Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002208	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAELSEN HEALTH CENTER	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

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S 000	Initial Comments Facility Reported Incident (FRI) dated 10/2/2020/ IL127743 Complaint Investigation # 2078095/IL127679: A partially extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)3) 300.1035c)1)2) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 made by nursing staff and recorded in the resident's medical record. Section 300.1035 Life-Sustaining Treatments 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, 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. 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) Based on interview, and record review, the facility neglected to follow its policy and procedure for advanced directives regarding initiating CPR (Cardiopulmonary Resuscitation) on a resident who was a full code. Also, the facility failed to do the following: - Initiate CPR (Cardiopulmonary Resuscitation) and summon 911 emergency life services for a resident who was a full code. -follow its policy for advanced directives and maintaining individual resident code status	S9999		

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-have a system in place so staff could promptly determine the code status of a resident.
-ensure that direct care staff (Nurses and Certified Nurse Assistants) have current CPR certificate
-ensure that staff was knowledgeable about assessing a resident who had an unexpected death.

This applies to 1 of 2 residents (R1) reviewed for improper nursing and death in the facility.

The findings include:

The facility's "CPR POLICY and POLST POLICY showed "If a resident does not have a completed POLST form on file, the resident is considered a FULL CODE. A signed, witnessed, and MD (Medical Doctor) signed POLST must be in chart to be valid. POLST should be kept in the chart as well as the POLST binder on each floor. ... CPR must be administered and 911 called if a DNR is not on file. A CODE BLUE with room number should be announced over the intercom to allow for quick response to the situation. ALL residents should have a POLST filled out, regardless of FULL CODE versus DNR ...."

The facility's policy for "Emergency Procedure-Cardiopulmonary Resuscitation (CPR)" with revised date of February 2018 showed ... "Personnel have completed training on the initiation of CPR and Basic Life Support ....6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: A) It is known that a Do Not Resuscitate (DNR) that specifically prohibits CPR for that individual .... B) There are obvious signs of irreversible death (e.g. rigor mortis). .... 7. If

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S9999	Continued From page 3 the resident's DNR status is unclear, CPR will be initiated ....8. Call 911 ... " The facility's policy for "Advance Directives" with revision date of December 2016 showed " ...6. Prior to or upon admission of a resident , the Social Service Director or Designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives ... 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." The POS (Physician Order Sheet) for the month of October 2020 showed R1 was admitted to the facility on July 9, 2020. R1's diagnoses were encounter for orthopedic aftercare, displaced fracture of the left femur, history of falling, hyperlipidemia, hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, atrial fibrillation, major depressive disorder, history of malignant neoplasm of the breast, acquired absence of left breast and nipple, spondylosis, osteoarthritis and pleural effusion. The POS for the month of July, August, September, and October of 2020 showed that R1 did not have a physician order for DNR (Do Not Resuscitate). There was also no order for palliative, and hospice care. The POSs mentioned showed: "Advance Directive: No relevant Advance Directives Entered." The clinical record showed that R1 did not have a completed POLST (Practitioner Order For Life-Sustaining Treatment) form to identify code status, wishes for life sustaining measures whether R1's wish was to be resuscitated or not, and what were her wishes for medical interventions whether full, selective, or comfort	S9999		

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S9999	Continued From page 4 focused. The POLST form is a legal and signed documentation that identify there was a discussion made with either the resident, or POA (Power of Attorney), the signature of the patient/POA, signature of the witness to consent, and the signature of the authorized practitioner to validate and ensure resident's life's advance directives. The clinical records entered by IDT (interdisciplinary team that included nurses, social worker, and physician) from the date of admission (7/9/2020) to the time of R1's unexpected death on 10/2/2020 showed the following synopsis of R1's stay at the facility: -7/9/2020: R1 was admitted on 7/9/2020 at 10:45 P.M. via ambulance direct from the airport as R1 came from another state. R1 had a fall on 4/2020 and had undergone left hip arthroplasty. -7/9/2020: physician order for PT/OT/ST (Physical/Occupational and Speech Therapy) order that was discontinued on 10/2/2020, the day R1 had expired. -7/11/2020: R1 was seen by V9 (R1's Attending Physician/ Facility's Medical Director). V9 documented as follows: chief complaint: weakness, gait disorder, fall of 4/2020, sustained left femur fracture, undergone arthroplasty. Dysphagia, complained of difficulty swallowing. Transferred to the facility for continuation of care and rehabilitation. The current care plan effective "7/9/2020 to present" showed that the facility did not address R1's advance directives and life sustaining measures. It did not address R1's wishes for code status whether she wish to be resuscitated	S9999		

