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S 000	Initial Comments Complaint Investigation:#2199215/IL141240, #2290321/IL142387	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) 300.1210d)3)5) 300.1220b)2)3) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional	S9999		

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S9999	Continued From page 2 status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were Not Met evidenced by: Based on observation, interview, and record review, the facility failed to provide incontinence care as needed and in according to the plan of care for two residents (R8 and R9) reviewed for incontinence care. Also, the facility failed in multiple failures related to their Wound Care protocol, including: failure to follow the interventions they put in place for a resident to promote healing and prevention of the worsening of a pressure wound by not monitoring the skin daily, per shift; not conducting and documenting shower/bath skin audits; not establishing turning and repositioning schedule for resident dependent on staff for bed mobility and not including the schedule as part of the residents' plan of care; failed to use low air loss mattress with the correct settings for the resident and with	S9999		

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S9999	Continued From page 3 multiple layers of padding; failed to prevent a resident from developing a new facility-acquired pressure ulcer (R9); and failing to refer a resident to the facility's wound care specialist in a timely manner once a wound was identified as a Stage III wound and/or once the wound was deteriorating (R7). This failure affected three of three (R7, R8, and R9) reviewed for pressure ulcers and resulted in R9 developing a facility-acquired, Stage 2, sacral pressure ulcer and R7's wound progressing to Stage 4 and being hospitalized with Fournier's gangrene, requiring emergent surgical intervention. Findings include: R7 is a 76 year old female admitted to the facility on 11/18/21 from local hospital for physical and occupational therapy. R7 has medical diagnoses that include (but not limited to): Type 2 Diabetes Mellitus, Pressure Ulcer of Sacral Region, Stage 2, End Stage Renal Disease, Difficulty in Walking, Cognitive Communication Deficit, Muscle Wasting and Atrophy, and Dementia. Progress note dated 12/22/2021 14:08 documents that R7 was admitted to local hospital for rapid heart rate and shortness of breath. Hospital record documents that R7 was admitted on 12/22/2021 with diagnosis of acute respiratory failure with hypoxia (HCC), with chief complaint of shortness of breath and rapid heart rate. Hospital Admission History & Physical (includes): In ER, found to be septic, elevated LA (lactic acid), WBC's (white blood cells), UA (urinalysis) positive for UTI (urinary tract infection) ... (Objective Assessment) SKIN: sacral wound with	S9999		

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S9999	Continued From page 4 fecal contamination limiting exam, minimal periwound erythema, +ttp ...ASSESSMENT - Sepsis - differential includes UTI and wound infection, c/n exclude pulmonary source or C.diff ...Sacral wound infection. ED notes continue to include: Per radiologist, the patient has red flags of Fournier's gangrene (infection in the scrotum, which includes the area between the anus and vulva; with dead/dying tissue). ED physician note (12/22/2021 9:56PM) includes, "I explained the gravity of the situation and the patient may spend many days in intensive care unit and may never come off of the ventilator. I explained her other comorbidities put her at serious risk for significant complication including death. The husband understood all of this and gave consent to me over the phone which was then confirmed by other staff members. We will proceed urgently to the emergency room for wide debridement of the perineum. CT Abdomen and Pelvis, 1. Extensive soft tissue gas within visualized perineum, left greater than right, and extending superiorly into the left ischiorectal fossa and posterior to the coccyx and compatible with sequela of acute of acute Fournier gangrene. Urgent surgical consultation management is recommended. 3. Large amount of fecal material in the rectum with associated mild rectal wall thickening and presacral edema and indicative of fecal impaction with associated stercoral colitis (occurs when a patient has chronic constipation leading to stagnation of fecal matter). Operative Report reads: Date of Procedure: 12/22/2021, Pre-operative Diagnosis: perineal abscess, Post-operative Diagnosis: perineal abscess, Procedure(s): Wide local debridement of sacral decubitus ulcer and associated abscess incision and drainage ...Procedure ...The patient has a decubitus ulcer that measures	S9999		

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S9999	Continued From page 5 approximately 10 cm in diameter. We debrided all the necrotic skin, subcutaneous fat, and necrotic muscle down to the bone itself. We removed a lot of the fascia on top of the bone using sharp scissors or cautery. This excisional debridement was done until we could go no further and the hemostasis was achieved with cautery. On the CT, we knew the patient had abscesses tracking on either side of the anus and tracking toward the labia. These areas both had crepitus. We opened both sides with cautery and purulent fluid was expressed. We obtained cultures. We achieved hemostasis at these new counter incisions and easily tracked and connected to the main decubitus ulcers. 11/19/21, admission facility skin breakdown assessment for R7 documented R7 was at risk for skin breakdown (Braden score 16). Physician Progress Note [written by V34 (Doctor)] dated 11/26/2021 at 19:31 includes under "Plan: ...3. Evaluate patient for falls and skin ulcer prevention by the nurse and implement protocol." Care plan includes: Focus: (R7) has dx of Diabetes Mellitus (Date Initiated: 11/30/2021) Interventions: Check skin when assisting with ADLS (Date Initiated: 11/30/21) Focus: (R7) is AOx3, Incontinent of B/B, with decreased mobility. (R7) has an actual impairment to skin integrity and is at risk for further breakdowns based on a BRADEN Score of 16 AND related to PMHX of HLD, DM Type 2, HTN, GOUT, UNSTEADY GAIT, HX Pressure injury, Anemia. Coccyx: Pressure Ulcer (Date Initiated: 11/19/2021) Interventions:	S9999		

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S9999	Continued From page 6 - Evaluate and monitor for pressure ulcer potential, review profile quarterly (q 3 months) and PRN (as needed). (Date Initiated: 11/19/2021) - right buttock: cleanse with normal saline, apply medicated ointment & cover with dressing as prescribed. (Date Initiated: 11/19/2021) - Skin check Q Shift. Pay special attention to bony prominences. Assess skin during bath and routine care. (Date Initiated: 11/19/2021) - skin inspection: The resident requires skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. (Date Initiated: 11/19/2021) Progress Note [written by V12 (Nurse Practitioner)] dated 12/2/2021 at 10:35 includes, "A/P: #11 At risk for skin breakdown, Plan: Because of her decreased mobility, she is at risk for skin breakdown. Her skin should be monitored daily and be kept clean and dry. Plan was discussed with pt's nurse." 1/19/22 at 1:15pm, V45 (Family Member) stated, (R7) expired on January 13, 2022. V45 stated, after R7 was discharged from the hospital she went to a different long term care facility. When asked (R7's) cause of death, V45 stated, (R7) never really cleared the infection 1/19/22 at 3:10pm V33 (Wound Care Doctor) said, I am in the facility every Wednesday at 6:00am. I saw R7 on 12-15-2021, she had a stage 4 wound to the sacral area. I do not have any idea why I was not consulted as soon as the patient was admitted on 11-18-2021, I cannot tell you the wound was better or worse, since I only saw her on two different occasions, but the patient was in the building for several weeks before. V33 was made aware R7 was sent to the	S9999		

