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
	IL6010433	A. BUILDING: ______ B. WING ______	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPARTA TERRACE	1501 MELMAR DRIVE SPARTA, IL 62286

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Z 000	COMMENTS Facility Reported Incident of 05/10/2021/IL133844 Complaint Investigation: 2193435/IL134010	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.700a) 350.1210 350.1220j) 350.1230b)7) 350.1230d)1)2)3) 350.3210o) 350.3240a) Section 350.620 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. 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 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of	Z9999	Attachment A Statement of Licensure Violations	

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that resident

Section 350.1210 Health Services
The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1220 Physician Services
j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

Section 350.1230 Nursing Services
b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.
d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.
3) First aid in the presence of accident or illness.

Section 350.3210 General
o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease,

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unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

Section 350.3240 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)

These requirements were not met as evidenced by:

Based on record review and interview, the governing body failed to implement policies and procedures to prevent neglect for 1 of 3 individuals in the sample (R1) when they failed to:

-Ensure staff followed the Facility's Policies and Procedures: Abuse and Neglect Program, Emergency Care-Basics, Accident/Incident Reporting (R1).

-Ensure staff followed Facility's Nursing Policies and Procedures: Nursing Services, RN Trainer Job Description, Contacting the RN Protocol (R1).

-Assess and monitor individuals for signs/symptoms of a worsening condition (R1).

-Ensure staff were competently trained to identify signs/symptoms of illness, reporting a worsening condition prior to hospitalization for Altered Mental Status (R1). and document a change in medical condition to the RN on a GER (General Event Incident/Accident Report) or RN Trainer sheet for (R1).

-Document assessments including vital signs (R1).

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-Ensure a follow-up assessment is completed for an unusual occurrence of intermittent nosebleeds lasting longer than 6 hours and abnormally low pulse vs oxygen level for R1

-Ensure safeguards were in place to monitor for signs and symptoms of hypothermia for an individual with a history of hypothermia.

-Follow physician orders including general standing orders (R1).

-Notify the guardian of a fall requiring an emergency service call (R1), and that facility unauthorized staff failed to ensure treatment by signing a refusal for treatment for 1 (R1) of 3 individuals.

These failures resulted in R1 being transferred to local hospital emergency room and admitted for treatment of Altered Mental Status, Hypothermia, Hypotension Bradycardia, Pancytopenia, Community Acquired Pneumonia. R1 expired while in the hospital.

1. The facility's policy titled, "Abuse and Neglect Program," dated 12/2020, documents in part: "Policy: It is the policy of this facility that residents have the right to be free from verbal, sexual physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property an neglect. Residents are not to be subjected to abuse, corporal punishment, and misappropriation of property or neglect by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other

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Z9999	Continued From page 4 individuals. Definitions: Neglect-failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness. Definitions: Neglect-Failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness. PROCEDURE-REPORTING: 1. If any incidents or possible incidents of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property or neglect are observed or suspected, it is the responsibility of each partner, regardless of his responsibilities, or if on or off duty, to immediately report the incident to his immediate supervisor. Immediate reporting means calling the immediate supervisor and/or administrator within 5 minutes of the incident." 2. The facility's policy titled, "Emergency Care-Basics," dated 3/2007, documents in part: "Procedure: Bleeding-Nose: 1. Assist the individual to a sitting position, leaning slightly forward. 2. Pinch the bridge of the nose firmly for 5 minutes. If the individual will allow, ice may be applied to the nose. 3. Keep the individual calm. 4. Assess vital signs. 5. Notify the nurse." The policy further documents, "Head Injury: 1. Maintain the individual in the position found if possible. 2. Determine if the individual can move their arms and/or legs. 3. Assess vital signs. 4. Apply ice pack to injured area if not open. If area is open and bleeding, follow bleeding protocol. 5. Contact the nurse." 3. The facility's policy titled, "Accident/Incident Reporting, Proper Filling out of Accident/Incident (GER) Forms," undated, documents in part: "1. When filling out an incident report (GER), only	Z9999		

