at 1:00pm. V17 stated V17 tried to feed R7, but he refused. V17 stated when she returned from break at 3:00pm, V17 checked on R7. V17 stated R7 was pointing to his nose. V17 asked R7 if he wanted his oxygen and R7 nodded yes. V17 stated V34 was busy in another resident's room, and she told V34 to check on R7. V17 stated V34 exited the room and went to R7's room and assessed R7. V17 stated V17 left R7's room to assist another resident. V17 stated V17 went back to R7's afterwards and R7 had eyes open, leaning towards the right side in bed. V17 stated R7 asked for the head of bed to be raised a little higher. V17 stated R7 stated R7 was feeling cold, so V17 covered him with blanket. V17 stated she touched his skin and R7 was cold. V17 stated V17 did not notice any other staff in R7's room. V17 stated she did not return to R7's room to check on R7. On 9/21/23 at 9:55am, V9 (social services) and V8 (social services director) stated social services documents on a care plan conference form which is uploaded to the resident's electronic medical record. V8 and V9 stated the care conference on 9/19/23 was with R7's family via telephone. V9 stated on the evening of 9/18/23, at about 5:30pm, V21 (wound care coordinator) approached both V8 and V9 and	S9999		

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mentioned a decline in R7. V8 and V9 planned a care conference meeting with R7's family on 9/19/23. V8 and V9 stated V21 stated R7 had discoloration in fingers, appetite poor, slow speech, glazed eyes, and lazy vision. V8 stated V8 contacted R7's family and explained to family R7's medical condition. R7's family asked what to do next and V8 and V9 mentioned hospice care. V8 and V9 stated R7's family stated hospice was not an option and family wanted R7 to remain a full code.

On 9/21/23 at 10:05am, V21 (wound care coordinator) stated on 9/18/23 V21 saw R7 in the afternoon for wound care treatment. V21 stated R7 was lethargic. V21 stated R7 informed V21 he didn't feel like eating, he was not 'feeling great today'. V21 stated R7 was alert and oriented. V21 stated V21 explained the importance of eating for wound healing. V21 stated R7's skin was pale, fingertips were discolored, and skin felt cooler to touch.

On 9/21/23 at 1:30pm, V26 (nurse) stated V26 received a telephone call from the outside laboratory company on 9/18/23 in the afternoon. V26 was informed of R7's critically low sodium level. V26 stated V26 called V40 (attending physician) with laboratory test results and received order for sodium tablet orally immediately and then twice a day. V26 stated R7's family was present in R7's room and V26 informed family of R7's condition. V26 stated R7's family informed V26 R7 is not eating as much as before. V26 stated V26 explained R7's decline to the family, V8 (social services), and V2 DON. When questioned to clarify R7's decline, V26 responded R7 was not eating much. When questioned if V26 asked R7 about R7's change in appetite, V26 did not respond. When questioned

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S9999	Continued From page 16 regarding R7's potassium level dated 9/18/23 having an asterisk instead of a number value, V26 responded V26 was not aware there was no potassium level resulted. V26 stated R7's vital signs were stable. V26 stated V26 asked V21 (wound care coordinator) and V2 DON to assess R7. When questioned reason V26 asked other nurses to assess R7's medical status, V26 responded R7 wasn't eating much. When questioned reason V26 discussed changing R7's full code status to DNR (do not resuscitate) with R7's family if R7 was stable, V26 did not respond. Review of V26's progress note, dated 9/18 at 5:18pm, noted: all laboratory results informed to V40 with orders. Per V40, he referred V42 (renal physician) to see R7. R7's family member informed about R7's condition. R7's family member said R7 is not feeling well or eating today. V21 and V8 informed and updated R7's condition and talked about DNR (do not resuscitate) plan, but R7's family does not want DNR. On 9/26/23 at 11:12am, V40 (attending physician) stated V26 (nurse) called V40 with R7's laboratory results. V40 stated V26 informed V40 R7's potassium level was 5.3 (normal 3.6-5.0) and sodium level was 119 (normal range is 138-147). V40 denied being made aware R7's potassium was not resulted. V40 stated V40 consulted with V42 (renal physician) regarding sodium 119 and potassium 5.3. V40 stated V42 wanted CMP repeated on 9/19/23. V40 stated V40 spoke with V26 and ordered CMP for the following day. V40 denied being made aware of R7's change in condition - generalized weakness, slow speech, glazed eyes, lazy eyes, blue discoloration to fingertips, cool swollen hands, and poor appetite. V40 stated if V40 had been	S9999		