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hospital on 12-22-22, the same day he saw her, and his description and wound measurements were significantly different than the assessment from the ER. V33 stated, I did not measure the wound, the nurse was the one responsible for the measurements. I just copy her measurements. I remember telling them they need to change the staging of the wound from stage 3 to stage 4 because the wound had necrotic tissue. I do not remember if the wound had any signs of infection. The one that referred the patients to me is the wound care coordinator, she gives me a list every Wednesday when I come into the building.

1/20/22 at 1:30pm V29 (Registered Nurse/Wound Care Nurse) said, I do not remember the patient (R7). I do not recall how the wound was, (looking at the picture of R7's wound). I do not recall (R7) wound. I see I did an admission and I documented the patient had an open area. I do not remember if it was getting better or worse. I did the assessment, took the pictures and reported to the coordinator (V32, Previous Wound Care Coordinator) and the full time wound care nurse (V28, Wound Care Nurse/LPN).

1/20/22 at 3:30 PM V28 (Wound Care Nurse/LPN) is the former wound care nurse and said, I left the facility at the end of November 2021. I do remember R7, she was a hemo-dialysis patient that had a big wound to the sacral area. I told the wound care manager the patient needed to be seen by the wound care doctor because the wound was getting worse. The husband was very involved with her care. I remember I did not do R7's admission, otherwise I would have called R7's husband and let him know that she came to the facility with a wound and describe how the wound looked. I would have put R7 for V33 (Wound Care Doctor) to see

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her immediately before the wound deteriorated. The wound doctor (V33) comes every Wednesday in the morning at 6am. I would have completed the admission by putting an order for turning and repositioning, nutritional supplements such as Vitamin C, Zinc, Juven, Pro-stat AWC, a low air loss mattress, and laboratory tests to see how the albumin level is and a referral to the registered dietitian for further recommendations. The manager was responsible for referring any wounds to the doctor; we do not have any criteria to follow but definitely stage 3, 4, DTI (Deep Tissue Injury), and unstageable wounds are definitely a must to be seen by the wound care doctor.

1/21/22 at 8:00am V32 (Wound Care Coordinator/LPN) said, I was the wound care coordinator at the facility for 4 months, I left at the end of December 2021. I remember R7, the patient was totally dependent on staff for all ADL's (activities of daily living), she was incontinent, had dialysis on Monday, Wednesday, and Friday. I know the husband was present when we were doing the patient wound care. I do not remember if I spoke to him about the wound and how it was doing. I remember R7 was on my list to be seen by the wound care doctor but she was in dialysis. I do not remember if I documented in R7's file. I know the patient wound was a stage 2 when she was admitted but when V33 (Wound Care Doctor) saw her the wound was stage 4. The wound had developed necrotic tissue while at the facility, a sign the wound was deteriorating compared to the admission wound.

01/21/22 at 1:47pm, V4 (CNA/Staffing Coordinator) stated, the CNA's do skin checks on all residents daily and on every shift. They do it every shift because things can change from one

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shift to the next. If the CNA finds something, then they are to notify the nurse. Once the skin checks are done and showers given, the shower sheet is filled out and if there are any new areas of concern it is documented on the shower sheet. When asked what the circled areas are on the sheet with "Treatment" written next to it, V4 stated, means that the area is covered because of a treatment of some sort (wounds, etc.) and they don't remove that when providing care. The CNA's should also document in the EMR (electronic medical record system).

On, 1/21/22 at 2:35pm, V36 (RN) was asked about the condition of R7's wound. R7 stated she did not remember this resident or the condition of the wound. However, R7 stated in general, when doing wound care, she observes for any issues with the wound, like dark in color, pain, and it if looks infected. Signs of infection would be pus, green color, warm to touch. V36 was shown a photo from R7's wound documentation in the facility's EMR (electronic medical record) dated 12/14/21 and was asked to describe the wound that she saw in the photo, V36 stated, I would have notified the doctor because it does look like there are signs of infection and the tissue along the edges looks necrotic and there is slough - but I don't remember doing the treatment on this resident and I don't remember this wound.

1/21/22 at 2:47pm, V37 (RN) stated, I don't remember this resident and I don't remember this wound but if my name is on the TAR, that means that I did the treatment. When I do a treatment, I look for drainage, odor, pain, changes if I've seen it before, and how the resident tolerates the procedure. I notify the MD of any changes and inform the family. I also notify the MD if there is

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any infection, if the wound is not healing, if there is pain, and if it looks like the current treatment is not working. V37 was shown a photo from R7's wound documentation in the facility's EMR (electronic medical record) dated 12/14/21 and was asked to describe the wound that she saw in the photo, V37 stated, looking at this wound I can see there is slough and necrotic tissue around the edges. It looks like it's starting to get infected. I would notify the doctor about this and I would have documented it. But again, I don't remember this resident.

1/21/22 at 4:10pm V34 (Doctor/Medical Director) said, I do remember R7, but I am not in front of a computer to give you full details. I saw the patient but the wound care assessment is done by the wound care team and the wound care doctor. V34 was asked if he had considered referring the patient to the wound doctor since he had wound orders in place for almost a month and the wound was deteriorating, V34 stated, I was never informed the wound was deteriorating. I give my orders based on the report and information that the wound nurse reports to me. I do not remember seeing the wound. If the nurses were to report the wound was not improving or getting worse or infected, I would start antibiotics, order laboratory tests, and make sure the wound doctor sees the patient for further recommendations. If the dietitian recommends any supplements I do not have any problem giving the order to improve the healing process.