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state the facts. What you noted, what you did, who you contacted, was there a follow-up, how the incident occurred, etc. Ask the resident as much information as you can on how they obtained the injury as that needs to be stated on the incident report. You must also write whether you applied first aid, if you called the nurse, what the nurse said to do, etc." The policy further documents, "4. Reportable incidents include, but are not limited to: a. Peer to peer, b. Unknown origin, c. ER visit, d. Stitches, e. X-rays, f. Anything out of the ordinary, g. Fire dept., police dept., or any outside official agency being called. 5. When you have a reportable, typically these people are notified: a. Administrator, b. RN, c. Guardian, d. Physician/Psychiatrist."

4. The facility's policy titled, "Nursing Services," dated 4/2021 documents in part, " Nursing Service Assessment: 6. Chronic ongoing health interventions. Unusual Occurrences: 1. Assessment completed within 24 hours of occurrence."

5. The facility's policy titled, "RN Trainer Job Description," dated 2/2014, documents in part: "Basic functions: To provide the best possible climate of health and well-being for every individual and staff member in the facility, and assuring each of proper medical care. To provide a service that meets the physical, medical, emotional and safety needs of the participant in a professional manner, while protecting the participant's uniqueness, dignity and right to privacy. Responsibilities: 8. Provide on-going oversight and yearly re-evaluation of authorized DSP's. 15. Perform monthly quality assurance reviews of medication records, and other documentation related to medication administration and adherence to medical plans of

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the individuals, (i.e. taking and recording vital signs, weights and menses)." The policy further documents, "32. Working in collaboration and communicating with DSP staff related to changes in medical, physical needs of the participant and provision of health related information that will increase their knowledge of medical conditions and related health problems, so as to enhance their ability to recognize and report potential health related issues to the nurse."

6. The facility's policy titled, "Contacting the RN Protocol," dated 5/2021, documents in part: "PROTOCOL: WHEN SHOULD I CONTACT/NOTIFY THE RN? 3. Anytime vital signs are not within normal limits 4. Any significant change in condition 5. When the individual is not acting as usual, or appears to be ill 7. Anytime there is an injury in which the client may need medical attention 8. Anytime there is an incident with injury-cut, skin tear, bruise, swelling, etc. 9. Anytime you feel uncomfortable with an individual's situation or have questions about an individual's disease or condition 13. Anytime you feel a medical problem with an individual is not being taken care of 15. Anytime a resident has a witnessed or unwitnessed fall. HOW TO NOTIFY THE RN? In the event of a minor injury, the RN shall be notified via GER or S-Com. For injuries that effect a change in condition, the RN shall be contacted immediately. WHAT IF THE RN DOESN'T ANSWER RIGHT AWAY AND YOU FEEL YOU HAVE A TRUE EMERGENCY? Call 911-EMS and/or send the individual to the ER and talk to the RN as soon as possible." The policy further documents, "Oversight: RSD will monitor for compliance and report any discrepancies to the administrator."

7. The facility's Policy titled, "Guardian

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Notification dated 3/2015 documents, "Policy: It is the policy of this facility that guardians are informed of individual's medical condition, developmental and behavioral status, attendant risks of treatment (refers to all treatment, including medical treatment) and the right to refuse treatment." Procedure: In order to improve the process of notification of guardians, please use the following guidelines. This will ensure adequate communication between the facility and the guardian. The Residential Service Director (RSD)/Qualified Intellectual Disabilities Professional (QIDP) may delegate the responsibility to the LPN (Licensed Practical Nurse/Registered Nurse for medical notifications. * Guardians are to be notified of at least the following: * Emergency Services (911, Emergency Room visit, Prompt care, Police) * Medical Services * Significant illness/Accidents (falls, illness or accident that require a physician notifications, injuries of unknown origin. * Unusual incidents."

