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| Z 000 | COMMENTS<br><br>COMPLAINT #1747026/IL98537<br><br>Statement of Licensure Violations | Z 000 | | |
| Z9999 | FINDINGS<br><br>350.620a)<br>350.1210<br>350.1230d)1)2)<br>350.1235a)3)4)5)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br>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.<br>Section 350.1210 Health Services<br>The facility shall provide all services necessary to maintain each resident in good physical health<br>Section 350.1230 Nursing Services<br>d) Direct care personnel shall be trained in, but are not limited to, the following:<br>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.<br>2) Basic skills required to meet the health needs and problems of the residents.<br>Section 350.1235 Life-Sustaining Treatments<br>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 | Z9999 | Attachment A<br>Statement of Licensure Violations | |

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implementation of such rights. Included within this policy shall be:
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.
Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review, the facility's governing body failed to maintain necessary oversight over the facility to ensure the health and safety of the individuals of the facility as evidenced for 2 of 2 individuals in the sample (R9 and R10) who were a Full Code and did not have a Do Not Resuscitate (DNR) order at the time of their death.

1) R9 was admitted to the facility on 09/06/17 as a Full Code and after his admission to the facility and was found on 09/23/17 without pulse or respirations and CPR (Cardiopulmonary Resuscitation) was not performed by facility staff and/or by the contract nurse even though R9 was a Full Code. After his death, the facility investigated but failed to:

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| Z9999 | Continued From page 2<br><br>a) Ensure that nursing staff are trained and demonstrate competency in their knowledge of oxygen tank locations and how to open the Emergency Crash Box to prevent a potential delay in emergency medical treatment;<br><br>b) Update their policy and procedures for the Emergency Crash Cart/Box and necessary emergency medical equipment needed during a Code Blue;<br><br>c) Update and provide training for utilization of the Emergency Crash Box and necessary emergency medical equipment needed during a Code Blue.<br><br>2) After sustaining a head injury from a fall, R10 was sent to the emergency room on 02/15/17 and the facility sent the wrong advance directive orders resulting in life sustaining treatments not being provided to him as indicated on his Uniform Practitioner Order for Life Sustaining Treatment (POLST) form 12/15/16. R10 expired at the hospital on 02/15/17 and after his death the facility failed to:<br><br>a) Investigate why the wrong advance directive form was sent with R10 at the time of his transfer on 02/15/17; and<br><br>b) Establish a system to ensure that each individual's advance directive orders are current to prevent future reoccurrence.<br><br>These failures pose a potential threat to the health and safety of all 62 individuals of the facility (R14-R75).<br><br>Findings include: | Z9999 | | |

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1) The facility's Death Investigation Report dated 09/29/17 identifies that R9 was a 69 year old male with diagnosis of Moderate intellectual disabilities, Cerebral Palsy, Arthritis, Chronic Pain, Depression and a Full Code at the time of his admission to the facility on 09/06/17.

The facility's Death Investigation Report states that on 09/23/17, "R9's breathing had changed" and that at 7:45 PM Z1 (Contract nurse) was called to House 5 to check on R9. It states that R9 had "Shallow breathing" and that she (Z1) left the house to get a pulse oximeter, and oxygen concentrator (if needed). It states that Z1 returned back to House 5 at 7:55 PM and found that R9 was, "no longer breathing". CPR was not started by either direct care staff or Z1 even though R9's record indicates that he was a Full Code.

Per record review, no DNR (Do Not Resuscitate) Advance Directive form is located for R9. As based on the facility's Death Investigation Report dated 09/29/17 and as confirmed through interview with E2 (QIDP) on 12/01/17 at 12 PM, R9 was a Full Code at the time of his death on 09/23/17.

R9's Illinois Certificate of Death record dated 09/23/17 states that the immediate cause of death was Respiratory Failure resulting from Aspiration Pneumonitis.

