STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	06/07/2022

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S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant 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. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999	**Attachment A** Statement of Licensure Violations	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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;9999	Continued From page 1 accident, injury or change in condition at the time of notification. 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: 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. These requirments are not meet as evidenced by: Based on interview and record review, the facility failed to thoroughly assess a resident reported to be in distress and recognize the need to call the physician for additional guidance after a change in condition to seek medical treatment for 1 (R166) of 8 residents reviewed for a change in condition in the sample of 34. This failure resulted when the facility failed to notify the primary care physician R3 was experiencing a change in	S9999		

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S9999	Continued From page 2 baseline status which included restlessness, increased confusion, anxiety, shortness of breath, pulling at foley catheter, and diaphoresis resulting in R166's expiration at the facility at 1:37 AM on 5/1/22. Findings Include: R166's "Admission Record" documents an original admission date to the facility as 4/20/22. This document lists V4 (physician) as R166's primary physician and the following diagnoses including but not limited to: Metabolic Encephalopathy, Hypokalemia, Acute Kidney Failure (unspecified), Chronic Kidney Disease Stage 3 (unspecified), Vascular Dementia without behavioral disturbance, Benign Prostatic Hyperplasia with lower urinary tract symptoms, other obstructive and reflux uropathy, retention of urine (specified), presence of urogenital implants, Type II Diabetes Mellitus with unspecified complications, Long term (current) use of insulin, Personal history of transient ischemic attack and cerebral infarction without residual deficits, abnormal weight loss, unsteadiness on feet, repeated falls, other abnormalities of gait and mobility, and other symptoms and signs involving cognitive functions and awareness. R166's most recent comprehensive Minimum Data Set (MDS) dated 4/25/22 documents a Brief Interview for Mental Status (BIMS) score of 7, indicating cognitive impairment. Review of section G0110 in this same assessment documents R166 requires limited assistance of one-person physical assist with bed mobility, transfer, walking in room and the corridor, and toilet use. Section G0300 documents R166 is not steady, and only able to stabilize with staff assistance for all positional changes.	S9999		

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S9999	Continued From page 3 V4's (Physician) physician note dated 4/26/22 documents R166 was in the local hospital for several days due to a "TIA" (transient ischemic attack). V4 documents, "Due to prolonged hospitalization and multiple medical issues, the patient gained significant weakness that worsened, constant, and persisted and radiated throughout the rest of the body. Patient was transferred to the nursing home for therapy in order to improve strength." R166's Progress Notes documents an entry made by V7 (Registered Nurse/RN) at 5/1/22 at 8:57 AM stating the following, "Elder was very restless in his bed during the night time hours. He was confused off and on, trying to climb out of his bed and walk on his own in his room unsafely, and was attempting to pull out his Foley catheter tubing from his penis. When asked what he was trying to do, he stated that he 'had to go pee.' Explained to Elder that he did not have to take the Foley out to 'go pee.' Attempted to explain the usage of Foley catheter in simple terms to help him understand to not pull on the tubing. He did stop for a short time and lay back down on the bed. Attempted to educate Elder to not get out of bed without assistance due to his falling earlier in the day and he was not steady at this time on his feet and walking. He laid down for a short period of time, indicated by nodding his head that he understood what was being told to him. Elder continued this behavior off and on during the evening time et his vital signs were stable early in the shift through the middle of shift et then noticed that Elder seemed out of breath, so Oxygen placed on Elder at 2 L (liters) per nasal cannula. This seemed to help relax him and he closed his eyes et rested a short time. Meanwhile, while checking Elder's vital signs, it	S9999		