R1's Individual Service Plan (ISP) dated 10/8/2020, documents R1 functions within the Severe Range of Individuals with Intellectual disabilities.

R1's Physician Order (POS) dated 5/2021, documents the diagnosis of Hypertension, Chronic Anemia, Mitral Valve Prolapse, Atrial Fibrillation.

R1's History and Physical dated 3/2/2021 from the Local Hospital documents, "(R1) was monitored on seizure precautions Ativan was ordered as needed for seizure activity. She was hypothermic, Temp. 95.1 degrees rectally. 93.7 and 91.4. IV fluids were warmed and bear hugger was applied, she was also hypotensive and

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received IV fluid bolus."

R1's office/clinic notes dated 4/13/2021 documents, "Patient was hospitalized last summer for an episode of hypothermia."

R1's Quarterly Nursing Physical Assessment dated 4/22/2021 documents, "Hospitalized 3-2021 for seizure disorder and Hypothermia. Temp. on this assessment 97.0 Extremities cool to touch per usual."

R1's Emergency Medical Service (EMS), Patient Care Report, dated 5/8/2021, timed 5:36 AM, documents, "On 5/8/2021 @ 5:36 AM we were dispatched to 40 year old (Inaccurate age provided by E6 to EMS) who rolled out of bed unable to get up. The caretaker (E6-DSP Direct Support Person) reports she witnessed the incident and the patient is not injured; caretaker reports patient is acting normal. Patient does not have any visible injuries currently. Patient was assisted up to her feet and then to her walker. The caretaker reports she does not believe the patient needs transport to the hospital, and that she and then other staff will be there to monitor the patient. Caretaker signed Refuse treatment and transportation."

On 5/18/2021 at 10:25 AM during telephone interview E6 stated, "On Saturday morning 5/8/2021 around 5:00 AM, I sat R1 up on the side of the bed and tried to get her up from a sitting position, R1 went backwards and fell off the side of the bed and landed on her right side, she did not hit her head, I called E3 Residential Service Director (RSD) to ask if I could call EMS for lift assist and she said I could. E6 further stated that before EMS arrived R1's nose began to bleed and R1 had also had a bowel movement, so I

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cleaned her up before EMS got there." E6 was asked if she reported the nosebleed to the EMS staff, E6 stated, "Yes." However, interviews with the EMS crew confirm that they were not told R1 had a nosebleed prior to their arrival. E6 was asked if she notified the administrator or the RN trainer, filled out any documentation, General Event Record/ Incident Report/ RN-Trainer notification on R1 falling out of bed and having a nosebleed? E6 stated, "No. I called E3 the Residential Service Director."

Telephone interview with Z5/EMT (Emergency Medical Technician) on 5/18/21 at 1:48 PM, when asked if Z5 was aware R1 had a nosebleed the morning of 5/8/21? Z5 stated, "Not that I can remember." Z5 was then asked if Z5 had known about R1's nosebleed if Z5 would have taken R1 to the ER? Z5 stated, "It would've been a different story and we would've asked more questions. I don't remember being told about her having nosebleeds."

Telephone interview with Z6/EMT on 5/18/21 at 1:54 PM, when asked if Z6 had been told about R1's nosebleed on 5/8/21? Z6 stated, "No, it's not in my documentation that R1 had a nosebleed on that morning." Z6 was then asked if he would have recommended to bring R1 to the ER based on her nosebleed alone? Z6 stated, "Yes."

R1's Accident/Incident Report, dated 5/8/2021 at 8:36 AM, completed by E2 RN Trainer documents, "DSP (Direct Support Person) reports resident's nose bleeding, picked a scab, stated blood "trickling" I gave instructions to apply mild pressure to bridge of nose and apply an ice pack to bridge of nose. Notify me if it starts to gush."

