STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004782	A. BUILDING: _____ B. WING _____	C 03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IONA GLOS SLC	50 SOUTH FAIRBANK STREET ADDISON, IL 60101

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Z 000	COMMENTS INCIDENT INVESTIGATION OF 3/4/19 /IL00110315	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	Z9999	**Attachment A** **Statement of Licensure Violations**	

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resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on record review, and interview, nursing failed to ensure emergent life sustaining measures were implemented and performed immediately for 1 of 1 client in the sample who suffered a heart attack, and was pronounced deceased by emergency dispatched personnel at the facility (R2).

Findings include:

The Summary of Deceased involving R2, was reviewed. The summary indicates that R2 was found unresponsive on her bedroom floor at approximately 6:30am on 3/4/19 by a direct care staff member. R2 was observed lying on the floor, pulse less, and was not breathing. CPR was performed until paramedics arrived. R2 was pronounced deceased. Pending cause of death is myocardial infarction (heart attack). R2 was a 41-year-old female who had no known history of heart disease. Her diagnoses included severe Intellectual Disability, Autism, Psychotic Behavior, history of seizures, and Hypothyroidism. She was on 15-minute checks in the home. (Home 3).

Z1(Agency CNA) was interviewed by the Assistant Facility Director (E2) on 3/6/19 at 2:30pm, as part of E2's investigation. During the interview, Z1 expressed that Z1 was told during report from the second shift direct care staff (E5) that R2 stated she wasn't feeling well. Z1 stated that around 4:30am, she was informed by her co-worker (Z2, Agency caregiver), that R2

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needed assistance because she was observed with bowel movement on her pants. Z1 stated that she changed her clothes, pull up, and wiped her down. Z1 stated that R2 told Z1 that she did not feel well. (There is no indication in this report if this information was passed onto R2's nurse). Z1 stated that as she went to get clients up for the day, when she entered R2's bedroom, R2 was found on the floor. Z1 touched R2 and stated that she felt cold. Z1 stated that she left the room and yelled out that she needs help and that she thought R2 was dead. Z1 stated that someone called a medical stat, but she wasn't sure who called it, as people were arriving into the home. The report does not indicate if Z1 started CPR, as she found R2 cold, and thought R2 was dead. Z1 was unable to be contacted for interview by this writer.

Z2 (Agency caregiver) was interviewed by E2 during her investigation process on 3/4/19 at 2:00pm. During her interview with E2, Z2 stated that she was not assigned to R2, but rather, Z1 was assigned to R2, and that E5 was assigned to R2 on the PM shift. Z2 stated that E5 reported to her that R2 had a runny bowel movement, and a hard movement during the second shift. E5 also reported that R2 did not eat her dinner either. Z2 confirmed that she saw R2 around 5:00am in her bedroom, soiled with bowel movement and informed Z1 that R2 needed assistance to be cleaned up. Z2 stated after Z1 cleaned R2 up, Z1 put R2 back to bed. Z2 stated that at 6:30am, she heard Z1 yell out that she thinks R2 is dead. Z2 stated that she ran into R2's bedroom. Z2 stated that she assessed R2, and noted that R2 did not have a pulse, and was cold to the touch. Z2 stated that she left the room, and attempted to call 911, but she was so upset, that she could not dial the number, so she instead sought the

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assistance of another staff in the home (E6, Direct Care Staff). E6 assisted her with calling the Coordinator (not 911). The Coordinator(E7) then called 911. Z2 did not start CPR, even though she determined R2 to be pulse less, not breathing, and cold to the touch.

During an interview with Z2 by this writer on 3/15/19 via the telephone at 12:15pm, Z2 stated that she was told personally by E5 that R2 had loose stools coming out, big, and then hard, back and forth. Z2 stated that she went to look in the log book to confirm how many stools, but none were recorded on the log as they should have been. E5 also reported to her that R2 kept saying that she didn't feel well. Z2 was asked if E5 had reported the loose stools, or the complaint of not feeling well to nursing, but Z2 stated she was not sure. Z2 stated that normally R2 is continent of urine and stool, and only wears an incontinent pad at night for an occasional accident. Z2 stated that when she saw R2 at 5am, R2 had a large amount of stool over her pajamas, falling off her clothing, Z2 stated that Z1 had to clean R2, as well as her bedding, because it too was soiled with stool. Based on record review, and interview, nursing failed to ensure emergent life sustaining measures were implemented and performed immediately for 1 of 1 client in the sample who suffered a heart attack, and was pronounced deceased by emergency dispatched personnel at the facility (R2).
The Procedure Number entitled, "Stat Calls", dated 10/18 was reviewed. The procedure states that a medical stat should be paged for any medical emergency that requires immediate assistance. Medical stats can include choking, uncontrollable bleeding, falls or an unresponsive person. Directions are provided on how to call a medical stat. The procedure dictates that 911

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should be called immediately before calling the STAT. The medical stat should be called by using the intercom by pressing #01. The procedure also indicates that all nurses should respond to the medical stat, and that one nurse should bring the crash cart from the Core building to the respective home. (In this case, it would be Home 3). Z2 did not call 911 first as their procedure states, but rather called the coordinator to call 911. Z2 also called the medical stat before calling 911.