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S9999	Continued From page 4 was noted by this nurse that Elder's SP02 (Pulse Oximeter Oxygen Saturation) was just above 88% to beginning 90's some of the time, et at another time, was found at 82% with 2 L oxygen per nasal cannula. Elder would not always leave oxygen tubing on his face. In his at times confused state of waking up after dozing off, he would pull it off. He was checked on by this nurse et CNA's (Certified Nurse Assistant) very frequently. He was found most of times attempting to get out of bed. At 0130 on the early morning of 5/01/22, Elder's vital signs were taken by this nurse et assessment made to call his doctor, due to the confusion et restlessness. VS were: 117/101, (Right wrist, lying down), Pulse 112, with Pulse oximeter showing 52 for Pulse while his SP02 was found to be 88% on 2 L per nasal cannula. His respirations were rapid and shallow at 42 per minute, et temp of 96.8 F. Blood sugar reading was 223. This nurse went to the desk to look over diagnoses of Elder to call the doctor et CNA indicated that Elder needed assistance immediately. Upon arriving to room, Elder's coloring in his face was dusky in areas et very white in others, he was staring off straight ahead et he took about 3 shallow breaths et all vital signs ceased at 0137 AM. Elder was head first at the foot of his bed, et he was laid down et all vital signs assessed by this nurse. There were no further heartbeats or breaths. CNA ran to determine if Elder was a Code et was found to be a DNR with Selective Treatment. The ambulance and fire department was immediately dispatched by a second nurse, (name) V16 (Licensed Practical Nurse, LPN). The ambulance service arrived at 0152 et they assessed Elder et also deemed cessation of vital signs. They left the building at 0200. Called V4's phone service at 0205. He returned call immediately. Called the nurse on call at the facility, V12 (Minimum Data	S9999		

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S9999	Continued From page 5 Set Coordinator) et let her know all that had happened. Called Elder's daughter, (name) V17 (Family Member) at 0230 et let her know that Elder had passed away. She requested to speak to her mother et tell her, which was the second person on his call list. From this time to after 0630, Elder's family arrived et left, with daughter bringing Elder's wife to visit. Daughter just said to call (name) local funeral home to set up arrangements. Called funeral home at 0730 et they arrived at 0820 to take Elder to the Mortician. Paperwork was signed et sent with patient." On 06/01/22 at 03:16 PM, V5 (CNA) stated she was working with V6 (CNA) the night R166 expired, along with V7 (RN). V5 stated she works 3rd shift (11 PM - 7 AM), and 2nd shift had reported at shift change that R166 had tried getting out of bed unassisted a few times that day. V5 stated R166's normal status is slightly confused, but "super mild," R166 didn't normally try to get out of bed, almost always slept through the night, and she had never witnessed him pull at his catheter before. V5 stated on 4/30/22, from the start of the shift, R166 was very confused, continuously trying to get out of bed on his own, pulling at his catheter, anxious, and sweaty. R166 stated that she and V6 had attempted to toilet R166 in case he needed to use the restroom but stated that didn't seem to help. V5 stated they reported R166's change in baseline status to V7 (RN) numerous times and even encouraged she call the physician to send R166 out for evaluation because she was worried about him and could tell something was wrong. V5 stated V7 continued her medication administration pass and never gave her any further instruction on anything special to do with R166. V5 stated herself and V6 had taken R166's vital signs which were all normal at the time they checked them, except his	S9999		

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pulse which was a little elevated at 110. V5 stated this too was also reported that to V7 with nothing done that she was aware of. V5 stated R166's abnormal status continued as the shift went on, and she would "definitely describe (name) R166 as appearing in distress." V5 stated herself and V6 had checked on R166 every 15-30 minutes throughout the night to try and keep him from falling and because he wasn't acting right. V5 stated herself and V6 entered R166's room around 1:30 AM on 5/1/22 and observed R166's head at the foot of the bed with no respirations noted and no pulse noted. V5 stated V6 ran to get V7 who came to assess, rolled R166 on his side she said in case he had a seizure, and left to check R166's resuscitation status, which was Do Not Resuscitate (DNR). V5 stated V7 called the ambulance to confirm death, in which they responded and confirmed. V5 stated herself and V6 repositioned and cleaned up R166 to prepare for his family and funeral home to arrive.

On 6/1/22 at 7:55 PM, V4 (Physician) stated he recalls (name) R166. V4 confirmed that should a resident be experiencing a deviation from their baseline status; he would expect to be notified immediately. V4 stated he was never notified that R166 was experiencing any concerns on 4/30/22 or 5/1/22 including increased confusion, anxiousness, diaphoresis, pulling at catheter, restlessness, etc.

