

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2020
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NAME OF PROVIDER OR SUPPLIER ST PAUL'S SENIOR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 WEST E STREET BELLEVILLE, IL 62220
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violation: 1 of 1 Violation Complaint #2044755/IL123994</p> <p>300.610a) 300.1030a)2) 300.1035a)4) 300.1035e) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1030 Medical Emergencies</p> <p>a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:</p> <p>2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).</p> <p>Section 300.1035 Life-Sustaining Treatments</p> <p>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:</p> <p>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;</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70]</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>This Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) for 1 of 22 residents (R2) reviewed for Advanced Directives/Full Code for CPR in the sample of 26. Facility staff failed to follow R2's Advanced Directive by not initiating CPR for R2, who subsequently expired. This failure had the potential to affect 17 of 74 residents (R1, R2, R3, R6, R7, R9, R11 through R26) whose Advanced Directives indicate Full Code Status.</p> <p>Findings include:</p> <p>R2's Medical Diagnosis Sheet, dated 3/8/20 and 4/28/20, documented Acute Kidney Failure, unspecified Diastolic Heart Failure, Dysphagia, Cognitive Communication Deficit, Hemiplegia and hemiparesis related to Cerebral Infarction affecting right dominant side of body.</p> <p>R2's Care Plan, dated 3/24/20, documented Code Status as Full Code, residents wishes for</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>Advanced Directive and End of Life Care will be honored.</p> <p>R2's Advanced Directive, dated 3/8/20, signed by R2's Health care surrogate decision maker, documented, Attempt Cardiopulmonary Resuscitation, full treatment of sustaining life by medically indicated means.</p> <p>R2's State of Illinois Certification of Death Worksheet, documented, Cause of Death, Congestive Heart Failure, pronounced death dated 5/25/20 at 1:05 PM.</p> <p>R2's Progress Note dated 5/25/20 at 1:23 PM, documented, in part, Resident expired at 1:05 PM, no further documentation if R2 was assessed, vitals obtained, CPR initiated and 911 was notified.</p> <p>The Facility's Final Investigation Report, dated 6/1/20, documented V4's (Licensed Practical Nurse/LPN) interview statement that (R2) stayed in bed at breakfast. At approximately 10:30 AM, V5 (Certified Nurse Aide/CNA) bathed R2. At approximately 11:00 AM-11:30 AM, Physical Therapy stated that they were discharging (R2) from therapy due to lack of progress. At approximately 12:00 PM-12:30 PM, V5 brought R2 to the dining room. At 12:45 PM, (R2) would not take her medication and V4 stated she would re-attempt when (R2) is eating. At approximately 1:00 PM, V5 sat with (R2) to provide feeding assistance and V5 identified that (R2's) hands were cold and blue. V4 stated that V5 reported to her (V4), she thinks (R2) is dead. V4 stated she noted color, cold and no pulse. V4 stated that she and V5 transferred (R2) to her bed. V4 stated she then notified the coroner and family. V4 stated she then noticed (R2's) code status</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>was CPR and thought it had been changed to DNR (Do Not Resuscitate) and placed on Hospice.</p> <p>The Facility's Employee Corrective Action Form, dated 5/25/20, documented, V4 (LPN) failed to follow policies and procedures that resulted in harm or potential harm to R2. Also included, V4's failure to follow policy on Advance Directive that resulted in CPR not being delivered to R2 who was a full code, resulting in R2's death. Corrective Action: V4's termination of employment.</p> <p>The Facility's Education Sign in Sheet, dated 2/21/20 at 8:30 AM, entitled, education on the following subjects: Advance Directives/CPR, documented V4's printed name, signature name and job title as LPN.</p> <p>On October 27, 2020 at 2:50 PM, V18 (Physical Therapist) stated that R2 was seen early in the morning of 5/25/20, and made the assessment that (R2) was not progressing with physical and occupational therapy and discharged therapy for (R2) on that same date.</p> <p>On October 27, 2020 at 2:05PM, V11 (LPN) stated "you need to access residents' electronic medical record, as the face sheet will identify a resident's code status, assess the resident, perform vitals, call 911, the physician and then family. This is for a resident full code or DNR." V11 stated she was recently in-serviced on the procedure to access a resident's code status.</p> <p>On October 27, 2020 at 2:15 PM, V12 (LPN) stated the same as V11, but included that there is a Crash Cart in the Crash Cart closet that has a clip board for quick access of residents who are</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>DNR and Full Code, the night shift nurses are responsible to assure this is currently updated and changed out every day, related to the recent in-service received from the facility.</p> <p>On October 27, 2020 at 2:25 PM, V13 (CNA) stated "A resident found unresponsive, I would stay with the resident, hit the call light or yell to notify the nurse assigned, obtain vitals, call 911, if the nurse requested."</p> <p>On October 27, 2020 at 2:35 PM, V14 (CNA/agency staff) stated, "If I find a resident unresponsive, she would 'Scream for help,' and stay with resident until the nurse arrives."</p> <p>On 10/21/20 at 3:30 PM, V1 (Administrator) stated, (V4) should have followed the facility's policy and procedure regarding (R2's) Advanced Directive as a Full Code to initiate CPR and should have notified the emergency medical service, (911).</p> <p>On 10/26/20 at 4:20 PM, V6 (R2's Nurse Practioner) stated the facility should have followed R2's Advanced Directive of Full Code Status and performed CPR.</p> <p>The Facility's policy and procedure, entitled, "Emergency Procedure-Cardiopulmonary Resuscitation, dated 10/2019, documented, "If a resident is found unresponsive and not breathing normally, a licensed staff member will verify code status using the medical record. If the resident is full code, per the medical record, a staff member that is certified in CPR will initiate. Facility staff certified for CPR is available for each shift in the case of an actual cardiac arrest. Staff will call 911 when CPR is initiated."</p>	S9999		

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