STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004246	A. BUILDING: _____ B. WING _____	C 11/20/2023

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ASCENSION HERITAGE VILLAGE	901 NORTH ENTRANCE AVENUE KANKAKEE, IL 60901

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S 000	Initial Comments Investigation of Facility Reported Incident of October 30, 2023/IL166343	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1035a)2)3)4)5) 300.1035c)1)2) 300.1035d) 300.1035e) 300.1035g) 300.1035h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1035 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: 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. (Section 2-104.2 of the Act); 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. c) Within 30 days of admission for new residents, and within one year of the effective date of this Section for all residents who were admitted prior to the effective date of this Section, residents,	S9999		

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S9999	Continued From page 2 agents, or surrogates shall be given written information describing the facility's policies required by this Section and shall be given the opportunity to: 1) execute a Living Will or Power of Attorney for Health Care in accordance with State law, if they have not already done so; and/or 2) decline consent to any or all of the life-sustaining treatment available at the facility. 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. e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70] g) The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act. 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	S9999		

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S9999	Continued From page 3 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. 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 300.3240 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) This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the facility failed to initiate CPR (Cardiopulmonary	S9999		

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S9999	Continued From page 4 Resuscitation) for a resident (R2) with full code status. The facility also failed to have a system in place to ensure that Advance Directives were accurate and complete (R1, R5, R11, R12). These failures resulted in R2 not receiving CPR as desired; and R1 being sent to the hospital, intubated, and later compassionately extubated at the hospital. These failures have the potential to affect all 22 residents residing in the facility. B. Based on interview and record review the facility failed to keep a resident free from neglect when they failed to notify the physician of a change in condition, provide medications as ordered, and initiate cardiopulmonary resuscitation. This applies to 1 of 12 residents (R2) reviewed for advanced directives in a sample of 14. This failure resulted in a potentially avoidable death when R2's change in condition was not addressed. R2 was later observed unresponsive and resuscitation and/or emergency interventions were not initiated. R2 expired unexpectedly. Findings include: The November 9, 2023 Facility Data Sheet showed 22 residents reside at the facility. 1. R2's Face Sheet dated 11/7/2023 identified R2 as a 72-year-old female admitted to the facility on 11/7/2023 with diagnoses to include Rhabdomyolysis and DVT (Deep Vein Thrombosis). The Department of Public Health Practitioner Ordered for Life Sustaining Treatment Form (POLST), completed 11/8/2023, documents R2 as a full code.	S9999		

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S9999	Continued From page 5 On 11/14/2023 at 12:50 PM V12 (Certified Nursing Assistant/CNA) stated around 8:20 PM 11/9/2023 R2 was moaning and groaning like she was in pain and was breathing abnormal when she was moved. V12 stated she couldn't stand as she could the previously when V12 cared for her and V7 (Agency Licensed Practical Nurse) was informed that something was wrong. On 11/13/2023 at 12:33 PM V4 (Registered Nurse Manager) stated a voicemail was left for V2 (Director of Nursing) by V7 on 11/9/2023 at 8:25 PM. V4 stated she is covering while V2 is on vacation, therefore, V2 forwarded the voicemail to V4. V4 replayed the voicemail for the surveyor and the message heard included "... (R2's) breathing was not stable...I do not know what to do...." V4 stated she called V7 at 8:35 PM and instructed V7 to contact V3 (Medical Director) for further instructions to address R2's shortness of breath. V4 stated she became aware the next morning V7 did not contact V3 as instructed. R2's Nursing Notes dated 11/10/2023, completed by V6 (Agency Registered Nurse), document, "Received report from night nurse at 7:35 AM that resident expired in bed at 7:10 AM. Verified death at 7:45 AM, no respirations, no pulse, no BP (blood pressure). Notified MD (physician) of resident death that resident expired at 7:50 AM." On 11/13/2023 at 12:48 PM, V8 (Certified Nursing Assistant) stated around 6 AM on 11/10/2023 she observed R2 in her bed without any concerns, asleep and breathing. V8 stated sometime shortly after 7 AM she went back into R2's room and she noted R2 was not breathing. V8 stated R2 was newly admitted, and she was not aware of her code status, so she immediately alerted V7	S9999		