Further review of Accident/Incident Report

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documents, calls received by RN from DSP staff E4 on 5/8/2021 8:51 AM-"Nose stopped bleeding, 9:20 AM, nose bleeding-gave instructions same as above and trim fingernails. Slow trickle. 2:20 PM-nose bleeding able to get stopped. Passed large blood clot which caused bleeding. No other reports of nosebleed."

Interview with E4 Direct Support Person (DSP) on 5/15/2021 at 8:15 AM, E4 stated, "On 5/8/2021 I was told by the night staff E6 that R1 had fallen out of bed earlier that morning and that EMS was called to help get R1 up. E6 told me that she had completed an incident report and had told the RN trainer. R1's nose started to bleed around 8:30 AM so I called the RN trainer. R1 was tired and sluggish. I didn't think much about it. R1 had nose bleeds quite a bit, I would get it to stop, she had some type of sore in her nose, we cut her nails, she continued to pick at her nose and have blood on her hands and arms. We had a hard time keeping the ice pack on, I have worked here for over a year and have never known R1 to have nosebleeds. R1 would not eat on her own and I had to spoon feed her." E4 looked over his telephone logs and stated, "I called the RN at 8:36 AM, 8:51 AM, 9:20 AM, 10:54 AM, 2:20 PM, 4:16 PM, 7:52 PM and 8:57 PM to report on R1. R1 showed sluggish and unmotivated behavior, seemed as if she was in a trance, ate very little and was declining in being able to eat or drink." E4 was asked if he completed any documentation, GER/Incident Report/ RN-Trainer notification on R1's condition change? E4 stated, "No I did not."

Interview with E7 DSP with hire date 5/5/2021, stated, "I worked 8 AM-4 PM on 5/8/2021. I came in and R1 was in the hallway in her wheelchair. I noticed her shirt was wet, there was a good

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puddle of blood. I got E4 and we cleaned her up. R1 had blood on hands and arms. We put an ice pack on her nose and tried to stop it by pinching her nose. The nosebleed would stop but started up again so we just continued the same protocol the RN trainer and given us." E7 further stated, "We ended up changing R1's shirt about three times, one of the shirts was red and one of the shirts was black. R1 would sniff her nose and blood would come out of her mouth. I think the nosebleed stopped about 2:00 PM. R1 did not eat Saturday, I tried to give her sips of water." E7 was asked if she herself contacted the RN Trainer or fill out any documentation, GER/ Incident Report/ RN-Trainer notification on R1's condition? E7 stated E4 had called the RN trainer several times. E7 further stated that she did not complete any documentation on R1's condition.

Telephone interview with E8 DSP on 5/18/2021 at 9:30 AM, E8 stated, "On 5/8/2021 I worked 2 PM-9 PM shift, I was told by E4 that R1 had fallen out of bed that morning and that she had several nose bleeds after that and that the RN trainer had been contacted several times. E8 continued to state that R1 seemed tired, not acting usual self, and would not eat. E8 was asked if she contacted the RN trainer or document on the GER/ Incident Report/ RN-Trainer notification on R1's condition? E8 stated, "No she did not document R1's condition and that E4 was making the calls to the RN."

R1's Accident/Incident Report, dated 5/9/2021 at 5:39 PM, completed by RN-Trainer, documents, "Direct Support Person reported resident spit one of her 4 PM meds out was partially dissolved and couldn't make out which one it was. Also stated oxygen on reading in 40's, asked if resident having resp (respiratory) distress, SOB

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(shortness of breath) stated, "No". I gave instructions to warm fingers up and continue to try checking. Let me know if she shows signs of distress."

Interview with E4 on 5/18/2021 at 8:35 AM, E4 stated, "I called E2 RN-trainer around 5:30 PM on 5/9/21 to report that R1 was spitting out her medications and letting pills fall out of her mouth. I also told her that the oxygen machine wasn't registering and the numbers for the pulse and oxygen levels were in the 40's. R1 was not her normal self, like no one was there. I was told by E2 to warm up R1's fingers and continue to try and check." E4 was asked if he rechecked? E4 stated that E8 DSP had checked R1's pulse manually and it was in the 40's and the oxygen saturations were 92. E4 confirmed he did not call E2 back. E4 was asked if he thought he should call EMS? E4 stated, "I didn't really think I could do that, I was hoping the nurse was going to help me out a little bit." E4 was then asked if he completed a GER/Incident Report or RN-Trainer sheet on R1's change in condition? E4 stated, "I did not."