01/21/22 at 4:20pm, V2 (DON) stated showers/baths are given twice a week and as needed. When residents are showered, the CNA completes the Shower Sheet/Skin Audit Form.

1/21/22 at 4:37pm, V38 (Dietician) stated, she

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makes dietary evaluations, she puts it in the chart and puts the orders directly into the EMR, the nurse is supposed to go in and approve the orders. It's the nurses' responsibility to check the record to see if there are orders that need to be approved. V38 stated, I usually go back the following day to make sure they were approved. I don't know what happened that these did not get started until December 2nd. When reviewing R7's dietary evaluation, V38 stated, I wrote this on 11/21/21. V38 was asked how soon orders should be started once she makes the recommendation and she stated that they are usually started within a day or two. In this case, she recommended the Protein Drink for R7 to promote wound healing since she had a Stage 3 pressure ulcer. When asked if there could be any negative outcomes of not starting the recommended supplements soon after they were ordered and waiting until 12/2/2021 to start, V38 stated, it could delay and prolong wound healing. During this interview, V38 did not confirm that she went back to verify the nurses confirmed the orders for the supplements.

Surveyor requested facility to provide all shower/skin audit forms for R7 while in the facility and only three were provided (11/20/21, 12/8/21, and 12/22/21). All three forms have only the sacral area circled and labeled "treatment." No other documentation was provided to confirm that R7 received shower/skin audits done as scheduled.

Surveyor asked for documentation that skin checks were done daily, every shift as listed in the plan of care for R7 and facility was not able to provide such documentation during the course of this survey.

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S9999	Continued From page 12 Review of wound documentation in R7's medical record includes the following nursing wound assessments: Wound assessment detail report dated 11/19/21 1:20PM (includes): Wound: Coccyx Clinical Stage: 2 Tissue Types: Pink or Red Non-granulating = 100% Exudate: Amount - Scant, Type - Serosanguineous Wound Edge: Distinct & Attached Odor: No Signs of Infection Present: No Size (cm): 3.40 x 2.70 x 0.20 (L x W x D) Undermining: None Tunneling: None Current Plan & Comments: Skin alteration to right buttock. Measurements 3.4x2.7x0.2. TX provided. Wound assessment detail report dated 11/23/21 10:06AM (includes): Wound: Coccyx Clinical Stage: 3 Tissue Types: Pink or Red Non-granulating = 5%, Slough White Fibrinous = 95% Exudate: Amount - Scant, Type - Serosanguineous Wound Edge: Distinct & Attached Odor: No Signs of Infection Present: No Size (cm): 3.40 x 3.00 x Unknown (L x W x D) Undermining: None Tunneling: None Current Plan & Comments: 11/24/21 06:01PM by V28 (Wound Care Nurse/LPN): Patient medicated for pain before wound care by wound nurse there is 95% slough white fibrinous issue	S9999		

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S9999	Continued From page 13 and 5% pink none granulating tissue with a scant amount of serosanguinous exudate length 3.40cm width 3.00cm patient educated on pressure reduction on low air loss bed. Length 3.40c width 3.00 cm. will follow the plan of care. Wound assessment detail report dated 12/2/21 3:18PM (includes): Wound: Coccyx Clinical Stage: 3 Tissue Types: Slough White Fibrinous = 100% Exudate: Amount - Scant, Type - Serosanguineous Wound Edge: Distinct & Attached Odor: No Signs of Infection Present: No Size (cm): 4.00 x 3.00 x Unknown (L x W x D) Undermining: None Tunneling: None Current Plan & Comments: 12/2/21 07:24PM by V32 (Previous Wound Care Coordinator/LPN): Coccyx assessed noted with 100% Slough White Fibrinous tissue, Scant - Serosanguinous exudate, No signs of infection noted Periwound are Normal, Wound Edge are Distinct and Attached. Length - 4.00cm Width - 3.00 cm Depth - Unknown, Patient was educated on pressure reduction and repositioning patient assisted by staff with repositioning. Patient has LAL Mattress in place. Will continue to follow plan of care. Wound assessment detail report dated 12/7/21 7:21AM (includes): Wound: Coccyx Clinical Stage: 3 Tissue Types: Epithelial (Pale Pink or Red) = 100% Exudate: Amount - Scant, Type - Bloody Wound Edge: Distinct & Attached	S9999		

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S9999	Continued From page 14 Odor: No Signs of Infection Present: No Size (cm): 4.00 x 4.00 x 1.50 (L x W x D) Undermining: None Tunneling: None Current Plan & Comments: 12/8/21 05:27PM by V28 (Wound Care Coordinator/LPN): Patient coccyx with 100% pale pink epithelial tissue there is a scant amount of bloody exudate. Peri wound is normal there is no sign of infection length 4.00 width 4.00cm depth 1.50cm patient educated on pressure reductions assisted with turning by staff will follow the plan of care. Wound assessment detail report dated 12/14/21 4:54PM (includes): Wound: Coccyx Clinical Stage: 3 Tissue Types: Bright Pink or Red = 85%, Slough Loosely Adherent = 15% Exudate: Amount - Moderate, Type - Serosanguineous Wound Edge: Distinct & Attached Odor: No Signs of Infection Present: No Size (cm): 4.00 x 4.00 x 2.20 (L x W x D) Undermining: Present Location/Avg Extent: 12 o'clock to 12 o'clock / 1.50 cm Tunneling: None Current Plan & Comments: 12/16/21 01:45PM by V32 (Previous Wound Care Coordinator/LPN): Coccyx wound assessed noted with Bright Pink or Red: 85%, Slough Loosely Adherent tissue: 15%, No signs of infection, Moderate - Serosanguinous exudate, Periwound is Normal, Wound Edge are Distinct and Attached, Undermining Present at 12 o'clock to 12 o'clock / 1.50cm, Length - 4.00cm Width - 4.00cm Depth - 2.20cm. Patient has lal mattress in place to	S9999		

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assist with pressure reduction. Patient is being followed by wound care DR. Will continue of follow plan of care.

TAR (Treatment Administration Record) for December 2021, documents that V36 (RN) provided wound care treatments for R7 on 12/10, 12/11, 12/15 - 12/17/2021.

TAR (Treatment Administration Record) for December 2021, documents that V37 (RN) provided wound care treatment for R7 on 12/20/21.