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S9999	Continued From page 5 or not. The facility's incident report dated 10/2/2020 showed that V6 assisted R1 to get up R1 from bed to chair at 7:30 A.M. V6 returned to R1's room with breakfast tray at 7:55 A.M. As showed on this investigation, V6 observed R1 slumped over and unresponsive. V6 then informed V3. V3 did not detect pulse, or respirations. V9, V10 and facility's administration were notified. The investigation also showed that upon further investigation, R1 "did not have a POLST form on file and therefore officially a Full Code, and CPR (Cardio-Pulmonary Resuscitation) should have been administered but was not provided." The facility investigation concluded that CPR was not provided to R1, 911 emergency life sustaining measures was not summoned by V3. The investigation also showed that V4 (Nurse Clinician/Unit Manager) who was on duty had failed to review R1's code status and guide V3 to perform CPR. Both V3 and V4 were terminated from their work employment for not following facility's policy for CPR. The investigation also showed that this incident had prompted V8 to review, and update code status for all residents. The facility's investigation also showed that V4 had mentioned that that if a resident was a full code, then CPR should be performed. V4 also stated that if a resident does not have a DNR form completed, then considered the resident as full code, and CPR should be performed. V4 also had stated during the facility's investigation, V4 does not know what POLST Form is. The investigation had also showed that V4 mentioned that if she was the primary nurse of R1, V4 would not have done anything differently as R1 was "already gone." The facility's investigation also showed that V3 did not realized	S9999		

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S9999	Continued From page 6 that R1 was a full code, did not check R1's chart and did not perform CPR to R1 when found unresponsive few minutes from (7:45 A.M. to 7:55 A.M. =10 minutes) after being seen alive. The investigation also showed that V3 had mentioned that if a resident had no POLST, then consider them a full code, CPR to be performed. -7/15/2020: R1 ambulated with distance of 10 ft. x 2 with PT and OT. -7/18/2020: "Telemedicine due to COVID precaution; (R1) well groomed, well nourished, sitting up in wheelchair." -7/28/2020: V8 (Social Worker) spoke with V10 regarding R1's last day of Medicare coverage on 7/30/2020 and is eligible for an appeal. -9/23/2020: nurse's documentation entered by V11 (Registered Nurse) showed "(R1's) left breast bleeding, stained on her clothes. No Pain, Notified (V9) and her reply was "second breast cancer and to monitor." -9/24/2020: nurse documentation entered by V3 (Registered Nurse) showed "Seen by (V9), antibiotic medication and dry dressing to the breast and hospice consult. Call placed to (V10) and update and discussion of hospice. (V10) stated will consider and will get back to me." There was no documentation by V9 regarding this visit, there was no order given by V9 for DNR and there was no documentation to show that DNR status was discussed with V10 by either V9 nor by V3. -10/01/2020: V8 (Social Worker) informed V10 that R1's last day of Medicare coverage would be on 10/3/2020. -10/2/2020: documentation entered by V3 showed "at 7:30 A.M., V6 (CNA, Certified Nurse Assistant) informed (V3) that (R1) had a foul smelling bowel movement. Out of bed, to chair. Up for breakfast. Provided juice at 7:45 A.M. At 7:55 A.M., (V6)	S9999		

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called (V3) to come to (R1's) room. (R1) was yellow, and waxy color, no heartbeat, no respiration. (R1) placed back to bed. (V9) notified. (V10) notified and stated she will see (R1) and that she will wait for her husband to drive her. (V10) arrived at 10:00 A.M., Coroner picked up (R1's) remains."

On 10/15/2020, 2:00 P.M. V1 stated that investigation regarding R1's unexpected death was conducted by V5. V1 also added that V3 and V4 were terminated from their employment on 10/2/2020 for not providing CPR to R1. V1 also added that R1 was a FULL CODE because the POLST Form was not completed and there was no DNR order. V2 (Director of Nursing) also was present during the interview. V2 stated that it is the standard of professional practice and also the facility's policy that if a resident had an incomplete or no POLST form and an advance directive was unclear, then considered the resident a FULL CODE and CPR should be initiated.