After R9's death, the facility's Death Investigation Report does indicate that Z1's (Contract Nurse's) agency was contacted and a request was made that she never return to the facility, E10 (Direct Care staff) was disciplined and E11 was

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terminated because of their failure to initiate CPR when R9 was found without pulse or breaths. Recommendations are noted for all staff to be inserviced on Emergencies including CPR and 911 Policies and Procedures as well as recommendations for each medication cart to be equipped with a pulse oximeter, a stethoscope and a blood pressure cuff. It also states that each house will have an oxygen tank or concentrator.

On 12/01/17 the medication carts for House 3, 4, 5 and 7 were observed to ensure that each cart is equipped with a pulse oximeter, stethoscope, blood pressure cup, and that oxygen is available at each house as recommended in the facility's Death Investigation Report.

On 12/01/17 House 5 and 7 were completed with E4 (LPN-Licensed Practical Nurse) from 8:45 AM to 9 AM. E4 stated that both houses have oxygen. At 8:53 AM a portable oxygen concentrator was located in the tub room of House 5. The concentrator was dusty and appeared to be unused. Once plugged in, the concentrator did not work. E4 then stated that she knew that there was an oxygen tank somewhere. E4 then located the portable oxygen tank in the laundry room. E4 and the surveyor then walked to House 7. E4 proceeded to look for an oxygen tank but did not locate an oxygen tank. She then stated that this house (House 7) did not have an oxygen tank because there is only one oxygen tank on each side of the facility grounds. E4 then said that the facility had talked about getting oxygen tanks in each house.

On 12/01/17 Houses 3 and 4 were completed with E5 (LPN) from 9:40 AM to 9:50 AM. and one portable oxygen tank was present in the tub room of House 3. E5 confirmed that House 4 does not

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have a portable oxygen tank.

E1 (DON - Director of Nursing) was interviewed on 12/01/17 at 9:55 AM and confirmed that the facility only has portable oxygen tanks located in House 3 and House 5. E1 stated that they plan to eventually have portable oxygen tanks in each house. E1 was then asked if the facility had a specific policy regarding portable oxygen locations so that if a new nurse was hired they would know where the oxygen is located and she stated, "No". E1 was then informed that E4 (LPN) did not know where the portable oxygen tank was located in House 5 as observed on 12/01/17. E1 stated that E4 should have known. E1 confirmed that looking for a portable oxygen tank could potentially result in a delay in emergency medical treatment.

On 12/01/17 at 9:50 AM, E5 (LPN) showed the surveyor where the Crash Box was located. A large tackle box was sitting on the counter in the room directly off of the nurse's office in the Administration building. When E5 was asked to open the Crash Box, E5 attempted to open the Crash Box but could not. E5 then called for E4 (LPN) to assist her in opening the Crash Box. E5 stated that she didn't know how to open the box because she had never had to use it. When asked where the CPR Board was located, E5 stated, "I'm not sure. There's a big cutting board back here so I'm taking that to be the CPR Board". When asked what was in the black bag behind the Crash Box E5 stated, "I'm not sure" and proceeded to unzip the bag. E5 then said, "Oh it's the suctioning machine".

In interview with E1 (DON) on 12/01/17 at 9:55 A.M., E1 was informed that E5 (LPN) did not know how to open the Crash Box. When E1 was

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asked if she felt that a nurse's inability in opening the Crash Box could potentially result in a delay in emergency medical treatment, E1 stated, "Yes". E1 then said that all nursing staff were trained on 07/28/17 during a nursing meeting regarding the Crash Box and Code Blue. The surveyor then informed E1 that E5 had told the surveyor that E5 had only been employed at the facility since August of 2017. E1 then confirmed that E5 was hired after 07/28/17 and that she had not been trained on Crash Box. E1 stated, "I should have gone through that training with her". E1 went on to state that the facility had switched to a Crash Box because the nurses were having such a hard time maneuvering the carts down the sidewalks.

The facility's Emergency Cart Policy and Procedures with a revised date 4/2010 states that it is the policy to have an emergency cart available in a centralized location for emergency treatment. It states that the Emergency Cart shall be kept in the beauty shop, and O2 Concentrators will be available in House 2, 4 and 5.

