STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000335	A. BUILDING: _____ B. WING _____	C 06/04/2021

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WESTMONT MANOR HLTH & RHB	512 EAST OGDEN AVENUE WESTMONT, IL 60559

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S 000	Initial Comments Complaint 2172980/IL133471	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)2) 300.1210d)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 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 interview and record review, the facility failed to verify and obtain a physician's treatment order regarding oxygen administration and tracheostomy care. This applies to 1 of 1 resident (R1) reviewed for oxygen and tracheostomy care.This failure resulted in R1 being found with seizure-like activities and having a hypoxic event with pulse oximeter reading of 77% ,which required a transfer to to the emergency room. The findings include: R1, was a 61 year old with diagnoses that included ESRD (End Stage Renal Disease, on dialysis), diabetes mellitus, metabolic encephalopathy, acute respiratory insufficiency, hypertension and observed-seizure like activity. The hospital record ED (Emergency Department) dated 2/6/2021 showed that R1 had a seizure like activity, altered mental status change, acute respiratory failure and was unresponsive when brought to the ED (Emergency department) on 2/6/2021. R1 was then intubated. R1 was admitted to the intensive care unit. R1 had undergone tracheostomy insertion on 2/19/2021. The most recent hospital notes regarding R1's	S9999		

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S9999	Continued From page 2 tracheostomy was dated 2/26 and 2/28/2021 which showed that R1 was on an oxygen mask over her tracheostomy tube opening. These multiple pages of hospital records, approximately 60 pages were sent to V3 (Business Development/Admission Director) for screening and referral for R1's admission to the facility. This hospital record included R'1s H&P (History & Physical), tracheostomy insertion, and oxygen mask administration. The record also showed that R1 has a gastrostomy tube, subclavian catheter and a peritoneal dialysis catheter that was clamped. The records confirm R1 was receiving hemodialysis via the subclavian catheter. The hospital record showed no documentation that R1's tracheostomy was capped. Instead, the record had showed the use of an oxygen mask over the tracheostomy tube opening. R1 was admitted to the hospital on 2/6/2021 and stayed until 3/3/2021. R1 was transferred to the facility on 3/3/2021. On 6/2/2021 at 1:00 P.M., V3 (Admission Director) stated that the facility cannot accept a resident with "active and uncapped tracheostomy because the facility cannot provide the needed services for these kind of residents." On 6/2/2021 at 1:15 P.M., V4 (Assistant Director of Nursing) stated that "Hospital records for incoming residents need to be evaluated by me or the DON (Director of Nursing) .The former Director of Nursing from R1's admission date is no longer working at the facility. I did not screened (R1). The facility has to make sure that we can accommodate resident's assessed needs. We have to make sure it was properly set up for the oxygen and emergency tracheostomy kit tray in case of unexpected dislodgement of the tracheostomy tube."	S9999		

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S9999	Continued From page 3 The nurse's admission progress notes dated 3/3/2021 which was documented by V6 (Licensed Practical Nurse , Staffing Agency) showed that "(R1), a 61 year old female was admitted from (acute hospital medical center). (R1) arrived in facility aprox 7:15 PM via ambulance accompanied by two paramedics. (R1) is alert, does not appear to be in any pain at this time. Heart rate is regular, I/S clear bilaterally upon auscultation, abdomen soft non tender. Resident is nonverbal at this time. Resident is a dialysis pt., unsure of scheduled days at this point. Resident also has a tracheostomy. MD has been notified, Director of Nursing aware. Order obtained to continue with discharge orders. Noted and carried out." The nurse' admission progress notes showed that there was no nursing admission assessment regarding the type of R1's tracheostomy, whether the tracheostomy was capped or uncapped, cuffed or uncuffed and the size of the tube, There was also no follow up with the attending physician to verify and to obtain order whether to continue oxygen administration with humidifier and how many liter per minute for administration. No physician order was obtained during R1's admission to the facility regarding management and care services of the tracheostomy so that the airway patency would be maintained, the tube would not be plugged and to prevent hypoxia (a condition in which oxygen supply was insufficient). There was no documentation that there was an emergency tracheostomy kit with a correct size of extra and unused tracheostomy tube. A kit would be deemed essential in an event that R1's tracheostomy be dislodged. The POS (Physician Order Sheet) for the month of March 2021 showed that there were no	S9999		

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S9999	Continued From page 4 physician orders that was obtained regarding oxygen administration and tracheostomy care when R1 was admitted on 3/3/2021. On 6/2/2021 at 3:41 P.M., V6 (Licensed Practical Nurse from staffing agency) stated that she does not remember admitting R1. V6 also added that the standard of practice was to verify orders from the admitting physician and verify any questionable transfer orders ,such as in this case, R1's oxygen administration and tracheostomy care. V6 also added that since she does not remember R1's admission V6 stated "whatever I wrote on the admission progress notes that was what had happened." When asked regarding tracheostomy care and oxygen administration that was not verified based on the documentation ,(V6's progress notes and admission orders dated 3/3/2021), V6 said she had no explanation. V6 further stated that she will review R1's record and will call back the surveyor if there would be an additional information. V6 did not call back the surveyor throughout the survey time. On 6/2/2021 at 2:53 P.M., V7 (Licensed Practical Nurse from staffing agency) stated that she came to work on 3/3/2021-3/4/2021 from 11:00 P.M. through 7:00 A.M. V7 added that she remembered very well what happened that night, because she left the facility at 11:00 A.M. versus the scheduled 7:00 A.M. because "it was madness and extra busy working and spending 3-4 hours for a patient that was not even at the facility because of the unprepared, disorganized admission of a patient that did not belong at the facility. V7 stated there was no tracheostomy care kit at bedside, no respiratory therapist and the physician order was incomplete and it did not have an order for oxygen administration, tracheostomy care, suctioning and monitoring of	S9999		