On 6/2/22 at 8:43 AM, V1 (Administrator) stated that she did not have much interaction with R166 during his short admission here, so cannot specifically speak on his baseline status. V1 stated R166 was admitted to the facility for short term rehabilitation services after a hospitalization. V1 stated prior to R166's hospitalization, he resided at home with his wife, and his plans were

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S9999	Continued From page 7 to complete rehab and return home. V1 stated that she has received complaints from other nurses regarding V7 that she is slow, but no complaints from residents. V1 stated nurses work 12-hour shifts, with V7 working 6 PM - 6 AM. V1 stated CNA staff work 7 AM - 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM. V1 stated that the shift that V5 and V6 work are 11 PM - 7 AM. On 6/2/22 at 10:42 AM, V7 (Registered Nurse) stated that she has worked at the facility for about 3 months. V7 stated she had previously worked with R166 prior to 4/30/22. V7 stated she works the 6PM - 6 AM shift. V7 stated that on 4/30/22, the only thing she can recall being given from the day shift report was that R166 had experienced a fall earlier in the day and had been trying to get out of bed. V7 stated R166 had not been at the facility long before he expired and describes R166's expiration as being unexpected. V7 stated she cannot recall if staff reported to her any abnormal concerns with R166 the night of his expiration, as she's cared for a lot of people since then. V7 stated she does recall that R166 was abnormally restless that night, but just wrote it off that R166 had a fall earlier in the day and was "out of sorts." V7 stated she does not feel it was abnormal for R166 to be restless as he previously had attempted to get out of bed during the night occasionally on his own, although she acknowledges he is usually easily re-directable and was not on this night. V7 stated while she did document an oxygen saturation level of 82%, she applied oxygen and would talk to R166, which seemed to help calm him down and improve R166's oxygen level, allowing him to doze off for short periods of time. V7 stated R1 would re-awaken and attempt to get out of bed and take the oxygen off. V7 stated she had occasionally applied oxygen per nasal cannula for R166 in the	S9999		

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past. V7 stated had R166's oxygen saturation level not improved with the application; she would have notified the physician. V7 acknowledges in some cases restlessness can be a sign of distress for some residents. V7 confirmed R166 did appear short of breath at times. V7 stated another abnormal occurrence R166 was exhibiting on 4/30/22 was that he was continuously pulling at his catheter and stating he had to pee. V7 stated she provided R166 education that he needed to leave his catheter alone, and that he didn't need to pee and had a catheter. V7 stated she never notified V4 (Physician) at any point on 4/30/22 or 5/1/22 prior to R166's exhibiting severe distress of respirations ceasing and expiration. V7 stated looking back the only thing she feels she could have done better, although it was not an option with staffing would be to provide R166 a 1:1 staff member to ensure he stayed in bed. V7 again stated she cannot specifically recall the timeline of events leading to R166's expiration as she's cared for many people since then. V7 stated an aide whom she cannot recall came to notify her R166 was in distress. V7 stated she believed V6 was working but cannot remember the other staff member. V7 stated when she arrived to R166's room, R166's head was at the foot of his bed, with his oxygen off. V7 stated R166 took a couple shallow breaths and respirations ceased. V7 stated R166 was "dusky" in color and after confirming his do not resuscitate status, she verified via auscultation and palpation that there were no respirations or a pulse. V7 stated she notified V4 of R166's passing and the local ambulance company to confirm death. V7 stated the ambulance and fire department arrived, and an asystole cardiac rhythm was confirmed. V7 stated R166's family was notified of the expiration. V7 stated the expectation is for staff to

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notify the physician if resident's experience a problem or change in their baseline status. V7 confirmed that V4 responds quickly and appropriately to resident needs when notified.

On 6/2/22 at 11:13 AM, V4 confirmed the cause of death listed as diabetes on R166's death certificate was due to the weakening effects Diabetes has on the immune system. V4 said it's fair to say that should he have been notified of the change in condition, R166 could have been treated. V4 stated, while the outcome may not have changed, the option of attempted treatment was possible.

