STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000079	A. BUILDING: _____ B. WING _____	11/04/2022

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PIASA MANOR	110 NORTH ALBY COURT GODFREY, IL 62035

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Z 000	COMMENTS ANNUAL CERTIFICATION SURVEY-EXTENDED ANNUAL LICENSURE SURVEY INSPECTION OF CARE SURVEY Complaint Investigation #2248419/IL152502	Z 000		
Z9999	FINDINGS 350.620a) 350.620b)6) 350.1210b)2) 350.1230d)1)2)3) 350.1235a)3) 350.2700d)2) 350.3000d)2) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, resident records, dental services, and	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 diagnostic service. Section 350.1210 Health Services b) The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: 2) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. Section 350.1235 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every	Z9999		

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Z9999	Continued From page 2 facility shall establish a policy concerning the implementation of those rights. This policy shall include: 3) Procedures for providing life-sustaining treatments available to residents at the facility; Section 350.2700 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a patient leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant twenty-four (24) hour a day supervision of the door, a signal is not required. Section 350.3000 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such	Z9999		

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Z9999	Continued From page 3 abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. (Section 2-107 of the Act) Statement of Licensure Violations: These requirements were not met as evidenced by, Based on observation, record review and interview, the facility failed to implement their policy to prevent neglect when: 1a) CPR (Cardiopulmonary Resuscitation) was not initiated on an individual (R1) who was unresponsive who did not have an Advanced Directive or Do Not Resuscitate, this has the potential to also affect the remaining 11 individuals residing at the facility (R2-R12), b) the facility had a staff member who was not CPR Certified working alone at the facility, affecting 1 of 1 in the sample who was found unresponsive (R1) and the potential to affect the remaining 11 individuals residing at the facility (R2-R12), c) the nurse was not notified of a change in condition, affecting 1 of 1 individual in the sample who was found unresponsive (R1) and the potential to affect the remaining 11 individuals residing at the facility and d) bedchecks were not performed by staff, affecting 1 individual in the sample (R1) who was to be checked every 30 minutes from 9:00 pm-6:00 am.	Z9999		

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Z9999	Continued From page 4 2) 1 of 1 individuals in the sample eloped from the facility without staff knowledge (R2). Findings include: Facility Abuse and Neglect Policy 3.402, dated 3/1/22 documents, "The facility shall be operated in a manner which ensures that individuals are not subjected to neglect or to physical, verbal, sexual, psychological abuse or punishment." Facility Roster undated identifies R5-R10 as individuals who function within the Mild Range for Individuals with Intellectual Disabilities; R4, R4, R11, R12 as individuals who function within the Moderate Range for Individuals with Intellectual Disabilities; R2 as an individual who function within the Profound Range for Individuals with Intellectual Disabilities. 1a) The 1/14/22 Individual Support Plan (ISP) identifies R1 as an individual who functions within the Moderate Range for Individuals with Intellectual Disabilities. R1's ISP includes the following diagnosis of Hypertension and COPD (Chronic Obstructive Pulmonary Disease). R1's ISP documents, "This past year my health has been a bit challenging, I have been hospitalized several times due to pneumonia, decreased temperature, and also due to psychiatric concerns (I made some suicidal threats)." R1's General Event Report (GER), dated 10/19/22 documents, "Bed and bathroom checks were done as told to staff per policy. R1 refused to go once and slept the others. Last bed check was done at approx 6:30 a.m.-6:45 a.m. to wake R1 up for meds. Upon entering I noticed R1 wasn't responding to my voice and went to touch	Z9999		

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Z9999	Continued From page 5 his ankle where I found it was cold, I touched R1's chest it was clammy and I felt for a pulse on his neck where I didn't find one." Audio recording from facility to local emergency services on 10/19/22 audio records, Z4 (Dispatcher) audio recording, "911 where is your emergency." E3 (Direct Support Person/DSP) audio recording, "Yes, I need an ambulance to facility." Z4 audio recording, "Ok, what's going on there." E3 audio recording, "I have a client that's unresponsive." Z4 audio recording, "Ok, not breathing." E3 audio recording, "Ma'am." Z4 audio recording, "Are they not breathing at all." E3 audio recording, "No, not at all." Z4 audio recording, "Is CPR (Cardiopulmonary Resuscitation) in progress." E3 audio recording, "No, I'm sorry." Z4 audio recording, "Is CPR in progress." Z4 audio recording, "No, we just found him. He's, he's not responding." Z4 audio recording, "Ok, what number are you calling me from." E3 audio documents her giving Z4 the facility phone number. Z4 audio recording, "Ok, alright is there a nurse on scene with him." E3 audio recording, "No, there's no nurse. No. No." Z4 audio recording, "Ok, do you need CPR instructions." E3 audio recording, "No." Z4 audio recording, "Ok, alright we're gonna be right out. Ok." E3 audio recording, "Ok. Thank you." Local Fire Department Patient Care Report, dated 10/19/22 documents, "Arrived: 6:51 am. Responded to a report that this 60 year old male (R1) was unresponsive. Local County Dispatch notified us in dispatch that CPR was not in progress and that staff had refused dispatch CPR instructions. Upon our arrival we were led to a bedroom where R1 was found unresponsive in bed with no CPR given. Staff reported the last time they saw him alert was at 4:30 am this AM	Z9999		

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Z9999	Continued From page 6	Z9999		

and they found him unresponsive at 6:30 am during morning checks. A carotid pulse was checked and absent. Due to patient size it took 2 firefighters and a staff member to move him to the floor to begin compressions. R1 was moist with a warm trunk and cool extremities. The room was dimly lit. Upon arrival of more personnel and additional lighting R1 was found to be mottling in the face and had bile on his check and right upper chest. Compressions continues while pads were placed and initial rhythm was Asystole with no shock advised. Ventilation's began with a BVM (Bag Valve Mask) and a OPA (Oropharyngeal Airway) placed. Local ambulance arrived and notified local hospital medical control and a stop order was given."