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S9999	Continued From page 6 (Agency Licensed Practical Nurse), also requesting V7 to check the code status. V8 stated V7 responded to the room, assessed R2, but did not start cardiopulmonary resuscitation (CPR) so she assumed R2 was a DNR. On 11/13/2023 at 11:52 AM V6 (Agency Registered Nurse) stated, when she arrived to begin her shift on 11/10/2023 at approximately 7:35 AM, V7 reported to her that R2 had expired at 7:10 AM. V6 stated V7 also reported around 8:30 PM on 11/9/2023 R2 was short of breath, and she provided R2 a pain pill which seemed to help. On 11/14/2023 V3 (Medical Director) stated he had reviewed R2's history and confirmed R2 was 72 years old with no apparent prior significant medical history, a full code status, and was living at home independently prior to her 11/4/2023 hospitalization for DVT and Rhabdomyolysis. V3 stated the night before R2 passed, she was having difficulty breathing and the agency nurse was instructed by a facility nurse manager to call him, and the agency nurse did not. V3 stated, "Unfortunately they didn't call me. I would have sent her to ED (Emergency Department). They would have completed a cardiac work-up and evaluated her symptoms. She had a DVT in the leg and it could have been a pulmonary embolus. Did the nurse really give her Eliquis? If they did, it was likely not a clot. Who knows? One thing I do know is they should have called me." V3 confirmed R2's death was potentially avoidable, further stating, "Yes, calling me to report her breathing the night before as instructed and implementing CPR could have potential changed the outcome. My job is to take care of my patients. They did not give me the opportunity to care for her. I cannot say she would have lived,	S9999		

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S9999	Continued From page 7 but ED would have evaluated her and if they found something, treated it..." V3 stated he was aware an agency nurse failed to code R2 when she was found expired in bed on 11/10/2023 and he expects them to initiate CPR if they are a full code status as she was. R2's Hospital Discharge Instructions 11/7/2023 documents R2 to receive Eliquis 10 milligrams twice daily for 7 days. R2's November 2023 EMAR (Administration Record) documents R2 did not receive Eliquis 10 milligrams on 11/7/2023 at 4 PM and 11/8/2023 at 8 AM and 4 PM. R2 received oxycodone-acetaminophen 10-325, 1 tablet, 11/9/2023 at 8:48 PM. On 11/16/2023 at 9:45 AM V2 (Director of Nurses) confirmed R2 did not receive her Eliquis as ordered for the treatment of her DVT and should have. V2 stated the first dose she received after admission was the morning of 11/9/2023. The policy Change in Resident's Condition or Status dated 2/2022 documents the facility shall promptly notify the residents healthcare provider of changes in the resident's medical condition or change in status. The facility's code blue policy dated 01/2023 documents, "The Procedure: Cardiopulmonary Resuscitation (CPR) and Code Blue policy documents if an individual is found unresponsive and not breathing the staff member who is certified in CPR shall initiate CPR. The chances of surviving sudden cardiac arrest may be	S9999		

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S9999	Continued From page 8 increased if CPR is initiated immediately upon collapse." The facility Serious Injury and Communicable Disease Report dated 11/10/2023 documents at 7AM R2 was found unresponsive and not breathing. The investigation determined R2 was a full code status and CPR was not administered. The facility Abuse Prevention policy dated 6/2020 documents the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish or emotional distress. The community's goal is to achieve and maintain an abuse free environment. As part of the resident abuse prevention program, the administration will provide a safe resident environment and protect the residents from abuse by anyone including, but not limited to community associates, other residents, consultants, volunteers, associates from other agencies, family members, legal representatives, friends, visitors, or any other individual. 2. R1's Face Sheet dated 10/25/2023 documents R1 as a 95-year-old admitted to the facility on this date at 9:42 PM with diagnoses to include herpes viral disease. R1's emergency contact is listed as V9 (R1's Daughter). R1's October 2023 Physician Ordered Sheet shows R1 with a Do Not Resuscitate Order (DNR/do no attempt CPR) dated 10/25/2023. On 11/9/2023 at 9:20 AM, V4 (Registered Nurse Manager) stated on 10/30/2023 she provided R1 medications at approximately 8:30 AM and R1 was talking and had no identified change. Approximately an hour later R1 was not	S9999		

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S9999	Continued From page 9 responding but was breathing and had a pulse; 911 was called. During this event V4 was unable to locate R1's POLST form but there was a physician order in the electronic medical record (EMR) indicating R1 was a DNR. V4 stated without the POLST form the resident is always a full code and considered without advanced directives so the DNR order was not honored. V4 contacted R1's family who stated R1 was a DNR. A final Serious Injury and Communicable Disease Form dated 10/30/2023 documents R1 was found unresponsive but was breathing and had a pulse. This form documents a POLST form could not be located and V9 (R1's Power of Attorney/POA) was contacted and confirmed R1's code status as no intubation or CPR; R1 was transferred to the hospital due to not having a POLST form. R1 was intubated at the hospital where she expired later that day. The facility investigation identified the POLST form had not been completed after admission on 10/25/2023. R1's Initial Emergency Department (ED) History and Physical dated 10/30/2023 at 10:22 AM documents R1 with respiratory arrest and arriving in the emergency room biting at her intubation tube which was placed by emergency medical personnel prior to arriving to the ED. This report shows R1 was found with bradycardia (slow heart rate) and liver shock. R1's ED Triage Notes 10/30/2023 at 10:13 AM show R1 arrived in the ED in respiratory distress, breathing over the intubation tube and fighting the placement of the tube. R1's Social Service/Case Manager Note, dated 10/30/2023 at 12:27 PM, completed by V10 (Hospital Social Worker), documents V9 as R1's	S9999		

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S9999	Continued From page 10	S9999		

POA. This note documents V9 reporting to V10 on the phone, a DNR had been done previously at another hospital, but it was unsigned by the physician (invalid). V9 stated R1 was not supposed to be intubated. V10 made V9 aware that R1 was currently intubated, and V9 stated no treatment was to be discontinued until V9 arrived at the hospital to assess R1. V9 provided V10 with direction to include R1 was not to receive CPR and was to be provided comfort treatment only. V10 initiated the DNR per V9's wishes, had the physician sign and the advanced directive was implemented after the phone conversation.