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S9999	Continued From page 5 oxygen saturation with acceptable parameters to indicate adequate oxygen supply. V7 stated "I had to call the hospital where (R1) came from to determine what I was dealing with here, what kind of tracheostomy and how many liters of oxygen that was administered to her at the hospital. I saw (R1) sitting at the edge of her bed in her room around 11:00 P.M. I saw she had a tracheostomy tube but there was no oxygen administered to her. I then received a shift report from (V6). I was surprised that (V6) did not give me any report about (R1). I only found out about (R1) being a newly admitted resident when the pharmacist had called me regarding (R1's) medications. I checked (R1) at 12:30 A.M. (3/4/2021) and found her lying in bed and her lower extremities having a seizure-like activity, She was barely responsive to commands and tactile stimuli. I asked her if she was okay, she replied slowly, with a gesture, indicating that she was not okay. I then immediately checked her pulse oximeter to see if she was having enough oxygen supply. I was surprised because the reading of her oxygen saturation level was very low and it was only 77% and the normal reading was 92% and above. I rechecked the pulse oximeter again, using the facility's oximeter, and the reading was the same 77%. I administered 5 liters of oxygen via mask over her tracheostomy tube opening, but the oxygen saturation level remained the same. I suctioned her, and still the reading was the same. I found out that her tracheostomy tube was plugged with her mucous. It must have been because there was no oxygen administration, with humidifying solution. No humidity had dried her mucus and had plugged her tracheostomy tube, and without the oxygen (R1) got low saturation level of oxygen and was hypoxic. I called 911 immediately, and R1 was sent to the hospital at 12:35 P.M. (R1) had returned to the facility	S9999		

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S9999	Continued From page 6	S9999		

around 4:30 A.M., and I received a report from the ED nurse that they had given (R1) a medication for restlessness and oxygen administration was bumped up to 15 liters. When (R1) had stabilized with the oxygen saturation level that went up, the oxygen administration was given at 5 liters per minute. I informed (R1's) spouse regarding R1 being sent to the hospital. As I was leaving that morning around 11:00 A.M. on 3/4/2021, I saw (R1's spouse and (R1's daughter?) coming into the facility. But (R1) was on her way to another facility that would accommodate her care and services for her uncapped tracheostomy."

On 6/3/2021 at 10:40 A.M., V8 (Registered Nurse) stated he took care of R1 on 3/4/2021 before R1 was discharged to another facility that could provide care and services regarding her uncapped tracheostomy. R1 also said that "management arranged for (R1's) transfer, and I don't know if family was made aware of the transfer." V8 also added that R1 left the facility via paramedics at 11:28 A.M. on 3/4/2021.

On 6/3/2021 at 11:00 A.M., V1 (Administrator) stated that during the morning meeting with the facility's IDT (Interdisciplinary Team) on 3/4/2021, it was discussed that R1's care for her uncapped tracheostomy could not be addressed at the facility. Therefore, R1 was transferred to another sister facility that handled uncapped tracheostomies. V1 also added that R1's family was made aware of the transfer.

On 6/3/2021 at 9:00 A.M., V9 (Nurse Practitioner) stated that it is an expectation that the facility should have reviewed and screened R1's discharged documentation and hospital medical records to determine continuity of care. V9 also

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S9999	Continued From page 7 added that if it was indicated on the hospital record regarding oxygen mask over the tracheostomy tube, then a verified order must have been done upon admission and an oxygen administration order obtained. V9 also added that if the order of oxygen administration was not clear, then a verification should have been made by the admitting nurse to determine proper care. V9 added that oxygen saturation level of 77% was "very low and indicate hypoxia", the normal was 92% and above. V9 expressed hope that the facility had sent her to the hospital via 911. On 6/3/2021 at 10:00 A.M., V10 (Medical Director) stated she did not see R1 because she was only in the facility 3/3/2021-3/4/2021. V10 did not see R1 because R1 was transferred to another facility. V10 stated she specializes in geriatric populations in nursing homes and "because of lack of resources , such as lack of staffing, there are mistakes that happens. What matters was that (R1) was sent out to the hospital when she had hypoxia. The facility should have followed-up with the physician regarding oxygen administration and tracheostomy care when (R1) was admitted to the facility. The main thing was that the facility should have not have accepted her (R1) at the facility because (R1's) tracheostomy was uncapped. (R1's) uncapped thracheostomy status should had been determined upon R1's admission assessment. If this would had been determined upon admission, then (R1) would have been placed to another nursing home placement so care and management of her uncapped tracheostomy would have been provided. That facility where R1 was admitted to originally, does not cater to residents with active, uncapped tracheostomy because these residents are considered very high risk for respiratory failure /arrest and that the	S9999		

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S9999	Continued From page 8 facility does not have a respiratory therapist to correctly manage tracheostomy care and monitor adequate oxygenation." (A)	S9999		