STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014138	A. BUILDING: _____ B. WING _____	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF LAKE ZURICH	900 SOUTH RAND ROAD LAKE ZURICH, IL 60047

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violation 300.1035a) 300.1035b)2) 300.3240a) 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. Section 300.1035 Life-Sustaining Treatments b) For the purposes of this Section: 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated.	S9999	Attachment A Statement of Licensure Violations	

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirementss were not met as evidenced by:

Based on interview and record review the facility failed to ensure emergency services were immediately initiated for resident's (R150, R149) having a significant change in condition.

This failure contributed to R150 expiring in the facility on February 24, 2019 and R149 expiring in the hospital on February 10, 2019.

This applies to 2 residents (R150, R149) outside of the sample of 30 reviewed for necessary care and services.

The findings include:

R150's Facesheet printed May 8, 2019 showed R150 was admitted to the third floor of the facility on February 22, 2019 and discharged on February 24, 2019. The Facesheet showed R150 as a "Full Code/Attempt Resuscitation/CPR (cardiopulmonary resuscitation)" under R150's Advanced Directives.

R150's Clinical Note dated February 24, 2019 showed at 5:45 AM, R150 was found unresponsive in bed with no blood pressure by V12 Registered Nurse (RN) with oxygen saturations (levels) of 81%. This Note showed R150's condition continued to deteriorate as R150 developed "faint pulses" and continued low

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oxygen levels as V12 RN "placed a call to MD (V14) and MD stated he will be in facility shortly." This Note showed R150 remained in the facility with 911/Emergency Services not initiated by V12 RN until 7:18 AM, after receiving an order from V32 Nurse Practitioner (CNP) to send R150 to the hospital emergently. This Note showed ambulance personnel arrived at the facility at 7:25 AM and "while paramedics were trying to stabilize resident to transport him hospital, resident arrested and CPR initiated with no success. Time of death 8:19 AM."

On February 8, 2019 at 11:45 AM, V12 RN was asked why there was a delay in sending R150 to the hospital on February 24, 2019, V12 stated, "I was waiting to send him out until I got an order from the physician (V14) to do so. Yes, he (R150) was unresponsive the whole time... Looking back, I should have called 911 and had him sent to the hospital immediately."
On February 8, 2019 at 11:30 AM, V13 Third Floor Nurse Manager stated, "I was not here when the incident happened with (R150). I'm not sure why (R150) was not sent to the hospital immediately. I guess the nurse was waiting for the doctor to call back and give the order to send him to the hospital."

R149's Facesheet printed May 8, 2019 showed R149 was discharged from the facility on February 10, 2019.

R149's Clinical Note dated February 10, 2019 showed at 5:25 AM, R149 was "noted to be lethargic" by facility staff with oxygen levels of 75-80%, a low blood pressure of 86/46, and a slow pulse of 44 beats per minute. This Note showed 911/Emergency Services was not called until 5:55 AM, after R149's nurse received an

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order from V32 CNP to send R149 to the hospital emergently. At 7:20 AM, the facility received a call from the hospital "informing us that resident expired."

On May 8, 2019 at 10:50 AM, V2 Director of Nursing stated, "I don't know why there was a delay in calling 911 for (R150) or (R149). Staff should call 911 right away if a resident is unstable with a change in condition or is found unresponsive and is a full code. They do not need an order from a doctor to send a resident to the hospital when they are unstable..."

On May 8, 2019 at 11:00 AM, V14 Physician stated, "If a resident is found unresponsive with no blood pressure and is a full code, they are to be sent out to the hospital immediately via 911 and staff should not wait to hear from me. In regards to (R150), I don't even remember getting a phone call about him. I would never say I am on the way to the facility and wait to do anything or send a resident out until I got there. I am not aware of this incident with (R150) at all. He should have been sent out immediately via 911." When V14 was asked about the incident with R149 on February 10, 2019, V14 stated, "She (R149) should have been sent out immediately with her change in condition. Even though she was a DNR (do not resuscitate), she was with it mentally and could talk. She should have been sent out ASAP."

On May 8, 2019, V8, V9 and V33 RN's each stated if a resident is found unresponsive or a resident becomes unstable after experiencing an acute change in condition, 911/Emergency Services should be called immediately.

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