On 10/15/2020 at 1:01 P.M., V5 stated she had received a text from V4 at 7:59 A.M. on 10/2/2020 that "(R1) just passed away at 7:55 A.M." V5 added that when she arrived at the facility around approximately 8:30 A.M since she was late that day, she went to the second floor. V5 stated that she saw V3, at the nurse's station and was talking to V10. Meantime, V4 was standing by the nursing station. V5 stated that she did not asked V3 and V4 if R1 was a FULL CODE or a DNR. V5 also added that she did not check R1's code status.

On 10/15/2020 at 12:54 P.M., V8 (Social Worker) stated that she had provided V10 a POLST Form but did not follow up for completion. V8 also

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added that she audits the residents' Advance Directives monthly. However, V8 had no explanation how come R1 had no documentation regarding Advance Directives from the month of July, when R1 was admitted, up to October 2, 2020, when R1 had expired. V8 also cannot explain why R1's POS for the past four months (July through October 2020) showed "Advance Directives: No Relevant Advance Directives Entered." V8 also added that the facility started auditing residents' POLST form after the incident with R1. V8 also stated that there was an audit list for this and during the audits, there were multiple residents without POLST documentation.

On 10/16/2020 at 1:37 P.M., V3 stated that on 10/2/2020 at 7:55 A.M., V6 called her to immediately check R1. V3 added that she quickly went to R1's room and found R1 sitting in her wheelchair, was slumped over and R1's skin color was "waxy yellow." V3 also stated that she checked R1's radial pulse, and respiration. V3 stated that R1 had no radial pulse, and was not breathing. V3 also stated that she told V6 and V7 to put R1 back to bed. V3 also stated that she did not initiate CPR to R1 and did not call 911. V3 added that she did not check if R1 was DNR or a FULL CODE. V3 also stated that she later realized around after an hour or so that that R1 was a FULL CODE and should have been resuscitated. V3 also stated that facility investigated R1's unexpected death and found out that R1 did not have a completed POLST Form. V3 further stated that if there was no completed POLST Form, then R1 was considered a FULL CODE. V3 also added that R1 did not have a physician order for a DNR status. However, as V3 added, she did not check R1's code status and R1's advance directives. V3 also added that the POLST Forms for residents on

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both floors were kept in a binder and usually located on the first floor. V3 also stated that if a resident on the second floor had coded, there was no immediate access for the staff to know the residents' code status. V3 also stated that the residents' medical chart hard copy was not updated regarding Advance Directives/POLST. V3 also stated that it will take time to open the computer to check the POS and figure out the physician order for any code order. V3 further stated that the facility does not have a system in place regarding an updated and accurate advance directives / POLST in order for the staff to easily access and determine residents' code status. V3 also stated on 10/2/2020 at 7:55 A.M., she had texted V4 (Clinical Manager) for guidance related to R1's "unexpected death." V3 further added that V4 did not respond to her text message. V3 also stated that she went to look for V4 on the first floor. V3 found V4 in one of the offices near the nurse station. V3 and V4 went to R1's room around 8:00 A.M., and found V6 and V7 putting R1 back to bed. V3 further stated that all of them including herself, V4, did not check R1's code status and did not initiate CPR to R1.

On 10/16/2020 at 12:26 P.M., V4 (Clinical Nurse Manager) stated that she received a text message from V3 at 7:55 A.M. on 10/2/2020 that R1 had just passed away. V4 added that she did not get the message at once since she did not have her mobile phone with her. V4 added that the test message sent showed "are you in a meeting, need you stat,.. (R1) just expired." V4 also added that V3 came to find her on the first floor. V4 added that they went to R1's room, and saw R1 with "yellow waxy skin color, (R1's) mouth was open." V4 added that V6 and V7 was cleaning up R1 and that "(R1) was gone." V4 also stated "when a resident was on the second