The ED Note 10/30/2023 at 3:40 PM documents V9 agreed R1 could be extubated under comfort measures.

The ED Notes Addendum 10/30/2023 at 4:47 PM documents R1 expired at 4:38 PM.

On 11/9/2023 at 10:27 AM, V5 (Social Service Director) states upon admission the admitting nurse is to clarify advance directive status and V5 then additionally meets with resident and/or family to verify and discuss their advanced directive wishes. V5 stated R1 arrived at the facility on 10/25/2023 late in the evening and V5 was busy on 10/26-27/2023 and unable to find time to meet with R1 and/or family to review R1's advanced directive status. V5 stated it is facility policy that all residents are a full code until a completed, signed POLST form is received.

On 11/13/2023 10:45 AM, V5 further stated, advanced directives are completed within the first 24 hours except weekends, in which V5 then follows-up on the following Monday. V5 stated she is responsible to follow up with the resident's physician to obtain a signature to activate the

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S9999	Continued From page 11 POLST form. V5 verified on weekends no staff are available at the facility to finalize advanced directives. V5 stated she educates the resident and family at the time of completion of the POLST that it will not be in effect until the physician signs. 11/14/2023 at 10:59 AM, V3 (Medical Director) stated he was aware R1 was admitted to the facility on 10/25/2023 and her advanced directives were not obtained timely after her admission. V3 stated on 10/30/2023 R1 was noted unresponsive, and the facility did not have her POLST form showing her as a DNR. V3 stated when the facility called him, he instructed them to send R1 to the emergency department (ED) and R1 was intubated. V3 stated he spoke with R1's family at the hospital and they were upset she had been intubated. V3 stated after further discussions in the ED, R1's family decided to extubate her where she passed away shortly after. V3 confirmed that the facility should have advanced directives put in place timely so R1's wishes (DNR) could have been addressed at the time she had a change in condition. V3 stated, "Yes, she would have had a more peaceful death had she remained at the facility as a DNR status." V3 confirmed if her advanced directives had been in place R1 would not have experienced the trauma from insertion of the intubation tube, hospital transfer, and unnecessary treatments. 3. R11's Face Sheet dated 11/11/2023 documents R11 admitted on this date. On 11/13/2023 at 11:20 AM R11 stated, "Today is the first time they (advanced directives) were discussed." R11's POLST form dated and signed by V3 on	S9999		

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S9999	Continued From page 12 11/13/2023 shows R11 requests no intubation or mechanical ventilation. R11's BIMS dated 11/17/2023 documents R11 as cognitively intact. 4. R5's Face Sheet dated 10/25/2023 documents R5 admitted on this date. On 11/13/2023 at 11:30 AM, R5 stated she has a POLST form completed through a lawyer years ago and requesting no intubation. R5's POLST form dated 11/1/2023 shows R5 requests all treatment, including intubation. R5's BIMS dated 10/30/2023 documents R5 as cognitively intact. 5. R12's Face Sheet dated 11/8/2023 documents R12 admitted on this date. R12's POLST form signed on 11/10/2023 shows R12 as a DNR. R12's November Physician Orders List shows R12's code status as full code dated 11/9/2023. 11/13/2023 at 11:52 AM, V6 (Agency Registered Nurse) stated, "It is not correct, I will fix that." R12's November Physician Orders form documents a new ordered dated 11/13/2023 for R12 to be a DNR. The policy Advanced Directives dated 3/2023 states it is the policy of the facility to inform residents/residents representatives about Advanced Directives to assist those who wish to complete advanced directives, honor choices	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004246	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION HERITAGE VILLAGE	901 NORTH ENTRANCE AVENUE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 identified in the advanced directives and to maintain records of advanced directives. Upon admission, the resident will be provided with information concerning the right to refuse or accept treatment and to formulate an advanced directive if he or she chooses to do so. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's representative. Prior to or upon admission of a resident the Social Services Director or designees will inquire about the existence of any written advance directives. Advanced directives shall be displayed prominently in the medical record. If the resident indicates that he or she has not established advanced directives, the facility will offer assistance in establishing advanced directives. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. A resident will not be treated against his or her own wishes the Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medial record. "AA"	S9999		