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
	IL6001705	A. BUILDING: ______ B. WING ______	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z 000	COMMENTS	Z 000		

Complaint Investigation 2191273/IL131279

Z9999	FINDINGS	Z9999		

Statement of Licensure Violations:

390.620 a)
390.1040 j)
390.3240 a)

Section 390.620 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. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. 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 390.1040 Nursing Services
j) Nursing care (including personal, habilitative and rehabilitative care measures) shall be practiced on a 24 hour, seven day a week basis in the care of residents. Those procedures requiring medical approval shall be ordered by the attending physician.

Section 390.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.\

These regulations are not met as evidenced by:

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ____ B. WING ____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 1 Based on record review and interview, the facility neglected to ensure staff followed their policy and procedure for Tracheostomy Insertion and Code Blue implementation, and failed to ensure nursing services provided the ongoing monitoring and assessments for 1 of 1 client in the sample whose tracheostomy tube became dislodged and untrained staff reinserted the tracheostomy tube (R1). A delayed code blue was called, R1 was transferred by emergency staff, and later expired in the hospital. Findings include: According to the facility investigation for the incident of 2/19/21, R1 is a 2 year old female (6/18/18 DOB) with a medical history of Dependence on Respirator status, Tracheostomy Status, Corpus Collosum Dysgenesis, Chronic Respiratory Failure, Epileptic Seizures and Congenital Malformations of the Brain. The Policy and Procedure entitled, Tracheostomy : Changing Cuffed Tubes/ #2101, dated July 2020, was reviewed. The policy states that an Registered Nurse (RN)/Licensed Practical Nurse (LPN) are to change the trach out. The patient should be suctioned thoroughly, including the mouth and oropharynx. Insert the new tube at an angle, and remove the obturator and replace with inner cannula and lock into position. Inflate the trach cuff using 10cc sryringe. Assess patient for any breathing difficulties. Hazards that can occur include bleeding, difficult insertion, hypoxia, paroxysmal coughing, pneumothorax and infection. Special considerations state that over inflation of the trach cuff causes poor circulation in the tracheal mucosa, leading to necrosis and erosion. Over inflation of the cuff can also result	Z9999		

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
	IL6001705	A. BUILDING: ____ B. WING ____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 2	Z9999		

in pressure on the tracheosophageal wall, causing tracheomalacia or fistula. Maintenance of the airway should include an on going respiratory assessment for wheezing, stridor or dyspnea. Monitor the patient's vital signs and observe for bleeding, restlessness or skin crepitation. Auscultate lungs for abnormal breath sounds and observe for unequal expansion or retractions after changing tracheostomy tube to ensure proper adequate gas exchange. Two persons should be present for the procedure so that oxygenation and monitoring of heart rate continues throughout the procedure.

The Policy and Procedure entitled, Code Blue / #3407, dated October 2015, was reviewed. In bold print, the policy states, " Always change the trach when the resident is cyanotic and before transferring." The purpose of the Code Blue policy is to provide emergency care to residents who need respiratory and/or cardiopulmonary assistance. All cardiac and respiratory emergencies are designated as a Code Blue.

The Report of Incident / Accident involving R1, dated and timed 2/19/21 at 8:05pm, was reviewed. The report indicates that E5 (Charge RN) was notified by E6 (Certified Nursing Assistant, CNA) that R1's trach was out. The charge nurse observed R1's trach was in place. E6 stated she put it back in, before notifying her. A Code Blue was called. CPR was started. Paramedics transferred R1 to the hospital.

The Fax notification to Public Health, dated 2/20/21, was reviewed. The notification indicates R1 expired at the hospital at 9:15pm.