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floor, it's long term care, it is their home, they know it is the end of life and they are going home. (R1) went peacefully, and she did not die in a traumatic way, it was a blessing." V4 also added that no CPR was performed, no 911 was called and neither V3 nor she had checked R1's medical file for code status. V4 also stated that R1 was on the second floor. V4 also added that the facility has no system in place that works for the direct staff to identify code status. V4 also added that she think's the POLST Forms binder was on the first floor and that the POLST forms binder was a mixture of both first, and second floor residents which added more frustration to identify, and easy access. V4 added that if a second floor resident coded, you have to go to the first floor to look for the POLST binder which was not current or updated. V4 also added that the medical chart hard copy was not audited for DNR/Full code orders, and has to log in to computer to check the POS if there are any order for code status and this take time. V4 added that "I'm sure there is a policy somewhere for CPR/911; emergency situation, assume death policy or assessment to determine death of a resident, but I don't know where these policies are. The nurses did not have a meeting for over months." V4 also stated that she was not familiar with POLST documentation. V4 also stated that she had texted V5 (Assistant Director of Nursing) of R1's "unexpected death" at 7:59 A.M. on 10/2/2020 and informed her that "(R1) had just passed away unexpectedly." V4 added that V5 went to the second floor station around 8:05 A.M. During this time of V5's arrival, V3 was at the nursing station talking to V10, and V6 was standing by the station. V4 added that V5 asked them "have you notified the department heads and physician?" V4 stated that V5 did not go to R1's room, did not check the medical chart hard copy, the POLST binder, and did not open

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the computer for DNR order in order to determine R1's code status. V4 also added that V5 did not ask V3 and V4 regarding R1's code status nor if they have check R1's POLST. V4 stated that she was sure of the time of the text messages that were sent because she did not erase the messages on her phone.

On 10/16/2020 at 5:08 P.M., V9 (R1's Attending Physician/ Facility's Medical Director) was interviewed. V9 stated that she had discussed with V10 regarding R1's comfort/hospice care. V9 also stated that "I assumed that (V10) was aware that (R1) would not be resuscitated if R1 would be under hospice care. But I am not sure if I have documented this." V9 was informed that review of R1's entire clinical record of the IDT (Interdisciplinary team that included nurses, social worker, dietician and physician including V9) showed that she had only documentation on 7/11/2020 and a telemedicine on 7/18/2020. Surveyor also informed V9 that a nurse's notes dated 9/24/2020 showed that she saw R1 on 9/24/2020 but no documentation of this visit. The clinical record showed no documentation that there was a discussion of DNR nor V9 had given an order of a DNR status for R1. Surveyor verified with V9 regarding R1's no DNR order and POLST not completed. Surveyor also informed V9 that based on interviews gathered from V3, V4, V6 and V7 showed that on 10/2/2020, R1 was last seen alive at 7:45 A.M and was unresponsive at 7:55 A.M. (more or less 10 minutes) and no irreversible signs of death as they noted. V9 was asked for verification what was her professional expectation from the staff since there was no DNR order and that it was around 10 minutes time frame between the time R1 was seen alive and unresponsive and no signs of irreversible death such as rigor mortis. V9 responded "I don't

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(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
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expect them to do CPR since (R1) was already dead." Surveyor verified as to when to perform CPR to a FULL code resident, V9 responded "when it is needed, I trust my nurses." V9 was also asked for verification if checking radial pulse by palpitation and respiration by auscultation were sufficient enough to pronounce death to a resident who had unexpectedly died. V9 responded "I think it is enough, don't you think so.? " Surveyor also verified how if R1 was only exhibiting Cheyne - stoke respiration, (temporary stop of breathing) since V3 and V4 did not check R1's pupils if they were fixed or dilated, nor had they checked any loss of sphincter muscles and failed to check pulses to other sites like the carotid pulse. V9 responded "I trust my nurses, besides (R1) died of cancer that had metastasize to other parts of her body."

On 10/17/2020 from 8:30 A.M. to 9:02 A.M., V6 and V7 (Certified Nurse Assistants) were both interviewed. V6 and V7 stated that at 7:30 A.M. on 10/2/2020, both of them assisted R1 to get out of bed. V6 stated that R1 had requested to be out of bed. V6 also stated that she did not notice anything different from R1 aside from the foul smelling bowel movement that R1 had. V6 also stated that during the period she assisted R1 out of bed that morning of 10/2/2020, R1 was verbally responsive and was able to verbalize her needs and was using call light buttons for assistance. V6 also stated that R1 even made a joke and was excited to get out of bed by saying "okay, I'm ready to get out of bed" and at the same time R1 had pulled out all of her top beddings. V6 also stated that she did not notice any change of R1's condition. V6 further stated that R1 was at her baseline, making jokes and pulling the call lights frequently. V6 also added that at 7:45 A.M., she saw R1 fiddling her fingers, and the silverware.