On 6/2/22 at 11:17 AM, V6 stated she and V5 were the aides working with R166 the night he expired, and V7 as the nurse for that wing. V6 stated she works 11 PM - 7 AM. V6 stated in report received from the off going shift that day, they had passed on that she can remember that R166 kept trying to get out of bed on his own, which he wasn't supposed to do and was not steady on his feet. V6 stated it would have been about 11:30 PM on 4/30/22 when she had first gone to check on R166 in his room and observed him as being very sweaty and trying to get out of bed. V6 stated he was sweating to the point that if you touched him, your hand was wet. V6 stated she immediately reported the observation to V7. V6 stated she knows R166 is diabetic so she was worried something may have been wrong. V6 stated V7 did go check R166's blood glucose at that time, and she couldn't remember the exact number, but it was one hundred and some and V7 said it was ok. V6 stated as the night went on both she and V5 expressed multiple times to V7 that something wasn't right with R166, and they thought he needed sent to the Emergency Room for evaluation. V6 stated R166 was restless,

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S9999	Continued From page 10 anxious, pulling on his catheter, needing oxygen, and would not stay in bed, all of which she stated is very abnormal for R166. V6 stated R166's normal status is mildly confused, but easily redirectable, normally slept all through the night, had never seen him require oxygen or pull on his catheter. V6 stated at one point she specifically recalls telling V7 that R166 was not ok. V6 stated this specific incident was when V7 was doing her medication pass and V7 had told V6 she would see about calling R166's doctor later. V6 stated she expressed her concern with R166's condition to V7. V6 stated herself and V5 checked on R166 about every 15 minutes due to R166's status and her fear of something being wrong and R166 would fall getting out of bed on his own. V6 stated around 1:30 AM on 5/1/22 she had entered in R166's room and observed him lying in his bed with his head at the foot of the bed and oxygen off, breathing at this time. V6 stated she left the room to go get V5 to help her get R166 turned back around in the bed. V6 stated when herself and V5 returned to the room, R166 took a couple of gasping breaths and quit breathing. V6 stated she hollered for V7 who came and observed R166 status, then checking his resuscitation code, noting he was a do not resuscitate. V6 stated the ambulance responded to confirm expiration and V7 instructed V5 and V6 to get R166 cleaned up for family to see him and the funeral home. V6 stated R166 displayed a definite change in his baseline status from the start of her shift until his expiration. V6 confirmed that Cardiopulmonary Resuscitation was not started (due to DNR status). On 6/2/22 at 2:49 PM, V2 (Director of Nursing) stated that it is the expectation that facility staff notify the physician immediately in the event a resident is experiencing a change in their	S9999		

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baseline condition. V2 confirmed that documentation completed by V7 that describes R166 as having increased restlessness, pulling on his catheter, attempting to repeatedly climb out of bed, not sleeping, experiencing an oxygen saturation rate of 82% would all be instances in which the physician should have been immediately notified. V2 stated that on 4/30/22, R166 had experienced a witnessed fall with no injury, and later that same day also an emesis. V2 states hindsight it seems R166 had several small occurring problems leading up to his distress and expiration. V2 stated V4 had been notified of the fall, due to facility policy, but not the emesis due to relief with no further concerns after the emesis. V2 describes R166 as being mildly confused stating he was oriented to person, time, and recognized he was in a nursing home for therapy but would be unable to give the specific name of the facility. V2 stated R166 propelled himself in a wheelchair around the facility and was planned to be in the facility for short term therapy needs, then return home. V2 stated she was notified of the death by V12 (Minimum Data Set Coordinator) who was on call. V2 stated on 5/2/22 the facility's Interdisciplinary Team which consists of herself, V13 (Assistant Director of Nursing, ADON), V12, V14 (Care Plan Coordinator), and V1 (Administrator) began an investigation into R166's death due to the unexpected nature. V2 stated it was determined the notable significant decline of R166 began during 3rd shift, which is 11 PM-7 AM on 4/30/22 in which V7 failed to notify the physician of R166's change in status. V2 stated beginning 5/2/22 and completed 5/6/22, the facility completed in-servicing with all nursing staff on the facility change in condition policy and the computer program "Interact Pathway-Change in Condition" which is described as a program you enter