Telephone interview with E8 on 5/18/2021 at 9:30 AM, E8 stated, "On Sunday 5/9/2021 R1 was more lethargic, not coherent and stayed in bed most of the day. E8 further stated when E4 was trying to get R1's vital signs, the machine was not registering and the pulse was in the 40's. E8 then stated, "I checked R1's pulse manually and it was 40 and her oxygen reading was 92. I gave R1 a bed bath, and when I put R1 to bed she was cold/tired and her tongue was outside the side of her mouth." E8 continued to state that she contacted E3 RSD because she was concerned about R1 and E3 told her to contact the RN and follow her instructions. E8 was asked if she

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Z9999	Continued From page 13 notified the RN on the manual pulse of 40 and R1's condition at bedtime? E8 stated, "No E4 made the call." E8 was asked if R1's temperature was taken due to her being cold. E8 stated, "No". E8 was then asked if she documented R1's change in condition? E8 stated, "No I did not." Interview with E6, DSP on 5/18/2021 at 10:25 AM, E6 stated, "I worked 9 PM-9 AM on 5/8/2021 and 5/9/2021. E6 further stated she had been made aware by E4 that R1 had had nosebleeds on 5/8/2021 with RN notification being made. E6 stated she was told on 5/9/2021, E4 and E8 had also reported that R1 had not been her usual self and more lethargic. E6 was asked if she documented on R1's condition either night 5/8/2021 or 5/9/2021 into 5/10/2021? E6 stated, "I did not document anything, I just checked on her every two hours, she was asleep and breathing." Interview with E3 , Residential Service Director (RSD)on 5/19/2021 at 8:35 AM, E3 stated, "I did get a call from E8 the evening of 5/9/2021 voicing concern for R1 and the pulse low, I think 40, I told her to contact the RN and follow her instructions. E3 stated when she arrived for work on 5/10/2021 E6 told her everything was fine and that R1 did not want to come out for breakfast. I took the medication cart down and did vital signs around 6:00 AM and R1 seemed tired, I took her vital signs, Temperature 98.4, Pulse 44, Blood Pressure 84/71, I tried to reach the RN and the administrator with no answer so I called 911 and had R1 taken to be evaluated. E3 was asked if there was any vomit noted on R1's shirt or in her mouth? E3 stated, "I did not see any vomit." R1's medical record was reviewed and has no documentation of an Incident Report/General Event Record being completed on R1's fall on	Z9999		

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5/8/2021 requiring EMS service until a late entry on 5/10/2021. There is no Incident Report/General Event Record or RN-Trainer notification sheets documenting R1's declining condition beginning on Saturday May 8th with reports of R1 not eating/being lethargic and/or a clear description of health status related to R1's nose bleeds. There is no documentation of vital signs being taken throughout the day during the time frame R1 had the nosebleeds except for the routine blood pressure readings documented at 8 AM and 8 PM. There is no Incident Reports/GER or RN-Trainer notification sheets completed on 5/9/2021 with the reports of R1 becoming increasing lethargic, not acting her usual self, being cold, and/or a clear description of pulse/or oxygen status/rechecking of R1's pulse and oxygen levels once reported low on 5/9/2021.

R1's EMS report, dated 5/10/2021 at 6:26 AM, documents, "Immediate, unconscious/fainting, Chief Complaint: Altered Consciousness/unresponsive. Primary Impression: Altered Level of Consciousness, Secondary Impression: GI bleed. B/P unable to complete, Pulse 50 Respirations 16, SPO2 (oxygen levels) unable to complete, 6:34 AM Blood pressure 75/53 Pulse 43, Respirations 14 SPO2 58 percent Ambient air."