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	IL6002208	A. BUILDING: _____ B. WING _____	C 10/22/2020

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S9999	Continued From page 13 V6 also added that it was less than 10 minutes when she returned to R1's room to bring breakfast tray which was around 7:55 A.M. This was when both V6, and V7 saw R1 slumped over, and was not responding verbally. V6 stated that she went to get V3 at once. V3 came immediately, checked R1's pulse and respiration, and instructed V6 and V7 to put R1 back to bed. V6 and V7 stated that V3 did not initiate CPR. V6 and V7 also stated that neither of them had initiated CPR to R1 since they were not told to do so and they follow what the nurse had said. Besides, V6 and V7 also said that they do not know R1's code status and also don't no where to check the code status of the resident. V6 and V7 also stated "We know that (R1) had just passed away, we just saw her just few minutes ago alive and playing with her fingers. (R1) was also was very warm to touch and her body was very flexible and not stiff at all." V6 also stated that she was not sure if her CPR card was current. V6 and V7 stated that around 8:00 A.M., both V3 and V4 came to R1's room. V6 and V7 also stated that V3 and V4 did not perform CPR to R1. However, V8 had no explanation how come R1 had no documentation regarding Advance Directives from the month of July, when R1 was admitted, October 2, 2020, when R1 had expired. V8 also cannot explain why R1's POS for the past four months (July through October 2020) showed "Advance Directives: No Relevant Advance Directives Entered." V8 also added that the facility started auditing residents' POLST form after the incident with R1. V8 also stated that there was an audit list for this and during the audits, there were multiple residents without POLST documentation. During a random observation on the first and	S9999		

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second floor on 10/15/2020 from 12:05 P.M. through 12:30 P.M., interviews were also held at the same time with on duty nurses which includes V12 through V15. They have mentioned that the medical chart hard copy was not updated with regards to residents' code status. They also stated that they were not sure of the POLST Form and where it was located. They also added that even after the "incident of (R1) with the unexpected death, and in- services, and auditing is in progress, the medical chart hard copy was still not updated with accurate documentation regarding residents' code status. Some of these nurses had pointed the medical chart at the nurse's station that it should have been color coded with a sticky note to promptly identify if a resident was a Full Code and DNR, however, some medical charts as pointed were not color coded.

Review of the POLST audit list provided by V1 (Administrator) and V2 (Director Of Nursing) on 10/15/2020 showed that on 10/5/2020 there were 14 out of 78 residents with no POLST completed form, and on 10/8/2020 there were 12 out of 85 residents without a completed POLST forms. The 14 residents identified without POLST form completed on 10/5/2020 were R5 through R18. The 12 residents identified on 10/8/2020 were R5, R7, R8, R10, R12, R15 through R21. This was verified and was confirmed via the audit list dated 10/5/2020 and 10/8/2020 with V2 (Director of Nursing) on 10/19/2020 at 3:36 P.M.

The facility provided a list of all nursing staff which includes CNAs, and nurses. There were 31 out of 59 CNAs and 5 out of 41 nurses that did not have CPR certification documentation, expired CPR certificate and requires recertification. V6 was one of the staff that

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S9999	Continued From page 15 needed recertification. The facility's "CPR POLICY and POLST POLICY showed "If a resident does not have a completed POLST form on file, the resident is considered a FULL CODE. A signed, witnessed, and MD (Medical Doctor) signed POLST must be in chart to be valid. POLST should be kept in the chart as well as the POLST binder on each floor. ... CPR must be administered and 911 called if DNR is not on file. A CODE BLUE with room number should be announced over the intercom to allow for quick response to the situation. ALL residents should have a POLST filled out, regardless of FULL CODE versus DNR ...." The facility's policy for "Emergency Procedure-Cardiopulmonary Resuscitation (CPR)" with revised date of February 2018 showed ... "Personnel have completed training on the initiation of CPR and Basic Life Support ....6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: A) It is a known that a Do Not Resuscitate (DNR) that specifically prohibits CPR for that individual .... B) There are obvious signs of irreversible death (e.g. rigor mortis). .... 7. If the resident's DNR status is unclear, CPR will be initiated ....8. Call 911 ... " The facility's policy for "Advance Directives" with revision date of December 2016 showed " ...6. Prior to or upon admission of a resident , the Social Service Director or Designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives ... 7. Information about whether or not the resident has executed an advance directive shall be displayed	S9999		

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S9999	Continued From page 16 prominently in the medical record." " A"	S9999		