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(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 12 information into and will lead you to notifications and referrals needing made. V2 stated V5 and V6 were determined to have acted appropriately, evaluating and reporting concerns to V7. On 6/2/22 at 3:18 PM, V9 (Registered Nurse/RN) stated she was the nurse who had worked 6 AM - 6 PM on 4/30/22. V9 stated R166 was his normal self that day and had experienced some nausea that resolved after an emesis of food. V9 stated R166 had also had a witnessed fall on 4/30/22, with no injuries. V9 stated V4 had been notified of the fall with no new orders, but not the emesis, due to the uneventful nature post emesis with R166 expressing relief. V9 stated she would describe R166 as being mildly confused, but always alert to person and time. V9 stated when she left for her shift on 4/30/22, she recalled seeing R166 lying in bed eating his evening meal with no concerns noted. V9 stated R166 was impulsive and if he wanted to get up, he would get up forgetting his weakness. On 6/2/22 at 4:52 PM, V15 (Certified Nurse Assistant/CNA) stated that he works the 3PM-11PM shift and confirms he worked on 4/30/22. V15 stated he was familiar with R166 and described R166 as being overall his normal baseline self on 4/30/22. V15 stated R166 had attempted to self-transfer a couple times that evening which was abnormal and stated R166 seemed a little more confused. V15 stated he passed on the concerns in report to next shift so they could watch him closely. V15 stated he never witnessed R166 appearing in any distress at that time. On 06/03/22 at 08:25 AM, V12 stated she recalls receiving a call from V7 during the night of 5/1/22, as she was the nursing staff on call that weekend.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	06/07/2022

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S9999	Continued From page 13	S9999		

V12 stated V7 seemed a bit shook up due to the unexpected nature, and when asked what happened, V7 stated she didn't know, that R166 had been restless, anxious, and up and down all night. V12 stated she went through the notifications needed to ensure V7 contacted everyone she needed to. V12 stated she believes she text V2 to notify her of R166's death. V12 stated the facility completed and investigation and implemented a quality assurance performance improvement plan re-training nursing staff on the facility Change in Condition policy and the "Interact Pathway-Change in Condition" computer program.

Review of the local ambulance report dated 5/1/22 documents at 1:44 AM, an ambulance was dispatched to the facility for report of a male not breathing. Emergency Service Personnel verified R166's DNR status and observed R166 lying in his bed, with his head at the foot of the bed. R166 is documented as being pulseless, apneic, cyanotic, pupils fixed and dilated, and cold to touch. A cardiac monitor is documented as being applied showing asystole, confirming death.

Review of the document titled "Certificate of Death Worksheet" documents R166 expired at the facility on 5/1/22 at1:37 AM, at the age of 90 years old. The manner of death is listed as being "natural" with the cause listed as "Diabetes". V4 is documented as the physician that completed the cause of death.

Review of the facility policy titled "Change in a Resident's Condition or Status" with a revision date of November 2016 documents, "A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident

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S9999	Continued From page 14	S9999		

representative when there is (e.g., changes in level of care, resident rights, etc.)." The same policy documents the resident's attending physician or on-call physician will be notified then there is "a. An accident or incident involving the resident, which results in injury and has potential for requiring physician intervention....d. A significant change in the resident's physical/emotional/mental condition psychosocial status to either life-threatening conditions or clinical complications...g. A need to transfer the resident to a hospital/treatment center." The same policy also goes on to state a resident's physician should be notified in the event of a significant change which is defined as a decline or improvement in the resident's status that, "a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. b. Impacts more than one area of the resident's health status."

Review of the facility policy titled, "Making an Emergency Transfer or Discharge" with a revision date of December 2016 documents, "Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law." This document states, "1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician of the change in condition and request immediate orders to transfer the resident to the hospital. In an emergency situation, another practitioner may order the hospital transfer and

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S9999	Continued From page 15 notification of the transfer will be made to the attending physician." (AA)	S9999		