R1's Certificate of Death Worksheet was reviewed. The report indicates that R1 expired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ______ B. WING ______	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 3 on 2/19/21 at 9:20pm. R1 was born on 6/8/18. The Cause of Death indicates Early Monoclonic Encephalopathy, Intractable Seizures, Acute hypoxia, Dysgenesis of the Corpus Collosum, Ventilator Dependent, and Cardiac Arrest. Per interview with E1(Administrator) on 3/11/21 at 9:00am, E1 stated an autopsy was not performed on R1. During an interview with E7 (Respiratory Therapist, RT) on 3/9/21 at 10:10am, E1 explained he was the RT assigned to R1 the evening of 2/19/21. E7 stated he gave R1 her nebulizer treatment and suctioned R1. E7 stated while he was suctioning R1, her O2 sat alarm was going off because she was moving around a lot. E7 stated the Certified Nursing Assistant in the room with him, E6, had mentioned R1's probe wasn't working appropriately that day, and the Charge RN was aware. E7 stated he left the room to find E6 to inquire about the probe, but when he left the room, R1's alarm was not going off, her trach was in place and she was stable, except her heart rate was slightly elevated at 130-137 bpm(beats per minute). E7 stated R1's baseline HR was around 100 bpm. E7 explained he would never leave the room if a client's alarm was going off. E7 stated when he came back up the hall later, and heard the Code being called, that is when he discovered that R1 was the client coding. E7 stated he found out after the code E6 had reinserted R1's trach. E7 again confirmed when he left the room, R1's trach was in place. E7 offered E6 is not trained to insert a trach, and if you don't know how to insert a trach, you could cause lacerations in the airway, or bleeding. E7 also stated R1's trach does not come out easily. E7 stated R1 was not known to cough forcefully enough to expell her trach, nor did she have a large stoma, which would cause the trach to slip	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ________ B. WING ________	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 4 out easier. During an interview with E6 (Certified Nursing Assistant,CNA) on 3/9/21 at 11:00am via the telephone, E6 explained she was the assigned staff to R1 the evening of 2/19/21. E6 stated alarms were going off when E7 left the room. E6 stated she went over to R1's bedside and checked to ensure all the tubing was straight, and all of the equipment was plugged into the outlets. E6 stated the alarms were still sounding, so she looked under R1's head, and noticed R1's trach was out. E6 stated she put the trach back in, and then called out to the Charge Nurse who was sitting in the nursing station which was directly across from R1's room. E6 stated she knows she is not supposed to reinsert a trach, she is not trained to perform such a skill, and only trained nursing staff should perform this skill. E6 stated she just thought the trach was the lifeline for R1, so she decided to put the trach in herself. During a follow up interview with E6 on 3/10/21 at 2:00pm, E6 stated in addition to reinserting R1's trach, she also silenced both the O2 probe alarm and the ventilator alarm on R1's ventilator equipment. E6 explained the alarms would not stop going off, so that is why she silenced them. E6 stated she knows she should not silence ventilator equipment either. E6 was asked how long it took her to insert R1's trach. E6 stated not that long, maybe a minute "max". E6 was asked if after she reinserted R1's trach, if their was air exchange coming through R1's trach tube. E6 stated there was not, but she thought R1's chest was still going up and down. E6 stated R1 was quiet at this point. E6 stated then she called for E5, and told her R1's trach was out. E6 stated E5 came in, looked to see if the trach was in, and when she discovered that the trach was in place, that is when E6 told E5 that she put the trach in	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ___ B. WING ___	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 5	Z9999		

herself. E6 stated that E5 never assessed R1. She just told her she was going to be back with new trach supplies. E6 stated while E5 left the room to get her supplies, she noticed that R1 was not acting like herself, and her color was changing. E6 stated when she lifted up R1's head, it just fell back. E6 stated she went down the hall to get another nurse, E8 (Licensed Practical Nurse, LPN) who was the assigned nurse to R1. E6 stated when E8 entered the room, E5 was coming into the room as well. E6 stated E8 took one look at R1 and stated they needed to call a code immediately because her color had changed and she was no longer pink, but more bluish. Code Blue was called, and the ambu bag was used, as well as the Automated External Defibrilator (AED) machine, back board, and CPR was started, until the paramedics arrived and took over.