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S9999	Continued From page 17 informed of R7's condition or the potassium level not reported, V40 would have sent R7 to the hospital on 9/18/23 for further evaluation. V40 stated V40 can only work with the information the nurse provides. Review of R7's POS (physician order sheet), dated 9/18/23, does not note V26 entered orders for the renal physician consult or CMP test for the morning of 9/19/23. On 9/21/23 at 2:00pm, V2 DON (director of nursing) stated R7's family called the facility on 9/15/23 and requested an update on R7. V2 stated V2 informed R7's family R7 was okay. V2 stated during this phone conversation, R7's family expressed concerns of R7's poor appetite. V2 stated V2 did not receive any report from staff R7 was not eating well recently. V2 stated R7's family stated R7 has had a poor appetite for a while. V2 stated R7's family member didn't specify when R7's appetite changed. V2 stated R7's family thought maybe R7 was depressed and needed to see psychiatry. V2 stated V2 planned to put R7 on psychiatry's list to be seen. When questioned if V2 did put R7 on list, V2 responded the psychiatrist only comes to this facility on Fridays. V2 stated V2 spoke with R7 on 9/18/23 at 6:00pm after R7's family left. V2 stated V2 asked R7 how he felt, R7 informed V2 he was okay and everything was good. V2 stated V2 assessed R7 at time. V2 stated R7's hand was pale due to edema (swelling), head of bed was elevated 40 degrees, R7 was alert and oriented x 3. V2 stated R7's skin was dry, R7 felt warm but his left hand felt cool. When questioned if V2 compared the temperature in both hands, V2 responded V2 only felt R7's left hand, both hands were swollen. V2 stated R7 was re-admitted to this facility 8/26/23 with	S9999		

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generalized edema. The NP's (nurse practitioner) progress note, dated 9/8/23, was reviewed with V2. The NP noted R7 with trace edema to right lower extremity. When questioned if R7's bilateral hand swelling would be a change in condition and if the physician should have been notified, V2 responded this could be considered a change in R7's condition based on the documentation. When questioned if V2 contacted the outside laboratory company regarding R7's potassium level reported on 9/18/23 having an asterisk instead of a number value, V2 responded she did not notice the potassium level was not resulted. V2 stated V2 was aware R7's sodium level was critically low at 119 (normal range is 138-147). V2 stated V26 (nurse) notified V40 (attending physician) of the lab results and R7's medical condition. V26's progress note, dated 9/18/23 at 5:18pm, reviewed with V2. V26's documentation notes all labs informed to V40. There is no documentation noting V40 was informed of R7's current medical condition. V2 acknowledged if it's not documented, it wasn't done. V2 stated V26 should have documented R7's condition in detail and informed V40. V2 stated V26 took R7's vital signs 3-4 times and R7's vital signs were stable. V2 was informed R7's vital signs were documented on 9/18/23 at 10:45am. V2 acknowledged V26 should have documented all vital sign results obtained.

On 9/22/23 at 2:08pm, V34 (nurse) stated V34 was assigned to provide care for R7 on 9/19/23. V34 stated R7 wasn't as interactive with V34 as he had been earlier in September. V34 stated R7 recently had an above the knee amputation and thought R7 was depressed. V34 stated V34 asked R7 if R7 was okay because V17 CNA informed V34 R7 had not eaten breakfast or

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lunch day. V34 stated R7 informed V34 R7 was not hungry. V34 stated V34 took a break from 2:00pm until 2:45pm. Upon returning to nursing unit, V34 stated V34 went to R7's room. V34 stated R7 informed V34 he was fine, but R7 was not his usual self. V34 stated just before dinner, at 4:00pm, V34 instructed V17 to round on the residents. V34 stated V17 came and informed V34 R7 was not looking well. V34 stated V34 went to R7's room to assess R7. V34 stated R7 had oxygen at 3 liters via nasal cannula; V34 increased R7's oxygen to 4 liters and exited R7's room and went to the nurses' station. V34 stated V34 notified V2 DON R7 was not looking well. V34 stated V34 also contacted V40 (attending physician), but V40 did not respond. V34 stated V2 informed V34 if he thought R7 did not look well, V34 should send R7 to the hospital via EMS (emergency medical services) 911. V34 stated V34 called EMS 911. V34 stated V34 was printing the paperwork for EMS and hospital when another resident was complaining of increased pain. V34 stated V34 was in the other resident's room when EMS paramedics arrived at R7's bedside. V34 stated V34 exited room and observed the paramedics working on R7. V34 stated V2 came onto nursing unit 2-3 minutes after EMS arrived. V34 stated V34 did not receive any information regarding R7 from the off going nurse at morning. V34 stated V34 reads the residents' progress notes at the beginning of V34's shift, at 7:00am, but on 9/19 V34 did not read R7's notes until after this event. V34 stated V34 did not review R7's laboratory test results from 9/18.