In continuing interview, E1 (DON) stated, "No" when asked if the facility had policy and procedures for where the portable oxygen tank is located and/or where other emergency medical equipment can be located during a medical emergency. During this interview, E1 confirmed that any nurse hired after 07/28/17 would not have been trained on using the Crash Box and where the emerency medical equipment can be located during a medical emergency.

As based on file review and as confirmed per interview with E1 (DON) on 12/01/17 at 9:55 AM, the facility has not updated their policy and procedures to address they are now using a

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| Z9999 | Continued From page 7<br>Crash Box and/or that the portable oxygen tanks are stored in House 3 and 5.<br><br>In interview with E1 (DON) on 12/01/17 at 9:55 A.M., E1 stated that during a Code Blue the nurses are to go to the Administration building and grab the Crash Box, the suction machine, the CPR board and the AED (Automated External Defibrillator). When E1 was asked if the facility had policy and procedures as to what emergency medical equipment is to be taken to the scene during an emergency/Code Blue, E1 stated, "No". E1 was then asked if she thought there would be a delay in treatment if a Code Blue was called and the nurse was passing medications in one house, had to take time to lock her cart up, get to the Administration Building, get the Crash Box, the suction machine, the CPR board and the AED and then get to one of the four houses where the Code Blue was called and she stated, "Do you think I should have a Crash Box and emergency medical equipment at each house?"<br><br>2) The Coroner's Office report dated 02/15/17 identifies that R10 was 73 years old at the time of his death at the hospital on this date. His death is listed as, "Sudden, Unexpected".<br><br>The facility's Resident Death Report form (undated) states that R10 had a diagnosis of Moderate Intellectual Disability. This report goes on to state that, "R10 had fallen and sustained a laceration to his forehead. After the fall, R10 was alert and responsive. When he left with the paramedics he remained alert and responsive... Per the Coroner's Office, R10 was pronounced dead (3:46 P.M.) with cause of death as cardiac arrest secondary to hypertension." It is also noted within the facility's report that R10 had an IDPH | Z9999 | | |

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| Z9999 | Continued From page 8<br><br>POLST (Practitioner Order for Life Sustaining Treatment) form stating Full Code on file with the facility.<br><br>The Emergency Room Visit Report dated 02/15/17 states that R10 was brought in by ambulance for a fall. It states that upon his arrival to the emergency department, R10 went into cardiac arrest and that CPR was started. An entry on this report at 16:37 (4:37 PM) states, "In reviewing the papers patient was limited code no intubation no mechanical ventilation ...In keeping with the patient's requested Code Status patient was not intubated. Patient was pronounced at 1546".<br><br>Review of R10's POLST form which was signed by his legal representative on 12/15/16 and witnessed on this date identifies that R10 was a Full Code and that resuscitation is to be attempted/CPR (Cardiopulmonary Resuscitation) if R10 had no pulse and is not breathing. This form goes on to state that R10 was to have Full Treatment defined as, "Primary goal of sustaining life by medically indicated mean. In addition to treatment described in Selective Treatment and Comfort Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated.<br><br>Further review of the facility's Death Report does not identify the discrepancy of the hospital report stating that R10 had advance directives to not resuscitate-DNR (Do Not Resuscitate) orders as compared to the POLST form on file.<br><br>Review of R10's record found that R10 has an Advance Directive form for Limited Addition Intervention which states no intubation or mechanical ventilator. This form was signed on | Z9999 | | |

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| Z9999 | Continued From page 9<br><br>01/16/14. On 12/15/16 R10 ' s legal representative signed a POLST form for Life Sustaining Treatment which would negate the prior DNR form .<br><br>On 02/15/17 when R10 was sent to the Emergency Room after a fall, facility staff sent the wrong Advance Directive form with R10 as confirmed per the Emergency Room report and E1 (Director of Nursing-DON) on 12/02/17 at 8:27 AM.<br><br>After this incident the facility failed to thoroughly investigate R10's death and take action to ensure that the current advance directives are on file for all individuals of the facility to ensure that in the event of an emergency transfer, the current life sustaining orders or the DNR orders are provided to medical personnel.<br><br>(A) | Z9999 | | |