

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2021
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-MOUNT ZION	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 WOODLAND DRIVE MOUNT ZION, IL 62549
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S 000	Initial Comments	S 000		
	Facility Reported Incident of October 7, 2021 IL139053			
S9999	Final Observations	S9999		
	Statement of Licensure Violations: 300.610 a) 300.1030 b) 300.1210 b) 300.2420 a)2) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1030 Medical Emergencies b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. Section 300.1210 General Requirements for Nursing and Personal Care		Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.2420 Equipment and Supplies a) Equipment 2) If the facility has residents who need the services of a suction machine, a sufficient quantity of such machines shall be provided to meet the needs of all such residents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide emergency medical equipment, airway management, and rescue breathing for R1 during a respiratory medical emergency for one of three residents (R1) reviewed for basic life support. These failures have the potential to affect ten (10) additional residents (R4-R13) who have chosen to be a Full Code. R1 subsequently died of Acute Cardiopulmonary Arrest.</p> <p>Findings include:</p> <p>R1's POLST (Physician Orders for Life Sustaining Treatment), dated 8/24/21, documents R1 is a</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Full Code, which means R1 has elected to have full life sustaining measures attempted, including cardiopulmonary resuscitation, in the event of a medical emergency.</p> <p>The facility Report to Illinois Department of Public Health, dated 10/7/21, by V2, DON (Director of Nursing), documents R1 was in the dining room, but had not eaten, when a CNA noted R1 had an ashen tint to R1's skin. This CNA notified the nurse. The nurse entered the dining room and completed an assessment on R1, and removed R1 from the dining room and took R1 to R1's room to further assess. During the assessment, R1 became unresponsive and subsequently CPR was initiated and 911 was called, due to R1 being a full code (full CPR during a life threatening emergency). EMS (Emergency Medical Service) arrived on scene and took over CPR for facility staff. Physician and POA (Power of Attorney) notified. Final Report to Follow.</p> <p>On 10/12/21 at 9:52 am, V1, Administrator, stated R1's incident is still being investigated, but R1 passed away.</p> <p>On 10/12/21 at 11:12 am, V5, RN (Registered Nurse), stated V5 gave R1, R1's medications that morning, and R1 was fine at that time. Then at lunch time, R1 was being brought down the hall in R1's wheelchair by V4, LPN (Licensed Practical Nurse), and an unidentified CNA. R1 had been in the Dining Room. R1 was pale, leaning to the right side, and drooling from R1's mouth. V5 stated, "You could hear (R1's) lungs were full by the way (R1) was breathing." V5 explained V5 wanted R1 in R1's room to further assess R1, so the unidentified CNA and V5 transferred R1 from the wheelchair to the bed using a mechanical lift, while V4, LPN, went to check R1's code status.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>V5 stated during the transfer into bed, R1 went into cardiac arrest and stopped breathing. V5 explained, "We immediately laid (R1) into bed and I (V5) got into bed with (R1) and started {chest} compressions." V5 stated V5 was yelling out orders for the crash cart and back board. The backboard was brought into the room so R1 was rolled onto R1's side, the backboard was placed under R1, then chest compressions resumed. V5 explained the staff were only doing compressions, no rescue breaths, because V4, LPN, was checking the crash cart, and V4 couldn't find an ambu bag (manual emergency resuscitation device). V5 stated another nurse, later identified as V3, Restorative Nurse, entered the room and took over doing compressions for a bit, while V5 continued shouting orders to call 911. V5 stated V5 then took back over doing compressions until EMS arrived. V5 explained V5 had checked R1's mouth and there was no food in R1's mouth or around R1's face, but R1 had a lot of saliva in R1's mouth and was drooling a lot.</p> <p>On 10/12/21 at 11:28 am, V3, Restorative Nurse, stated V3 was coming down the hall and someone told V3 staff were in R1's room due to a code situation. V3 explained V3 went into R1's room to help until EMS arrived, and when V3 walked in, V5, RN, was already doing chest compressions on R1. V3 stated V3 offered to give V5 a break with the CPR and took over for a bit, then V5 started again until EMS arrived. V3 stated chest compressions were being given, R1 had drool coming from R1's mouth, and V3 never saw rescue breaths being delivered. V3 stated during the time that CPR was ongoing at the facility, R1 never regained a heart beat or respirations.