On 9/27/23 at 12:40 pm, V34 (nurse) was asked to clarify 'not looking well'. V34 stated when V34 asked R7 if R7 was okay, R7 stated he was fine, but it was in a low voice and R7 was speaking

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slowly. V34 stated R7 did not respond per usual. V34 stated R7 was receiving oxygen at 3 liters per nasal cannula and oxygen saturation level was 94%. V34 increased oxygen to 4 liters and oxygen saturation level increased to 96%. V34 stated V2 came onto the nursing unit at 4:40pm. V34 stated V2 called EMS 911. V34 stated V17 CNA informed him another resident was complaining of pain. V34 stated he left R7's room and went to assess the other resident. V34 stated he went into R7's room just as paramedics were arriving; the paramedics immediately started performing CPR on R7. V34 stated R7's skin coloring was normal and warm and R7 did not exhibit any signs of labored breathing.

On 9/27/23 at 2:00pm, V34 stated he texted V2 DON at 4:38pm R7 didn't look right. V34 stated V2 came onto nursing unit. V34 stated he informed V2 of R7's vital signs. V34 stated V2 left R7's room to call 911. V34 stated no staff was at R7's bedside continuously monitoring R7 until EMS crew arrived at R7's bedside.

V34's progress note, dated 9/19/23, notes at 4:40PM - R7 seen with altered mental status, appears lethargic. Vital signs - blood pressure 154/84; heart rate 94; respirations 16 per minute; oxygen saturation level 91% on room air; blood sugar level 172. Oxygen per nasal cannula administered at 3 liters. At 4:50PM- 911 called.

On 9/26/23 at 11:23am, V45 (EMS paramedic) stated this facility called EMS at 4:54pm for an unresponsive resident. Upon arrival at R7's bedside, it was determined R7 was in cardiac arrest. V45 stated R7's skin appeared grey/cyanotic. V45 stated there were no staff present in R7's room when EMS arrived. V45 stated EMS connected R7 to a heart monitor and

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began CPR. V45 stated V45 was met outside of R7's room by a nurse. V45 stated she wasn't R7's nurse and was not able to provide any information to V45. V45 stated eventually V34 (R7's nurse) appeared and was able to provide some information to V45 regarding R7.

R7's EMS (emergency medical services) 911 run sheet, dated 9/19/23, notes 911 dispatch was notified at 4:54pm for an unresponsive resident. EMS crew were at R7's bedside at 4:59pm. The EMS crew found R7 in cardiac arrest. Per nursing home staff, R7 had last been seen "normal" approximately 30 minutes prior to calling emergency services. R7 was placed on a monitor which confirmed asystole (no heartbeat). Crew began chest compressions which would continue throughout the remainder of the resuscitative efforts and bagging via non-rebreather mask. A total of 5 epinephrine doses were given throughout efforts, with R7 maintaining asystole the entire time. The local hospital was contacted to end resuscitative efforts. Time of death 5:26pm.

On 9/22/23 at 10:25am, V41 (outside laboratory representative) stated all critical test results are called to the nurse. V41 stated the technician marked the potassium level with an asterisk because the results were questionable. V41 stated the potassium level test is a very sensitive test and a high level resulted on 9/18 and it needed to be repeated to verify the results. V41 stated V26 was notified on 9/18/23 at 2:24pm by the technician of the critical low sodium level. V41 stated it is up to the nurse to decide if the potassium level should be re-drawn or not when there is an asterisk instead of a number value.