Review of Physician Orders and Treatment Records document R7's wound care treatment and orders were being managed by her primary care physician (V34, Doctor/Medical Director) from the time of admission thru December 15, 2021. The facility's wound care specialist did not see R7 for evaluation until 12/15/2021 - almost a month after the resident was admitted with pressure ulcer on the coccyx.

Medical record includes a Dietary Evaluation conducted on 11/21/2021 for R7. The evaluation includes documentation R7 has skin alteration related to a Stage 3 pressure ulcer on the coccyx. Dietary recommendations include: Protein drink 30 ml BID (twice a day) and Protein Drink BID.

R7's Physician Orders include:
Protein drink, two times a day for Wounds, Start Date: 12/2/2021
protein drink, two times a day for Wounds, Start Date: 12/2/2021

Review of medical record confirms that R7 was initially seen by V33 (Wound Care Doctor) on 12/15/2021 at 6:00AM and Visit Report reads:

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S9999	Continued From page 16 "New patient being seen for wounds ...Wound #1 status is open. The wound is currently classified as a Category/Stage IV wound with etiology of Pressure Ulcer and is located on the coccyx. The wound measures 4cm length x 4 cm width x 2.3cm depth ...There is muscle and Fat Layer (Subcutaneous Tissue) exposed. There is a small amount of serosanguineous drainage noted. There is a large (67-100%) amount of necrotic tissue within the wound bed including Eschar, Adherent Slough and Necrosis of Muscle. The periwound skin appearance exhibited: Ecchymosis. The periwound skin appearance did not exhibit: Callus, Crepitus, Excoriation, Induration, Rash, Scarring, Dry/Scaly, Maceration, Atrophie Blanche, Cyanosis, Hemosiderin Staining, Mottled, Pallor, Rubor, Erythema ...Active Problems ICD-10 pressure ulcer of sacral region, stage 4 ...General Notes: comorbidities affecting wound healing and prevention include: impaired mobility - reposition q 2 hours; incontinence - evaluate q 2 hours; anemia; protein malnutrition ... Visit Report completed by V33 (Wound Care Doctor) on 12/22/2021 at 6:00AM reads: "Follow up for wounds ...Wound #1 status is open. The wound is currently classified as a Category/Stage IV wound with etiology of Pressure Ulcer and is located on the coccyx. The wound measures 4cm length x 4 cm width x 2.2cm depth ...There is muscle and Fat Layer (Subcutaneous Tissue) exposed. There is a small amount of serosanguineous drainage noted. There is a large (67-100%) amount of necrotic tissue within the wound bed including Eschar, Adherent Slough and Necrosis of Muscle. The periwound skin appearance exhibited:	S9999		

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S9999	Continued From page 17 Ecchymosis. The periwound skin appearance did not exhibit: Callus, Crepitus, Excoriation, Induration, Rash, Scarring, Dry/Scaly, Maceration, Atrophie Blanche, Cyanosis, Hemosiderin Staining, Mottled, Pallor, Rubor, Erythema ...Active Problems ICD-10 pressure ulcer of sacral region, stage 4 ...General Notes: comorbidities affecting wound healing and prevention include: impaired mobility - reposition q 2 hours; incontinence - evaluate q 2 hours; anemia; protein malnutrition ... Facility "Wound Care Program" (Adopted: May 1, 2015 and last Reviewed: April 2021) reads under Procedures: 1. Timely identification of residents assessed to be at risk for skin breakdown. a. The Braden Scale must be completed by a licensed nurse on admission/re-admission and weekly for the first 4 weeks of admission/re-admission in the facility ... c. Each risk factor and potential cause(s) identified should be reviewed individually and addressed into the resident's care plan ... 3. Prevention of skin breakdown includes but not limited to: c. Inspection of the skin every shift with care for signs of breakdown ...h. Administration of scheduled shower/bath and completion of Shower and Skin Audit Form and document findings. 4. Activity, Mobility, and Positioning ... b. Establish an individualized turning and repositioning schedule if the resident is immobile or with impaired physical functioning. c. While in bed or in wheelchair, resident should be turned/repositioned at least every 2 hours or as indicated in the residents' plan of care ... 9. Documentation	S9999		

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S9999	Continued From page 18 a. (Named electronic wound documentation software) - using an (name brand) phone device connected to the internet that allows nursing staff to evaluate, monitor, track and treat residents and/or patients at risk for pressure ulcers while providing one-step wound assessment documentation. b. Shower and Skin Audit Form shall be completed by designated nursing personnel on shower days or other designated day. If shower is refused by the resident/patient, the nursing staff needs to indicate the resident's refusal on the sheet and notify the charge nurse. c. The care plan shall be evaluated and revised based on resident's response to treatment; treatment goals and outcomes ... 10. Pressure Ulcer Treatment ... c. Timely referral to the facility's Wound Care Specialist for stage III/IV pressure ulcers and/or any recalcitrant wounds ... 11. Wound assessment for pressure, diabetic, venous, and arterial wounds: Wound assessment documentation shall include but are not limited to: type of wound and/or ulcer, location, date, stage, (if applicable), length, width and depth; wound bed description, wound edge description and if present, exudates, undermining, tunneling, and wound related pain. R8 is a 102 year old female originally admitted on 1-4-2015 with medical diagnoses that include and are not limited to: cerebral infarction, anxiety and dementia. MDS (Minimum Data Set) assessment dated 11-26-2021 document: TOILET USE: require(s) Extensive Assistance x2 staff participation.	S9999		

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S9999	Continued From page 19 BIMS dated 11-18-2021 score of 4/15 (Severely Impaired Cognition) On, 1/19/22 at 1:10pm, R8 was observed in her bed on a low air loss mattress with a flat sheet, a pad under her, and incontinence brief (three layers of padding). V30 (CNA/ Restorative Aide) said I started here one year ago. (R8) is supposed to have only a flat sheet and an incontinence brief, but no pad because it defeats the purpose of the mattress. I do not know who did that. At this time, observed V30 provide incontinence care for R8. V30 stated, R8 is soaked in urine. R8 has an open area with no dressing in place. Observation made of R8 with open area to the sacrum, no dressing in place, open area noted over a scar tissue approximately 2x1 superficial. V31 (LPN/EMR Nurse) said, I can see R8 has a wound to the sacral area, the upper layer is gone. I am going to check and see if she has any orders in place. V31 said, I cannot see any wound care orders in R8's record, I will call the wound care nurse to come and evaluate the patient. R8 should not have multiple layers under her; only the flat sheet and an incontinence brief since she is incontinent. 1/19/22 at 2:34pm V39 (Wound Care Nurse/LPN) said, (R8) is using a low air loss mattress and is supposed to have only a flat sheet and an incontinence brief if they are incontinent, no more, no pad; having multiple layers is unacceptable and defeats the purpose of the mattress. Facility policy titled, "Specialized Mattress and Appropriate Layers of Padding" (Revised 7/28/21) reads under Procedures: Limit the amount of layers on top of specialized air mattress such as	S9999		