</p> <p>On 10/12/21 at 12:04 pm, V4, LPN, stated V4</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>was sitting at the desk when V9, CNA, said R1 wasn't being R1's normal self, so V4 went to check on R1. V4 explained, R1 "didn't look okay, he was leaning to one side, and wouldn't respond to me when I (V4) talked to (R1)." V4 stated at that time, V4 did not check for a pulse or respirations, "My main priority was getting (R1) out of the Dining Room and to (R1's) room to be assessed." V4 stated V4 did check R1's mouth since R1 was in the Dining Room with R1's food tray in front of R1, but that didn't have any food in R1's mouth. V4 stated on the way to R1's room, with R1 in the wheelchair, V4 passed R1's nurse, V5, who followed to R1's room. V4 stated once in R1's room, V4 left to check R1's medical record for R1's code status, and by the time V4 finished that, "things were getting hectic", so V4 grabbed the crash cart on the way to R1's room. V4 explained upon entering R1's room, chest compressions had already been initiated. V4 explained V4 had to leave the room again to get oxygen, but once back in the room, realized the O2 (Oxygen) connectors were not in the crash cart, so V4 had to leave R1's room again to get the needed supplies. V4 stated once back to R1's room, V4 took over doing chest compressions for about 15 seconds until EMS arrived. V4 stated no rescue breaths were being delivered, only chest compressions. V4 stated, "The contents of the {crash} cart had been emptied onto the floor and people were grabbing what they needed, but I (V4) did not see an ambu bag." V4 explained V4 is an agency nurse, so V4 has only been in the crash cart once or twice, and that was just to check where it was and that it was stocked, but never needed anything out of it. V4 stated V4 does not "recall ever seeing an ambu bag in the cart."</p> <p>On 10/12/21 at 12:28 pm, V3, Restorative Nurse,</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>stated V3 knows rescue breathing is an important part of CPR, but "there was no ambu bag in the cart or in (R1's) room to my knowledge. I (V3) was just focused on the {chest} compressions."</p> <p>On 10/12/21 at 12:32 pm, V5 confirmed the contents of the crash cart were emptied, "everything was everywhere." V5 stated, V5 did not see an ambu bag, but V5 was on the bed with R1 and V4 was the nurse looking for it, and no mouth to mouth was provided due to the large amount of secretions coming from R1's mouth, and there not being a suction machine on the cart to clear the secretions. V5 explained, "We did the best we could with the supplies we had."</p> <p>On 10/12/21 at 1:02 pm, V9, CNA, stated V9 was in the Dining Room with R1 and V10, R1's wife. V9 stated R1 was talking to V10, and then V10 left the facility so V9 gave R1, R1's lunch tray and asked R1 if R1 was going to eat. V9 explained V9 attempted to give R1 a bite of food, but R1 pushed V9's hand and the tray away, and said R1 didn't want anything. V9 then left to gather drinks for other residents and came back a couple seconds later to find R1 leaning to the side in R1's wheelchair with R1's arm dangling over the side. V9 stated R1's "eyes looked different", they were half open. V9 explained at that time, R1's color was normal, and R1 hadn't had any changes in R1's breathing, but knew that something wasn't right, so V9 went and got the nurse.</p> <p>On 10/12/21 at 2:58 pm, V2, DON, stated when a resident goes unresponsive from cardiac arrest, nurses are expected to initiate CPR & call 911. V2 explained CPR consists of opening the airway, performing rescue breathing, and chest compressions. V2 stated R1 should have been</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>suctioned due to the secretions, but the suction machine was not on the cart. V2 also stated R1 should have received rescue breaths via an ambu bag. V2, DON, confirmed the crash cart should be stocked with a suction machine and materials, oxygen tank and ambu bag. V2 stated V2 was aware there was not a suction machine on the crash cart at the time of R1's code, but was not aware the cart didn't contain an ambu bag.</p> <p>On 10/12/21 at 3:12 pm, V12, Physician, explained R1 has a history of cardiac disease ,and with R1 drooling that much, R1 "could have been choking on (R1's) saliva, it can happen so fast, they {facility} should have suctioned (R1) to ensure an open airway." V12 also stated rescue breathing should have been attempted with an ambu bag if R1 wasn't or couldn't be intubated. R1's Death Certificate documents R1's cause of death on 10/7/21 as "Acute Cardiopulmonary Arrest".</p> <p>On 10/13/21 at 10:35 am, V1, Administrator, stated the crash cart should be checked at least a couple times a week, and after each use by the night shift nurse to ensure all the equipment is available and restocked for the next medical emergency.</p> <p>The facility did not provide any documentation of the crash cart being checked and restocked.</p> <p>The facility provided an undated list of all residents with Full Code Status, which included R4, R5, R6, R7, R8, R9, R10, R11, R12, and R13.</p> <p>The facility undated and untitled CPR Policy documents staff must provide basic life support, including CPR, to a resident who requires</p>	S9999		
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S9999	Continued From page 7 emergency care prior to emergency medical services arriving, consistent with resident's advance directives (POLST Form). The facility undated Crash Cart Checklist documents Emergency Care Items that are to be in the Crash Cart, which consists of an Ambu Bag, Suction Machine, Oxygen Tank, Oxygen Key, Pocket Mask, Suction Tubing, Suction Catheters, as well as other emergency care equipment items. (A)	S9999			