On 9/26/23 at 3:28pm, V46 (diagnostic imaging

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S9999	Continued From page 22 company representative) stated R7's chest x-ray result was faxed to this facility on 9/13/23 at 6:34pm. V46 stated these results were also faxed to this facility today, 9/26/23, at 1:00pm. On 9/26/23 at 3:30pm, V2 DON stated the outside diagnostic imaging company will fax results or upload results directly into this facility's computer system. V2 stated the nurse should communicate any pending laboratory and x-ray results on the 24-hour shift report. V2 stated all the nurses should follow-up with pending results and notify the physician of the results when known. R7's chest x-ray results, dated 9/11/23, notes study limited by R7's suboptimal inspiration. Faint retrocardiac infiltrate could represent a small focus of pneumonitis. Correlate clinically. Follow-up chest radiographs recommended after medical management. There is no documentation found in R7's medical record noting R7's chest x-ray results were reviewed by the nurse and relayed to V40 (attending physician). R7's CMP (comprehensive metabolic panel), dated 9/18/23, notes R7's sodium level was critically low at 119 (normal range is 138-147). It also notes an asterisk for R7's potassium level. R7's meal intake for September 2023 notes on 9/17, R7 consumed 0-25% of each meal. There is no documentation noting R7 consumed any meals on 9/18 and 9/19. R7's POS (physician order sheet), dated 9/10/23, notes V44 (infectious disease physician) ordered a chest x-ray.	S9999		

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S9999	Continued From page 23 R7's progress notes: On 9/15 at 9:17pm, V2 DON noted: returned R7's family member's phone call tonight, R7's family concerned about R7's weakness, mental status, and poor appetite. Reviewed R7's labs, last potassium 5.3, sodium 128, blood pressure 135/75, temperature 97.6, respirations 19/minute, pulse 80 beats per minute, oxygen saturation level 97%. Blood culture and chest x-ray results still pending. Called V44 for new orders. V44 ordered CBC and CMP in am, 9/16. On 9/18, V9 (social services) noted V21 (wound care coordinator) reported change in wound status and noticed a decline in care: discoloration in fingers/wound, slowed speech, glazed eyes, and lazy vision. V8 (social services director) called R7's family member for family meeting at 10:30AM on 9/19/23. This facility's resident change in condition policy, reviewed 9/21/23, notes when there is a change in condition, the nurse will perform an assessment, provide immediate nursing interventions, continue to monitor, and follow current order to manage symptoms/emergent situations. (AA) Statement of Licensure Violations (4 of 4): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 24 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999		

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S9999	Continued From page 25 and assistance to prevent accidents. 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. These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to monitor/supervise a resident requiring assistance in the shower room and failed to ensure effective fall prevention interventions were in place to prevent fall incidents. This affected 2 of 4 residents (R19, R2) reviewed for falls and fall prevention. This failure resulted in R19 being in the shower room, unmonitored, experiencing an unwitnessed fall sustaining a cervical spine fracture requiring immediate surgery. This failure also resulted in R2 having four falls in three weeks. Findings include: 1. On 10/6/23 at 12:24pm, V30 (Nurse) said she was passing medications and overheard R19 reporting to staff at the nursing station that R19	S9999		

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fell in the shower room and bumped her head. V30 was unable to identify staff by name (agency, female, African American) R19 was talking to at time. V30 said R19 said R19 hit her head. Physical assessment completed no visible injuries but when V30 touched the right side of R19's forehead, R19 had pain. R19 had left or right hip was painful also. V30 stated she told R19 to stay in the room but r19 insisted on walking to the church services. V30 stated she called V2 (DON) and was instructed to send R19 out 911. V30 stated R19 usually goes to the shower room herself. R19 will usually ask if she can shower. The shower room is not locked. Usually someone will supervise her while in the shower and unsure if anyone was with her at time. V30 stated R19's hair was wet and R19 had her walker but no oxygen at time. V30 stated R19 is alert and oriented x 3 and uses rolling walker. V30 stated R19 uses an oxygen concentrator in her room and will get a portable tank that hangs on her walker if she leaves the room. There was no portable oxygen in her room or with R19. V30 stated R19 went down to church without oxygen but V30 checked R19's oxygen saturation level and it was 93-94% on room air. EMS (emergency medical services) arrived.