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S9999	Continued From page 20 Low Air Loss mattress in order to promote healing ... IPUP data includes that "additional linen layers increased the odds of both superficial and severe hospital-acquired pressure injuries." Facility policy titled, ADL Care (Date: October 31, 2018) reads: Care Guidelines: ADL care is provided for each resident in the facility in accordance to the comprehensive assessment. Interpretation and Implementation (include) ...2. Nurses and CNAs are trained in providing general /routine ADL care to the residents. The facility has an active program of restorative nursing services which is developed and coordinated through the resident's care plan ...4. ADL nursing care is performed daily for the residents based on the plan of care. Such care may include as appropriate, but is not limited to: a. Maintaining good body alignment and proper positioning, b. Encouraging and assisting bedfast residents to change positions at least every two (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities; c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care and ambulation activities; use of appropriate locomotion and mobility devices ...g. Incontinent care and Bowel and bladder training as indicated; and h. Daily assistance in eating; grooming/hygiene; transfer, locomotion and mobility; i. Other ALD support and assistance in accordance to the restorative nursing assessment and/or comprehensive resident assessment ...6. General/Routine ALD Care of the residents are included in the orientation	S9999		

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S9999	Continued From page 21 program and the ongoing Staff Development Program. R9 is a 75 year old male admitted to the facility on 12/27/21. His medical diagnoses include (but not limited to): hemiplegia and hemiparesis, dementia, muscle wasting and atrophy, unsteadiness on feet, other abnormalities of gait and mobility, repeated falls, and cognitive communication deficit. Admission Summary, effective date 12/27/21 23:47, note text documents that R9 was admitted to the facility with skin intact. R9's MDS (Minimum Data Set) Assessment documents that R9 requires extensive assistance/2+ person physical assistance (3/3) for bed mobility and requires extensive assistance with one person physical assistance for toilet use (3/2). R9's current care plans include focus areas related to requiring assistance with ADL's (activities of daily living), including toileting. Interventions include: Keep call lights within reach; If incontinent, apply moisture barrier to the peri-area after incontinent episode; Remind, offer and assist with toileting as needed. 1/15/22 at 2:45pm, as surveyor walked past R9's room, R9 was heard calling out he needed to use the bathroom. Surveyor stood outside of R9's room as V41 (CNA/Agency) walked into R9's room at 2:50pm and could be heard telling R9 to go ahead and use the bathroom in his incontinence brief and she would be back in to change him and then she walked out of the room. As V41 walked out of the room, R9 could be heard saying, "I don't understand" and he kept	S9999		

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S9999	Continued From page 22 saying he had to use the bathroom. Surveyor stayed in hall, outside of R9's room. At 2:55pm, another staff member entered R9's room and said something that could not be heard clearly and then walked right back out. At 3:04pm, the call light went on in R9's room and surveyor entered the room and V41 came in right after. R9 stated, "My diaper is totally wet from one end to another." R9 was asked if he was provided with care this morning and he stated he couldn't remember exactly but could only remember being changed once today. Surveyor continued to observe V41 provide incontinence care. V41 was clearly disgruntled and voicing that previous CNA should have changed the resident because it was clear that he had "not been changed at all today because he is soaked." Surveyor observed R9's gown was wet, his incontinence brief was drenched in urine and sheets on his bed were visibly wet and soiled - urine had soaked thru the sheets and the mattress was wet underneath where R9 was laying. When R9 was rolled over during care, a beefy red, open area was noted to his sacrum. The area was approximately 3x3cm in size and has a whitish cream stubstance that was wiped off. R9 winced as V41 was cleaning him and surveyor asked if he had pain in that area, he said, yes. V41 finished providing care and changed the bed sheets. V41 added a flat sheet under the fitted sheet and stated, I know there's not supposed to be this sheet under here but I have to put it under him because the mattress is still wet and if I just lay the (clean) sheet, it's just going to get wet. I will come back later and pull it out. Surveyor asked if that was a new open area on R9's sacrum and V41 stated, she believed so	S9999		

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S9999	Continued From page 23 but would notify the nurse. Review of R9's medical record on 1/15/22 did not document that R9 had any current wounds. 1/16/22 at 10:41am, surveyor observed R9 in bed, slumped over, with call light on the floor near his bedside table (out of reach). Surveyor observed R9 was on a low air loss mattress, which he did not have during observations the previous day. The low air loss mattress was set to Upright Mode, 140 pounds. R9 appears to weigh more than 140 pounds. R9 stated no one's been in today. At 10:49am, V42 (CNA/Activity Aide) and another staff member repositioned R9 in bed and V42 stated, she was going to check on his CNA and acknowledged R9 was in need of incontinence care. At 10:57am, V16 (CNA) came in to R9's room and confirmed she was assigned to R9 for the day. V16 was asked if she had provided incontinence care today and V16 stated, "I haven't changed him this morning - I didn't have time. I just gave him breakfast." At 11:05am, V42 (CNA/Activity Aide) came back into R9's room and stated, I am the activity aide but I'm also a CNA so I will change him since his CNA didn't get to him yet. Surveyor observed V42 provide incontinence care and noted there was a gauze applied to R9's sacrum that was soaked in urine. The writing on the gauze was unreadable because it was smeared from being wet. V42 removed the gauze and stated, she would tell the nurse it needs to be changed. At 11:20am, V19 (RN) confirmed she was the	S9999		