During an interview with this writer on 3/14/18 at 1:40pm, E8(Licensed Practical Nurse) verified that he was the first person in the home to start CPR on R2. E8 explained that when he heard the medical stat being called, he immediately ran from the Core building where he currently was and ran to Home 3(R2's home). E8 stated that when he entered R2's bedroom, he saw E9 (Licensed Practical Nurse) in R2's room. E8 was asked if E9 was performing CPR at that time. E8 stated that he thinks E9 was trying to take R2's blood pressure, but she was not doing CPR. E8 stated that E9 directed him to grab the oxygen tank, so he ran out and grabbed it from the closet. E8 stated that when he came back into the room, E9 was still trying to obtain a blood pressure reading, so that was when he stated that CPR needed to be started. E8 explained that he could see that R2's lips were blue and looked to be not breathing. E9 then stood up and let me do CPR. E8 was asked what E9 did once he started CPR. E8 stated that she just backed away and stood behind him. E8 stated then a third nurse entered the home and assisted him doing CPR. E8 stated that he had to perform mouth to mouth until the next nurse came into the room and could assist with an ambu bag. E8 offered that he wondered why E9 had not been

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doing CPR, but rather, waited until he came into the room to start CPR. E8 also offered that he thought it was strange that E9 did not offer to assist administering CPR to R2. E8 was asked how long it took him to run from the Core building and then obtain the oxygen tank as E9 directed him to do. E8 stated that it was at least a minute to run from the Core building to Home 3, and then another 30 seconds to obtain the oxygen tank, so a total of approximately 1 minute 30 seconds. E8 offered he does not know how long it was that R2 had been lying on the floor, until the medical stat was called though. E8 was asked where Z1 and Z2 were. E8 stated he is not sure, but no other staff were around. E8 stated that he heard one of the direct care staff crying up by the dining room area, but he does not know who that was. E8 stated that the nurse that assisted in administering CPR to R2 with him was E10 (Licensed Practical Nurse). E8 was asked if it is typical to try to obtain a blood pressure when someone is already pulse less and not breathing. E8 stated that it is not typical and wondered why E9 why trying to obtain one. E8 stated that their CPR policy does not indicate that you should attempt to obtain a blood pressure reading once someone is determined to have no heart rate and is not breathing. E8 was asked what time he entered the room. E8 stated that he did not really look at his watch, but thinks it was around 6:25am. E8 was asked if E9 was R2's nurse assigned to her that day, and E8 confirmed that she was. E8 stated that soon after, the emergency personnel arrived, and they took over CPR.

The untitled Procedure for CPR-Cardiopulmonary Resuscitation was reviewed. The procedure states that you should assess for breathing and pulse for 10 seconds. Once it is determined that

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the client has no pulse and is not breathing, you should shout for help, and direct someone to call a medical stat. If the client is not a DNR (Do not resuscitate), begin CPR. The person should be on a flat surface if possible. This procedure does not indicate that you should obtain a blood pressure. It also does not indicate when 911 should be called. Z1, Z2 and E9 all determined that R2 was pulse less and not breathing, yet none of the above-mentioned staff started CPR. It was not until E8 entered the home, when CPR was finally started. Z1 and Z2 both left R2 instead of staying in the room with the client, performing CPR.

During an interview with E9 (Licensed Practical Nurse) via the telephone with this writer on 3/13/19 at 2:00pm, E9 confirmed that she was the nurse assigned to R2 the morning R2 passed away. E8 stated that Z1 came into another client's bedroom where she was passing medications and stated to come and check R2. E9 stated that Z1 then started to run down the hall to the dining room, so she started to follow her. E9 stated that when Z1 realized that she was following her, she turned around, and asked me why she was following her. Z1 told her that R2 was in her bedroom. Z1 then continued to go into the dining room area. E9 stated that when she entered R2's bedroom, she found R2 on the floor with only her incontinent pad on. E9 stated that she immediately covered her up, because she wanted to provide for her privacy. E9 stated that she felt R2 and she felt cold. She watched for the rise and fall of her chest and noticed that she was not breathing. When she checked for a pulse, there was none. Then she decided that she should move some of the furniture out of the way, so she could make room to start CPR. R9 stated that she also tried to obtain a blood