The Narrative for the 5/10/2021 EMS call documents, "Was dispatched to the above location for a 65 Y/0 (Inaccurate age provided by E6 to EMS) female patient who is unresponsive with labored breathing. Arrived at the sending facility and received report on the condition of the patient from the staff member (E3 Residential Service Director) who states that the patient was found this morning to be unresponsive with labored breathing. She states that the patient was

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Z9999	Continued From page 15 last reported at her base line by staff when she went to bed last night. Arrived at the patients side and found the 65 year old female patient to be conscious and alert to pain. The patient was found to be pink, warm and dry with clear and equal lung sounds. The patient was found to have a black tongue and has looks like black emesis on her shirt. Vital signs and history were taken and recorded. The patient was placed on the cardiac monitor and sinus brady noted." R1's Clinical Report from the local hospital dated 5/10/2021 at 6:42 AM documents, "Chief Compliant: Changed Mental Status. This started last night and is still present. The patient is described as having decreased responsiveness. Physical Exam: Vital signs 7:12 AM, blood pressure 77/46, MAP (mean arterial pressure) 56, Heart rate 66, respirations 18, oxygen saturations 97 percent non-rebreather at 15 liters/minute. Hypotensive. Bradycardic. Temperature 84 F (rectal) Hypothermic. Oxygen saturation low. Appearance Lethargic, ENT (ears, nose and throat) coffee ground emesis in mouth." R1's laboratory results, dated 5/10/2021 at 7:52 AM, documents R1's White Blood Cell count was low at 1.6 (range 3.7-10.9), Red Blood Cell count low 3.20 (range 3.50-5.30), Hemoglobin low at 8.8 (range 10.8-15.8), Platelet count low at 44 (range 140-450), Partial Thromboplastin Time (PTT) high at 57.8 (range 23-33), Creatinine high at 1.88 (range 0.60-1.10), Blood Urea Nitrogen (BUN) high at 89 (range 8-23) and Chloride high at 112 (range 96-108). R1's Chest X-ray taken on 5/10/2021 at 7:39 AM, documents, "Impression: 1. Prominent diffuse bilateral confluent central lung opacity of uncertain etiology. Congestion, consolidation, and	Z9999		

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edema are all considerations. 2. Enlarged Cardiac silhouette not significant change from prior studies."

R1's Hospital Assessment Plan documents, "1. Community Acquired Pneumonia- IV Primaxin given, repeat chest x-ray, oxygen with as needed breathing treatments. 2. Hypothermia: Bear hugger. 3. Severe hypotension: family does not wish to continue vasopressors, will continue IV fluids with comfort focused care. 10. Pancytopenia (a condition that occurs when a person has low counts for all three types of blood cells: red blood cells, white blood cells, and platelets): repeat in am."

R1's History of Present Illness (HPI) dated 5/10/2021 at 12:16 PM documents, "HPI is taken from the emergency department record. Patient was brought into the emergency department per EMS after staff at the residential home noticed patient had a decreased mental status which was worsening over the last 1 days. The patient is typically nonverbal but has periods of yelling out. On admission to the emergency department the patient's blood pressure was 77/46, heart rate 40, respiratory rate 24, O2 (oxygen) saturations 86% on room air, rectal temperature 84.0. The patient received Intravenous fluid bolus and levophed and family was consulted. Family wishes for comfort care, IV fluids, antibiotics, and oxygen. The do not want intubation, CPR, or vasopressors."

R1's Death Summary dated 5/10/2021 at 4:51 PM documents, "Cause of Death: Multi-system failure, Principle Diagnosis: Community Acquired Pneumonia. Secondary Diagnosis: Hypothermia, Severe Hypotension, Developmental disability/severe, and Pancytopenia."