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S9999	Continued From page 24 assigned nurse for R9. She stated she thought the wound nurse was responsible for the settings on the low air loss mattress but she would check it. V19 pulled up R9's medical record and confirmed that his current weight is 178 pounds and stated I will go check it and proceeded to the room to adjust the mattress settings. 1/19/22 at 2:29pm, V39 (Wound Care Nurse/LPN) stated, when there is a new resident, I assess them, to see what wounds they have. Get initial wound care order from the primary care MD and I always call the family. I document the orders and treatment in the medical record. New patients are assessed weekly. Floor nurses are supposed to contact doctor and family and asked for a wound consult (if needed). Surveyor asked facility to provide all initial and weekly assessments for R9 and skin audit forms per their policy. Facility provided weekly Braden scale scores indicating that R9 was "At Risk" for wounds and provided three shower/skin audit forms dated 1/6/22, 1/16/22, and 1/20/22. Surveyor noted 1/6/22 shower form indicates there is a treatment on R9's sacrum. 01/21/22 at 1:47pm, V4 (CNA/Staffing Coordinator) stated, the CNA's do skin checks on all residents daily and on every shift. They do it every shift because things can change from one shift to the next. If the CNA finds something, they are to notify the nurse. Once the skin checks are done and showers given, the shower sheet is filled out and if there are any new areas of concern it is documented on the shower sheet. When asked what the circled areas are on the sheet with "Treatment" written next to it, V4	S9999		

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S9999	Continued From page 25 stated, that means that the area is covered because of a treatment of some sort (wounds, etc.) and they don't remove that when providing care. The CNA's should also document in the EMR (electronic medical record system). On 01/21/22 at 4:20pm, V2 (DON) was asked why there was documentation of treatment on R9's sacrum on the shower form if the "wound" was just identified on 1/15/22 and V2 responded, "I know you identified it on the 15th, I don't know why that's on there or what that means." Daily skin checks provided with multiple days missing (only provided for 1/14/22 PM, 1/17/22 AM and PM, 1/19/22 PM, 1/20/22 PM, and 1/21/22 Midnight). Facility provided Wound Assessment Details Report for R9 includes: Assessment Date: 1/15/22 4:20PM Wound: Sacrum Type: Pressure Classification: Ulceration Source: Facility-acquired Clinical Stage: 2 Tissue Types: Pale Pink Non-granulating = 100% Exudate: Amount - Scant, Type - Serosanguineous Size (cm): 5.00 x 5.00 x 0.10 (L x W x D) Current Plan & Comments: 1/15/22 05:53PM by V8 (Registered Nurse/Wound Care): Writer was called to see patient regarding open wound and upon wound assessment per writer patient is seen with Stage 2 pressure injury to his sacrum, 100% non-granulating tissue with very scant amount of serosanguineous drainage with mild discomfort per patient upon touch. Treatment order was given per MD and medical honey gel applied to patient's sacral wound after NSS	S9999		

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S9999	Continued From page 26 cleanse and covered with hydrocolloid dressing to be change 3x a week. Treatment applied as ordered. Floor nurse at bedside and aware of patient's new wound. Repositioned patient. Will continue to monitor patient's wound. Facility provided Wound Assessment Details Report for R9 includes: Facility policy titled, ADL Care (Date: October 31, 2018) reads: Care Guidelines: ADL care is provided for each resident in the facility in accordance to the comprehensive assessment. Interpretation and Implementation (include) ... 2. Nurses and CNAs are trained in providing general /routine ADL care to the residents ... 4. ADL nursing care is performed daily for the residents based on the plan of care. Such care may include as appropriate, but is not limited to ...b. Encouraging and assisting bedfast residents to change positions at least every two (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities ...g. Incontinent care and Bowel and bladder training as indicated; and h. Daily assistance in eating; grooming/hygiene; transfer, locomotion and mobility; 6. General/Routine ALD Care of the residents are included in the orientation program and the ongoing Staff Development Program. " B"	S9999		

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S9999	Continued From page 27 (2 of 2) 300.610a) 300.1210b) 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 300.1210 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. These Requirements were Not Met evidenced by:	S9999		

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S9999	Continued From page 28 Based on observation, interview, and record review, the facility failed to ensure that agency hired nursing staff (V17) was trained on facility emergency procedures prior to allowing her to work on the unit and provide care to residents. This failure affected one resident (R12) in the sample. As a result of this failure, V17 did not immediately response to call a code and start (CPR) for R12, who was found unresponsive in her bed. Also,the facility failed to ensure that nursing staff had the necessary competencies required to care for a resident during an emergency situation. This failure applied to one of one (R12) residents reviewed for staff competence and has the potential to affect all 122 residents currently in the facility. Findings include: R12 is a 91 year old female, admitted to the facility on 9/20/19 with diagnoses that include (not limited to): unspecified dementia w/out behavioral disturbance, personal history of traumatic fracture, low back pain, and hypertension. Review of medical record, documents that R12's advanced directive lists her as a full code. R12's current care plan includes Focus: Code Status, FULL CODE and Interventions (include): As indicated, document the code status on the Physician's Order Sheet (POS) in the EMR system. Date Initiated: 12/31/2020; Scan the original POLST form into the EMR chart and consider placing one or more copies of the POLST form in a notebook on the unit for easy access during a medical emergency or when transferring the resident. Date Initiated: 12/31/2020; The EMR chart should identify FULL	S9999		

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S9999	Continued From page 29 CODE status. Date Initiated: 12/31/2020. 01/15/22 at 1:11pm, surveyor entered R12's room and saw resident lying in bed, her right eye was open and her left eye was closed, her mouth was open and she appeared stiff and not to be breathing (chest was not visibly rising). Surveyor called resident's name and she did not respond. Surveyor immediately stepped out to the hall and called over V16 (CNA), who was coming out of another resident room, and asked her to come to R12's room. When CNA entered the room, at 1:12pm, surveyor advised her to do what she would normally do. V16 called the resident name and shook R12, R12 was not responding and V16 said, "Is she breathing?" Again, surveyor reiterated to V16 to please proceed as she should per her facility's protocol. V16 left the room to get the nurse. At 1:13pm, V16 (CNA) and V17 (RN/Agency) came back into the room and V17 proceeded to assess R12; she checked her pulse, checked to see if she was breathing, did sternal rub - all while calling the resident's name. V17 said (talking to V16), she's (R12) not responding, I think she's a full code; that's what the nurse said this morning but I don't trust anything because this place is a mess; I've been getting wrong information all day. I'm not putting my license on the line, I need to make sure she is a full code before doing anything. V16 and V17 then stepped out of the room. Surveyor stayed in the room conducting observations. At 1:17pm, V16 and V17 came back in the room.	S9999		