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pressure reading, but the machine would not register. E9 explained that Z1 never told her that she thought R2 was dead, (as she told Z2). E9 stated that when E8 arrived in the room, she directed him to obtain an oxygen tank. E9 stated that when he returned with the oxygen tank, E8 suggested that she should stop trying to obtain a blood pressure reading, because R2 needed CPR. E9 stated that was when E8 performed CPR. E9 was asked if anyone was in the room, when Z1 told her to go and see R2. E9 explained that no staff was with R2. E9 was asked why she did not start CPR, as she determined that R2 did not have a heart rate and was not breathing. E9 stated that she was trying to move furniture out of the way. E9 offered that she wondered why Z1 or Z2 had not started CPR though. E9 was asked if Z1 or Z2 had informed her at any time during her shift that R2 was having loose stools and was complaining of not feeling well. E9 stated that she was never made aware of either complaint. E9 explained that R2 usually is constipated, and rarely has diarrhea. E9 stated that she would have assessed her had she known that she was not feeling well. E9 was asked how long R2 had been on the floor before CPR was started. E9 stated that she had no idea. E9 stated that it all happened so fast. She said eventually the police came and the paramedics came, and they took over with CPR. E9 confirmed that R2 was pronounced dead at the scene.

During a follow up interview with E8 on 3/14/19 at 1:40pm with this writer, E8 was asked if he brought the crash cart with him, as their Medical stat procedure indicates. E8 stated that he did not bring the crash cart, nor did E10 who also came from the Core building. E8 stated that he should have. E8 was asked what all is contained in their crash cart. E8 stated that there is an

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oxygen tank with an ambu bag, a blood pressure cuff, some bandages and a suction machine. E8 offered that luckily the oxygen tank in the home had an ambu bag attached to it, but confirmed that if suction was needed, without the crash cart, suction could not be provided.

The Paramedic report was received and reviewed on 3/15/19, (The facility did not have this report as part of their investigation). The report indicates that they were notified by dispatch at 6:27am on 3/4/19 and arrived at the scene at 6:33am. The narrative states that when they entered R2's bedroom, she was unconscious, and not breathing. R2 was only wearing an incontinent pad, lying supine on the floor. Staff(unnamed) stated that they moved R2 to the floor. Staff stated that they found R2 not breathing approximately 10 minutes prior to paramedic's arrival (6:23am). Staff report to the paramedics that they had last seen her normal, approximately 2-3 hours prior to their arrival when they changed her diaper(3:33am-4:30am). R2 was cold to the touch and blue in the face and arms. R2 had no pulse or blood pressure. Crew placed a heart monitor on R2 and found R2 to be in asystole in all leads. Due to these signs, crew did not attempt CPR. Local hospital contacted and gave crew a time of death of 6:43am. This report conflicts with the facility investigation's interview with Z1, as Z1 stated they found R2 on the floor, yet the paramedic report states staff reported they moved R2 onto the floor. There are also time discrepancies as to when R2 was last seen, and when she was first discovered to be unconscious.

The nursing notes for R2 were reviewed. The nursing note authored by E9, dated and timed 7:00am on 3/4/19 was reviewed. The note reads

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that temporary staff called her into the room of R2. R2 was on the floor, not breathing, no pulse. Medical stat was paged. Two nurses arrived who started CPR. The time of this entry states that she was called into the room at 7:00am, when the paramedic report indicates that R2 was pronounced dead at 6:43am. During an interview with E9 on 3/13/19 via the telephone, E9 was asked to clarify her entry time in the nursing notes. E9 stated that her note was a late entry, and she did not put the time the incident occurred. E9 confirmed that she does not know the actual time, but figures it was sometime around 6:30am.

The conclusion of the facility investigation states that it is believed that R2 was attempting to get dressed that morning and collapsed to the floor. There was no physical injury or evidence of mistreatment. Per the coroner's office and the facility Medical Director, the cause of death is Myocardial Infarction. The facility did not determine that three staff assessed and determined that R2 was pulse less and not breathing but did not start CPR immediately. They did not follow either their Medical stat or CPR procedure as written. R2's complaints of loose stool and not feeling well were not reported to the nurse assigned to her. Charting indicates discrepancies as to when R2 was found on the floor, and when CPR started. The paramedic report indicates that a staff member told paramedics that R2 was moved to the floor, yet the investigation and all interviews indicate that R2 was found on the floor.

(AA)