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Further review of R1's Medical Record/Physician Order Sheet, dated 5/2021 documents, "Check Blood Pressure and Pulse twice daily. Notify RN Trainer if Top # > 150 or < 100, Bottom # >90 or <60, Pulse >100 or <60."

R1's Medication Record reviewed from April 10th 2021 through May 10th 2021 documents, 2 pulses obtained and documented out of the ordered 30 days/60 opportunities:
1) April 10th recorded a pulse of 67 and
2) on May 2nd recorded a pulse of 48.
R1's Blood Pressures were documented twice daily with one out of range on 4/30/2021 of 155/75.

Interview with E2/RNT on 5/20/2021 between 11:15 AM-12:00 PM, when asked if staff should be documenting on R1's pulse record? E2 stated, "Yes." E2 then stated, "It doesn't say in the nursing services policy how often to review the RN trainer sheets and MARS." E2 was asked if R1's pulse of 48 was reported to you? E2 stated, "No." E2 was then presented with R1's MAR (Medication Administration Record) for April 2021 that documents numerous holes in pulse records and the documented pulse of 48. E2 then stated, "I must've overlooked hers that month. I should've caught that; I'll take the blame for that."

Interview with E1/Administrator on 5/20/2021 at 11:39 AM, when asked if she would expect the RN to review the MAR to ensure compliance? E1 stated, "Yes."

Interview with E2/RNT on 5/20/2021 at 10:45 AM, E2 was asked what interventions were in place to monitor R1's hypothermia? E2 stated, "They were doing daily temperature checks with the COVID

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monitoring."

Interview with E3 Residential Service Director (RSD) On 5/20/2021 at 1:00 PM, E3 stated, "We stopped doing daily temperatures in April after the residents received their COVID Vaccinations, we have been doing temperatures monthly."

Review of R1's temperature documentation from April 2021-May 10th, 2021, documents 4 temperatures obtained on 4/1/2021 at 98.9, 4/9/2021 at 98.7, 5/1/2021 at 98.7. On 5/10/21, at 6:10 AM, prior to EMS call for change of condition, R1 had a temperature of 98.4. Upon arrival to the emergency room, R1's temperature was documented at 84 degrees.

Interview with E2/RNT (Registered Nurse Trainer) on 5/18/21 at 11:30 AM, when asked if E2 was aware of R1's fall on 5/8/21? E2 stated, "No, not prior to Monday 5/10/2021." When asked who authorized E6 to refuse treatment? E2 stated, "I would not expect them to make the call for refusing EMS to transport to the hospital." When asked if E2 heard anything more that day regarding R1? E2 stated, "I was contacted around 8:30 AM with a report of R1 having nose bleeds, I was told R1 had picked her nose. I received 4 calls beginning at 8:36 AM, 8:51 AM, 9:20 AM from E4 that R1's nose had stopped at 8:51 AM but began bleeding again at 9:20 AM. I told E4 at that time to trim R1's fingernails. I received another call at 2:20 PM, from E4 stating that R1 had passed a large blood clot and R1's nose had stopped bleeding. I did not receive any calls after 2:20 PM on 5/8/2021." E2 was then asked if she followed up with a physical assessment after R1's reported nose bleeds? E2 stated, "No the nose stopped bleeding and I was not told R1 had any

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change in condition, being lethargic or was not eating." E2 was then asked what was R1's pulse ox on 5/9? E2 stated, "It wasn't working properly, I instructed them to warm her fingers due to the pulse ox not reading pulse pressure or oxygen. In order for a correct reading, both numbers need to be shown. The staff did not tell me that R1's pulse was at 40. I was unaware of the symptoms R1 was displaying. There was confusion, they said her pulse oxygen level was 40, not her pulse and that she was not in distress and I heard her in the background and I was not told that R1 was lethargic, cold, and not eating so, there was no follow-up." In the same interview, E2 was asked how often do you check the MAR (Medication Administration Record) for vital signs? E2 stated, "I try to check them every 2 weeks, but for sure monthly." When asked if the DSP's documented anything on R1 the weekend of 5/8/21? E2 stated, "There is nothing documented by the DSP's on R1's nosebleed, her fall or symptoms and they are trained on how to report and notify properly. R1 has been steadily lethargic for the past year and declining, not wanting to walk and tired, but nothing she hasn't been already doing."