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S9999	Continued From page 30 Discussion continued amongst staff on whether the resident was a full code or not. At 1:18pm, V18 (CNA/Agency) came in the room and said, I swear, I just saw her 30 minutes ago. I fed her lunch. Discussion continued amongst nursing staff in the room. At 1:19pm, more staff starting coming into the room [V19 (RN), V21 (RN), and V20 (Nurse Practitioner)], with the crash cart. V20 started to assess the resident and stated, we should start CPR. At that point, V17 initiated chest compressions. It had been six minutes since V17 entered the room and found R12 unresponsive before she initiated CPR. At the same time, V20 could be seen trying to get vitals on R12 and R12 was given glucose and hooked up to the AED (Automated External Defibrillator) machine. Surveyor continued to make observations as facility staff proceeded to run the code. At 1:28pm, the local fire department/paramedic arrived and took over. V22 (Paramedic) asked who was responsible for the resident and what is her medical history. V17 (RN/Agency) provided the paramedics with some information regarding R12's medical history and then stated, I'm not sure how accurate that is because this is my first time working here and reports in this place are terrible. At 1:22pm, a CPR board was placed under the resident. At 1:24pm, V9 (Assistant Director of Nursing/RN) entered the room with some papers in her hand and told the staff to use the bag valve mask (to	S9999		

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provide oxygen).

At 1:25pm, V20 (Nurse Practitioner) stated she was going to call the family and left the room.

At 1:27pm, V21 (RN) was observed checking R12's glucose level.

At 1:28pm, the local fire department/paramedic arrived and took over. V22 (Paramedic) asked who was responsible for the resident and what is her medical history. V17 (RN/Agency) provided the paramedics with some information regarding R12's medical history and then stated, I'm not sure how accurate that is because this is my first time working here and reports in this place are terrible.

At 1:36pm, surveyor still in the room, overheard paramedics continue asking V17 questions and V17 stated, I don't know anyone's name, again, this is just my first time here, I don't even know their protocol. V22 (Paramedic) was heard telling V17, I'm not placing blame, I'm just letting you know that she (R12) already has rigor in the jaw and that tells me that she's been dead for more than 30 minutes and CPR should not be started if there are obvious signs of death but since it was started we have to continue the process; it's just that then the hospital gets upset at us. Surveyor overheard V22 on phone call (apparently giving a report) and stating that R12 was maintaining rigor and heart rhythm was asystole.

Since paramedics had taken over, facility staff were disbursing and leaving the room. Surveyor went out to talk to staff.

1/15/22 at 2:07pm, V17 (RN/Agency) stated that

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S9999	Continued From page 32 this was her first time working in this building. She stated that she saw R12 this morning when she gave her, her meds at around 10am but hadn't had time to go in the room since. V17 stated that she almost didn't stay when she came in this morning because she could tell it was unorganized because they were going to give her 28 residents because another nurse wasn't coming but then they got someone to cover the other 14 residents; so she was left with 14. She stated that she didn't feel the report she received in the morning was adequate and that she even came in early so that she would have time to be oriented before she started her shift from 6:30am - 2:30pm but that the only "orientation" she received was the report from the outgoing nurse; she did not receive any special instructions regarding facility protocols, emergency procedures, how to determine a resident's code status, COVID precautions, or nothing else. Again, she emphasized that all she got was a report from the nurse. She stated that they are clearly short staffed and she's been busy all day and trying to help out the CNA's when she can because they need help too. V17 stated, "I'll never come back." 1/15/22 at 2:20pm, V16 (CNA) stated that she had been in R12's room earlier today but not for R12; she was not assigned to her. V16 was asked if she had received any training on what to do in the event of an emergency in the facility such as finding a resident unresponsive and/or CPR and she stated that she has not received any training on what to do. She also stated that her CPR certification is not current. 1/15/22 at 2:27pm, V18 (CNA/Agency) stated that she was assigned to R12 today. She's worked at this facility before. She stated that she had been	S9999		

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in the room with R12 for lunch because she had to feed her but she could tell that R12 "wasn't right" because she was pocketing her food and not really eating. She decided to stop trying to feed her and then shortly after, R12 coded. When asked what type of training or orientation she had received from the facility, she stated that the other CNA just walked her thru her set and that's it. She stated that she did not receive any training on the facility's emergency protocols or code policies. V18 confirmed that her CPR certification was current.

1/16/22 at 2:56pm, V2 (Director of Nursing) stated that in regard to the code called for R12, it was already going on when she got to the room. When asked what roles staff played in the code, she stated that generally, whoever calls the code is the lead and then the other nurses would be able to help with everything else that needs to be done. She continued to state that in this case, V9 (Assistant Director of Nursing) was the lead and the nurse practitioner was also in the room and that V17 (RN/Agency) was the recorder (documenting events during the code). V2 stated that V17 documented her report of the code in R12's medical record. Surveyor asked V2 how it was possible that V17 was recording during the code if the surveyor observed V17 performing chest compressions throughout the code, at which point V2 stated that V3 (RN) was also taking notes.

Surveyor informed V2 that surveyor was in the room during the code and had observed that there was a 6 minute time frame from when the nurse first assessed R12 to when CPR was initiated and V2 stated I would expect them to start CPR as soon as they verify the code status which they can verify by the computer, the book

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at the nurses station, or wristband on the resident. The wristbands identify the DNR (Do Not Resuscitate) residents. I would not expect there to be a delay; waiting six minutes to start is too long.