During an interview with E5 (Charge Nurse, RN) on 3/10/21 at 1:30pm via the telephone, E5 confirmed E6 called out to her while she was in the nursing station, and stated R1's trach was out. E5 stated no alarms were sounding in R1's room at the time. E5 stated she entered R1's room, and discovered R1's trach was in place. E5 questioned E6, stating R1's trach was in place. E5 stated E6 reported to her that she put the trach back in. E5 confirmed she did not assess R1. E5 stated her immediate thought was that she needed to change R1's trach out, since a staff not trained to insert a trach put the trach back into R1. E5 stated she just knew she needed to place a new trach in, so she left the room to obtain new trach supplies. E5 was asked what R1's vital signs were at this time. E5 stated she did not know. She never obtained a heart rate, O2 saturation level, or assessed if R1 had air exchange, or if her cuff was inflated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ______ B. WING ______	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 6	Z9999		

appropriately. E5 confirmed she did not call out for any other staff to assist to obtain the new trach supplies. E5 told E6 she would be right back. E5 stated she did not know how long she had been out of the room, but stated when she returned to R1's room, she saw E8 and E6 walking into R1's room. E5 stated at this time, R1 was bluish in color, and a code was called. E5 stated she never ended up changing the trach because the code was started. E5 stated R1 does have seizures, but she is not normally one that desaturates fast. E5 stated she does not know how long R1's trach was out before E6 put it back in and called for help. E5 stated E6 should have called us for assistance, and a Code blue should have been called, because anytime a trach comes out you need to call a code. E5 stated when E6 initially called her into the room, no alarms were going off. E5 stated E6 told her she silenced R1's alarms. E5 stated E6 is not allowed to silence the alarms. E5 admitted she did not assess R1, except for making sure her trach was in place. E5 explained her first thought was airway, and obtaining a new trach. E5 stated the trach ties were in place when she saw R1, and R1 is not usually one of the clients whose trach comes out easily. E5 confirmed R1's trach never was changed out, because once the Code Blue started, they never had a chance to do so.

The Incident Report Final Conclusion, dated 3/11/21, involving R1 for the incident of 2/19/21 was reviewed. The conclusion summary states after an in-person meeting with Administrative staff and review of equipment readings and witness statements, the final conclusion was reached. To summarize, at 7:40pm, E7 saw R1 as his last patient in Room 110. E6 was in the room at the time documenting in the electronic health records. Prior to suctioning, E7 silenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ___ B. WING ___	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 7 the alarms before suctioning R1. The ventilator will silence for 30 seconds, and then will reprogram. While suctioning, R1's pulse ox went off. E7 inquired with E6 about replacing the probe on her finger, however, the pulse ox alarm was no longer going off, so E7 left the room at approximately 8:07pm. E6 walked over to R1 to check on her, and reported that she silenced the pulse ox machine before she discovered that R1's trach we dislodged. E6 stated that she put the trach back in. At approximately 8:13pm, E6 tells the charge nurse, E5, that R1's trach is out, and that she put it back in. E5 verified that the trach was in. E6 indicated that the trach ties needed to be changed out, so E5 went to obtain new trach ties in the supply room behind the nurses station. E6 left the room around 8:14pm to summon E8(Licensed Practical Nurse) who was down the hall. E8 immediately went into R1's room to look at R1, as E5 was returning to the room at the same time with the trach ties. E8 called a Code Blue at 8:16pm. At this time R1 was gray, and life saving measures were immediately taken. E5 call 911. R1 was pronounced dead at the hospital at 9:20pm. The company policies that were violated include the timeliness of calling a Code Blue, trach insertion by a TA/Certified Nursing Assistant, and tampering with equipment. During an interview with E1 on 3/11/21 at 2:50pm via the telephone, E1 stated she terminated E7, E5 and E6. E1 stated she is not clear on what exactly occurred on the night of 2/19/21, because of conflicting witness statements and interviews, but it appears after looking at the ventilator reports, R1 was not stable as E7 left the room. E1 stated E7 should not have left the room if R1 did not have stable readings. E1 also stated the CNA should not have inserted the trach, as she is	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001705	A. BUILDING: ____ B. WING ____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HABILITATION CENTER	121 WEST 154TH STREET HARVEY, IL 60426

(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
Z9999	Continued From page 8 not skilled to do so and it is against company policy. E6 should not have silenced the machines either. E5 should have assessed R1 and not left the room to obtain trach supplies. E5 and E6 should have called the Code Blue as soon as they were aware R1's trach came out. "That is in our Code Blue policy as its considered a respiratory emergency. Our staff did not meet up to our facility expectations, and therefore, all three staff have been terminated." (A)	Z9999		