Interview with E2/RNT on 5/20/21 at 10:53 AM, E2 stated, "Staff should be completing a GER when any changes happen with a client." E2 was asked if staff should be filling out an RN Trainer sheet in addition to a GER? E2 stated, "Yes." When asked if staff have received training on completing an RN Trainer sheet? E2 stated, "I don't know if that's part of their orientation." E2 was asked if a formal training has been provided to staff regarding use of an RN Trainer sheet? E2 stated, "No."

Interview with E1/Administrator on 5/20/21 at 1:10 PM, when asked if E6/DSP had the authority to

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refuse treatment by EMS for R1? E1 stated, "That's a good question, I wouldn't have refused treatment for her. E1 Administrator further stated "I myself was not notified of R1 falling from the bed on 5/8/2021 until 5/10/2021." E1 confirmed that R1's guardian was not notified of the fall until after 5/10/2021. E1 was then asked if staff should have reported and documented the events regarding R1 after her fall? E1 stated, "Staff should have been documenting everything that happened over the weekend, made a GER (General Event Report) and a nurse notification." E1 was then asked if there is a procedure in place for monitoring clients overnight? E1 stated, "If there are any concerns, staff fill out a GER." E1 was then asked if there were any bed checks that are done for R1 overnight? E1 stated, "The QIDP (Qualified Intellectual Disabilities Professional) ended bed checks and I don't know why."

Telephone interview with Z2/ Hospital Attending Physician on 5/18/21 at 1:16 PM, Z2 stated, "It would have been a better thing if she were brought in on Saturday 5/8/21. If she had a fall, we would've had some imaging, but we were unaware of her falling, so no CT scan was done."

Telephone interview with Z3/Emergency Room Physician on 5/18/21 at 1:34 PM, when asked if R1 should have been evaluated sooner for her fall and nosebleed on 5/8/21? Z3 stated, "In my mind, given her age and baseline altered mental status, the nosebleed, I probably would've needed a head scan. I would have expected her to be evaluated after her nosebleeds and falls due to her age and baseline altered mental status."

During telephone interview on 5/20/2021 at 2:57

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Z9999	Continued From page 21 PM with Z4/R1's Primary Physician, Z4 stated, "Most of the time a fall from a resident would be sent to the hospital for an evaluation." Z4 continued to state that an individual that has a nosebleed with having difficulty stopping, (even without an unknown injury) would also be sent to the emergency room for an evaluation. Z4 stated R1 has not had any history of nose bleeds. Z4 stated that if there was any question related to the accuracy of the staffs assessments on R1 over the weekend of 5/8/2021-5/10/2021, the RN should give a clear direction of interventions...as "warm up R1's fingers and I want to be called back with an update," never leave it open to "call if there's a problem." Z4 was asked about R1's history of Hypothermia, if she would expect routine monitoring of temperatures, Z4 stated, "Yes, more than monthly since R1's previous episodes." Z4 was informed R1 had orders for B/P and Pulse twice daily with only 2 recorded readings of Pulses in 60 opportunities with one Pulse of 48 on 5/2/2021. Z4 stated that she would expect the facility to be documenting and reporting any abnormal reading, Z4 stated a recheck of R1's pulse should have been done. Z4 was asked if it was possible for a temperature of 94.4 to decrease to 84 rectally in an hour and 12 minutes? Z4 stated, "There is no way a temperature would drop that quickly." Z4 stated that she could not imagine a temperature of 84 degrees on someone being inside. Z4 further stated, "I find it concerning that the facility staff would not call anyone when a resident was deteriorating, and they would not reach out to someone. There has been poor communication with the facility for a while now." (A)	Z9999		