1/16/22 at 3:56pm, V9 (Assistant Director of Nursing) stated that she initiated the code. Per V9, when she went into the room, the agency nurse was in the room and when she saw that the resident was unresponsive, she told her (V17) to start CPR and told someone else to go get the crash cart. V9 stated, I was the lead, I called the family, and I called 911 and I announced the code. V17 (RN/Agency) was the recorder and V3 (RN) was also recording, V3 took vitals. Usually the Director of Nursing would be responsible for ensuring that the code is documented and post-mortem care is provided. Surveyor then presented V9 with information that surveyor was in fact the first person in the room and alerted staff and that after initially entering the room, V17 and V16 had left the room before coming back and then eventually initiated CPR and that surveyor did not observe V9 (Assistant Director of Nursing) enter the room until five minutes after CPR had already been initiated. In which case, V9 stated that the resident should have never been left unattended. V17 should have initiated CPR at that point when she saw the resident unresponsive ...it's not acceptable to wait 6 minutes to start CPR ...6 minutes is unacceptable. V9 was asked how are agency staff oriented to the facility and policies/protocols when they arrive to work in the building and V9 stated that there is a binder at the front desk with all of the policies and procedures and when the agency nurses come in, they are to review it and sign an attestation sheet affirming that they have reviewed the information before they start their

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shift. Surveyor asked V9, who is responsible for ensuring that new agency staff review this binder before starting their shift and V9 could not confirm who was responsible for doing so, but added that the scheduling coordinator is the one who assigns agency staff.

At this time, surveyor obtained the binder from the front desk and confirmed with V9 that there was no attestation sheet signed by V17 (RN/Agency), even though it was the first time (V17) had worked in the facility.

Progress Note written on 1/15/22 at 14:24, written by V17 (RN/Agency) reads:
0730 Night nurse (named) gave report, when I entered the room the pt was moaning, per (night nurse) "this is her baseline." She's been steadily declining. And her arms and legs are always contracted.
0800 Morning vitals were taken. BP 116/64, HR 74, RR 18, O2 95% RA.
1030 Morning meds were given crushed with apple sauce.
1115 checked in on patient she presented the same; moaning and contracted. The CNA (V18/Agency) stated, "she really hasn't eaten much." I informed her the per the night nurse her appetite is poor.
1305 The CNA (V16) came out of the room and stated, "(R12) is unresponsive." I left the pt room I was in and did a pulse check and sternal rub on (R12) and she didn't respond. The NP (V20) advised to begin compressions. Compressions were started and AED pads were placed on the pt. 911 was called by the nurse manager. EMS took over when they arrived roughly at 1317. They begin to run the code from that point. They were unable to revive her and she was pronounced dead at 1350. ME released body to

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S9999	Continued From page 36 the family per officer (local police officer). 1/16/22 at 11:20am, V19 (RN) stated that there is no reason to delay CPR, it should be done immediately. Only time you don't do CPR is if there is a DNR. 1/16/22 at 12:28pm, V21 (RN) stated that if a resident is found unresponsive the emergency procedure would be to check for breathing and a pulse and if there is no response, then you call for help and call 911. The book should be checked or the computer to see if the patient has a DNR, if not, CPR should be started right away. There should not be a delay. You cannot wait even five minutes, the person can be dead by waiting that time. 1/16/22 at 12:15pm, as surveyor was walking down the hall, V23 (CNA/Agency) asked surveyor if she was a nurse, surveyor identified herself and V23 said, oh, okay. Surveyor then asked V23, what her role was and she stated that she was a CNA. Surveyor asked if she was working thru an agency and if she had been in the facility before, V23 stated that she was with an agency and had been here before. Surveyor asked V23 what type of training she had regarding the facility's emergency protocols and/or what to do during a code and V23 stated that she had not received any, the other staff on duty just walked her thru her set when she started her shift. 1/16/22 at 4:18pm, V2 (Director of Nursing) came into the conference room, where V9 (Assistant Director of Nursing) was being interviewed - V9 presented V2 with the binder and asked if she had any attestation sheets for V17 and V2 responded, "What's this?" V2 then stated that she had some papers on her desk from V17 this	S9999		

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	IL6007322	A. BUILDING: _____ B. WING _____	C 01/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA EVERGREEN PARK	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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
S9999	Continued From page 37	S9999		

morning and that she would check if she had the attestation sheet at which time she went to her office and came back with a password protocol form signed by V17. V2 stated that she did not have the attestation sheet for V17, just the password form. V2 was asked who is responsible for ensuring that agency staff are oriented before they start their shift and that they have reviewed the policies and sign off on the attestation sheet and V2 stated that it's at the front desk so she guesses that is the responsibility of the supervisor on duty but that she would check and get back to surveyor. V2 was asked about staff training regarding emergency protocols/procedures and she stated that all staff are trained monthly on different topics ...emergency code procedures in-services are done annually and as needed. She stated that after a code, they look at their videos and do a de-briefing. V2 was also asked if there was any type of debriefing done after the code with R12 to identify any issues or concerns and to discuss how the code went. V2 responded that they had not had a chance to debrief because surveyors were in the building, but that the only concern was that the agency nurse did not know how to verify the code status.

Facility was asked to provide any CPR or Advanced Directive policies and they only provided a copy of their Code Blue policy. Per V1 (Administrator) on 1/17/22 at 2:22pm, there are no other policies.

Facility policy titled, "Code Blue" (Revised: 7/27/21) reads:

Policy Statement

To maintain a well-coordinated and organized emergency care to a resident at any given time

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S9999	Continued From page 38 while emergency medical interventions are managed according to the established standard of care. Procedure 1. An Emergency Code Blue Team will be established. When a "Code Blue" and (location) is announced, it will be responded to by the following staff: a. Supervisors/Nurses will respond to the code and coordinate the medical emergency protocol. b. Emergency crash cart will be brought to the site of emergency. c. The assigned nurse will initiate the medical emergency interventions (for full code status) per facility's protocol after evaluating the sign and symptoms of cardiopulmonary arrest. d. The nurse/other staff will start the CPR if indicated. e. One staff will lead the team by assigning staff while CPR is in progress: i. Call 911 ii. Notify the primary physician iii. Call the family / guardian iv. Prepares the transfer form, copies of POS, list medications, face sheet and notifying the hospital of transfer v. Recorder (minutes of the event, vital signs, etc.) f. Other staff will initiate other emergency procedures such as IV line, suction secretions, take turns with the CPR intervention. g. The Nursing Supervisor or designee will facilitate in maintaining a non-chaotic emergency care environment (not overcrowding the room, hallways, etc.) h. The nursing assistant assigned to the resident involved must be present during the emergency procedures. i. Other nursing assistants on the same floor	S9999		

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S9999	Continued From page 39 must redirect residents to their rooms and will continue to provide care to their residents to meet its skilled needs. "B"	S9999		