On 10/6/23 at 1:28pm, V2 DON (director of nursing) stated V30 (nurse) reported to V2, R19 had a fall in the shower. V2 stated R19 is a poor historian and can be delusional. V2 stated R19 had an unwitnessed fall in the shower on 10/1/23. V2 stated R19 walks by herself with a rolling walker. V2 stated residents must let staff know before he/she takes a shower so staff can make sure no other resident is in shower. V2 stated the restorative nurse does an assessment to determine if a resident is safe to shower

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S9999	Continued From page 27 independently. V2 stated the resident's care plan will have documentation if the resident can shower independently. R19's functional abilities assessment, dated 8/9/23, notes for shower/bathing, R19 requires partial/moderate assistance from staff. R19's care plan notes R19's memory is impaired, initiated 11/12/21. R19 has problems with decision-making, insight, logic, calculation, reasoning, planning, organization, sequencing, and judgement. R19's ADL (activities of daily living) care plan, initiated 12/2/22, notes R19 has a self-care deficit and requires assistance with ADLs to maintain the highest level of functioning. Intervention identified R19 requires assistance of one staff member for bathing. R19's falls care plan, initiated 12/2/22, notes R19 is at risk for falls as evidenced by the following risk factors and potential contributing diagnoses - decreased strength and endurance, cardiomyopathy, dementia. Interventions identified on 12/2/22 - nursing staff will complete a fall risk assessment per facility fall protocol and follow facility fall protocol. Review of R19's medical record notes R19 with diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease), heart failure, hypotension, cardiomyopathy, unsteadiness on feet, lack of coordination, and dependence on supplemental oxygen. Review of R19's POS (physician order sheet) notes an order for oxygen at 4 liters via nasal cannula continuous.	S9999		

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S9999	Continued From page 28 Review of R19's hospital medical record, dated 10/1/23, notes after fall at this facility, R19 found to have severe flexion teardrop fracture of C5 (cervical spine, 5th vertebrae) vertebral body with subluxation ligamentous injury posteriorly, as well as concern for anterior longitudinal ligament rupture. R19 hesitant to move due to the pain. R19 was admitted to the neurological critical care unit after anterior cervical corpectomy C5-C6, anterior plate and cage C4-C7, and posterior fusion C2-T1 Review of R19's fall risk assessment, dated 9/28/23, notes R19 is at high risk for falls. R19's MDS (minimum data set), dated 8/9/23, notes R19's BIMS (brief interview of mental status) score is 5 out of 15, bathing requires extensive assistance of one staff member. R19's MDS, dated 2/10/23, 5/11/23, and 8/9/23, notes R19 has not exhibited any behaviors. This facility's incident report, dated 10/1/23, notes R19 is alert and oriented to person and place. Predisposing physiological factors: confused and gait imbalance. It notes R19 insists on privacy and independence and non-compliance with shower schedule. Review of R19's POC (point of care) charting for the past 30 days notes R19 required physical assistance of one staff member with showers on 9/8, 9/9, 9/13, 9/14, 9/17, 9/18, 9/20, 9/21, 9/23, 9/26, 9/29, and 9/30. R19 required supervision of one staff member with showers on 9/12, 9/22, and 9/24. R19 required physical assistance of one staff member for bed baths on 9/7, 9/11, 9/13, 9/16, 9/18, 9/19, 9/20, 9/23, and 9/30.	S9999		

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S9999	Continued From page 29 Review of R19's medical record does not note any documentation R19 insists on privacy and independence and is non-compliant with shower schedule. This facility's fall prevention and management policy, dated 10/29/21, notes high risk residents for falls will receive individualized interventions. High-risk fall precautions will be implemented for residents whose scores on fall risk screen shows high risk. Staff will remain with the resident when assisted to the bathroom. Interventions will depend on identified and assessed risk factors, including root cause(s) after each fall. 2. R2 was admitted on 7/18/22 with a diagnosis of hemiplegia following cerebral infarction affecting left side, end stage renal disease, type II diabetes, morbid obesity, atrial fibrillation, hypertension, heart disease, hyperlipidemia, dementia with behavioral disturbances, chronic kidney disease, extrarenal uremia, major depressive disorder, lack of coordination, muscle weakness, limitation of activities due to disability. R2's brief interview for mental status dated 7/18/23 documents: 05/15 which indicates severe cognitive impairment. R2's minimum data set dated 7/18/23 documents under functional status: transfer indicates 3-extensive assistance (resident involved in activity; staff provide weight -bearing support and 3- two persons physical assist; bed mobility documents 3-extensive assistance (resident involved in activity; staff provide weight -bearing support and 2 indicating one-person physical assist. Under balance during transitions and walking documents a score of 2 not ready, only able to stabilize with staff assistance for moving from seated to standing	S9999		

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S9999	Continued From page 30 position, walking, turning around. Moving on and off toilet, surface to surface transfer. R2's incident report dated 7/12/23 documents: writer called by staff member that resident was on the floor. Resident observed sitting on the floor. Resident stated, "I fell on the floor on my butt while trying to move to the side of the bed". R2's care plan Interventions created on 7/17/23 with initiated date of 7/13/23 documents fall 7/12/23 visual cue to be placed in the room to ask for assistance. Physical therapy to continue reinforce safety with patient. R2's incident report dated 7/24/23 documents: writer called by staff member that resident was on the floor. Resident observed lying on the floor. Resident stated, "I was too close to the end of the bed and fell on the floor while trying to move to the side of the bed". R2's care plan Interventions created dated 7/24/23 document low bed and floor mats. Interventions created date 7/27/23 with an initiated date 7/25/23 documents fall 7/24/23 educate on proper transferring techniques. R2's incident report dated 8/1/23 documents: Patient was on the floor, sitting and leaning on the bedside, trying to get up. Resident stated he was trying to get to the door. R2's care plan Intervention created date 8/4/23 documents bed rest after dialysis and wheelchair for locomotion for fall 8/1/23. R2's dialysis treatment information dated 8/3/23 documents under nurse's notes: patient alert and conscious, a bit aggressive, slip on the floor while	S9999		

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S9999	Continued From page 31 trying to transfer to wheelchair, complaints of pain in the hips afebrile. On 9/22/23 at 12:48PM, V2 (DON) said R2 had a short temper and did not like people telling him what to do. R2 had a wheelchair and sometimes he would follow direction and other times he would forget. V2 said she is unsure where they previous staff documented root cause of falls. On 9/26/23 at 3:36PM, V2 (DON) said a resident with a brief interview score of five is a lower score and has lower cognition. Fall interventions should be placed as soon as possible after a fall based on the cause of the fall. When asked how these interventions were effective in preventing R2's falls, V2 said that he had a behavior of trying to get up and leave the building. Staff would redirect resident as needed. On 9/22/23 at 12:06PM, V33 (restorative nurse) said she updated fall care plans but did not help with the development of interventions. Interventions would be placed after cause of fall determined. V33 said she only wrote in the care plan with whatever the new intervention was at the time. When asked if R2 would be able to remember and be educated on proper transferring techniques, V33 said she did not know and that previous staff had developed interventions. V33 verified the that the created date is when intervention was put into the care plan. R2's fall care plan created on 7/28/23 documents R2 is at risk for falls as evidenced by the following risk factors and potential contributing diagnosis: diabetes, end stage renal disease, generalized muscle weakness, atrial fibrillation, and hypertension. Interventions created on 12/7/22: "I	S9999		

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S9999	Continued From page 32 would like staff to review information on my past falls and attempt to determine the cause of my falls; Staff to provide me with a safe environment with floors free from spills and clutter, a working call light, be din lowest position at night, bed mobility positioning devices and transfer devices to support highest level being; complete fall risk assessment per facility fall". Interventions dated 12/8/22 document: "Ensure I'm wearing proper footwear and check to ensure that bed brakes are locked prior to transferring". Interventions on 7/28/22 documents: Physical therapy and occupational therapy, anticipate needs, place call light in reach and encourage use, follow fall policy. Facility falls prevention and management policy reviewed 11/10/22 documents: facility is committed to its duty of care to residents and patients in reducing the risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. Under fall risk screening: high risk residents and patient falls will receive individualized interventions as appropriate to risk factors. High risk precautions will be implemented to residents and patients who scores on resident/family notification fall risk screen shows high risk will be considered on this precaution. Universal fall precautions will be implemented in addition to high risk fall precaution interventions; pharmacy medication review; physical therapy and occupational therapy evaluations; restorative program; room near the nursing station. Procedure for post- fall management: post fall observation will be completed; perform verbal assessment to cause for fall and potential for injury; perform physical assessment including head to toe assessment, vital signs, range of motion and neurological	S9999		

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S9999	Continued From page 33 assessment as indicated; notify the provider and family; document fall event under risk management; nurse with knowledge of the event will document pertinent facts in the medical record. Other staff will be interviewed and or written witness statements will be completed. Under fall response: evaluate and monitor resident for 72 hours after the fall; investigate fall circumstances; Under procedures for fall with potential head injury: falls where patients/residents may have sustained a head injury or on blood thinners will be assessed for neurological check. R2's fall risk review dated 7/24/23 documents high risk for falls. (A)	S9999		