Coroner's Office Case Report, dated 10/19/22 documents, "Z2 (Senior Investigator) arrived on scene at 7:43 am. It should be noted that Z2 pronounced R1 deceased at 7:45 am on 10/19/22. Z5 (Sheriff's Deputy) reported that R1 was found without signs of life this morning by E2 (DSP). Z5 reported that E2 had gone in to R1's room this morning to give him and his roommate their medications. Z5 reported that the fire department had responded and performed life-saving efforts, including CPR, until they received medical direction to cease. Z5 reported that E2 had checked on R1 this morning at approximately 4:30 am and noted him to be alive and well at that time. R1's face and head appeared purple in color. Lividity had pooled in the posterior aspect of the body and would blanch with direct pressure."

E2 Witness Statement, dated 10/19/22 includes, "I started to administer meds and at 6:30 am I went to wake up the clients that were still sleeping. I found R1 at approximately 6:45 am.

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Z9999	Continued From page 7 He, his roommate and another client are usually the last ones. R1 room was the last I entered. I told them to wake up for meds but he didn't respond. I said it again still no response. So I touched R1's ankle, then his chest, then his neck for a pulse. When I didn't feel his chest raising. I then ran to inform my supervisor who then called 911 and all the necessary staff and personnel per policy." Interview on 10/20/22 at 11:25 am, E3 was asked what time did you come to work on 10/19/22. E3 stated, "5:00 am." E3 was asked if that is your normal time that you come in. E3 stated, "Yes." E3 was asked if there was other staff at the facility. E3 stated, "Yes." E3 was asked who was the other staff. E3 stated, "E2." E3 was asked if R1 had passed away when she got to the facility. E3 stated, "No." E3 was asked to tell the surveyors about what happened the morning of 10/19/22. E3 stated, "E2 had went back to R1's room to wake him up for meds and E2 said I think R1 has passed. I went and checked on him and called 911. E3 was asked if 911 instructed you to start CPR. E3 stated, "No." E3 was then asked if CPR was going on/started. E3 stated, "No." E3 was asked should you have initiated CPR. E3 stated, "Yes." E3 was asked are you CPR certified. E3 stated, "Yes." E3 was asked after calling 911, who arrived at the facility. E3 stated, "Ambulance/fire department and sheriff department." E3 was asked how long did it take them to get to the facility. E3 stated, "I'm not sure." On 10/20/22 at 1:49 pm, Z3 (Assistant Chief) was asked what time they arrived at the facility. Z3 stated, "We arrived to patient around 6:52 am, CPR had not been initiated and dispatched informed us that CPR instructions were refused	Z9999		

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Z9999	Continued From page 8 by the facility." On 10/20/22 at 2:05 pm, E4 (Administrator) was asked why CPR had not been started by facility staff. E4 stated, "I can't answer that question. I would have started it and I would expect staff to initiate CPR." On 10/20/22 at 2:02 pm, E1 (House Manager) confirmed there is no training with staff regarding when to perform CPR if an individual does or does not have an Advanced Directives or if an individual does or does not have a DNR. E1 also confirmed that no individual at the facility has an Advanced Directive or a DNR. On 10/21/22 at 8:17 am, E6 (Cook/DSP) was asked do you know what advanced directives are. E6 stated, "No." E6 was asked do you know what a DNR is. E6 stated, "Do not resuscitate." E6 was asked if she know where individuals advanced directives and/or DNR is located for staff to see. E6 responded, "Is it in the MAR (Medication Administration Record)?" b) Facility Staffing Schedule documents staff scheduled for midnight shift (11 pm-7 am) on 10/18/22 was E2. Staff scheduled for Dayshift (7 am-3 pm) for 10/19/22 was E1 (House Manager) and E3 (DSP). Interview on 10/20/22 at 10:08 am, E1 was asked who was working the night R1 passed away. E1 stated, "E2." E1 was asked if she was the only staff working midnight shift. E1 stated, "Yes." E2's Timesheet documents on 10/18/22, E2 clocked in at 11:03 pm and clocked out on 10/19/22 at 10:21 am.	Z9999		

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Z9999	Continued From page 9 E3's Timesheet documents on 10/19/22, E3 clocked in at 4:35 am and clocked out at 12:21 pm. Facility Employee List with Start Dates documents E2's facility hire date is 6/29/22 and E6's facility hire date is 7/25/22. Facility unable to produce evidence of E2 being CPR Certified. On 10/20/22 at 2:02 pm, E1 confirmed E2 is not CPR Certified. On 10/21/22 at 8:17 am, E6 was asked if she feels comfortable performing CPR or know when to. E6 stated, "I'm not certified yet." On 10/26/22 at 2:10 pm, E4 was asked if a staff who is not CPR Certified should be working by themselves. E4 stated, "No, they should have a CPR Certified staff with them." c) Facility Reporting Health Emergencies 5.602, dated 5/1/22 documents, "During an emergency, staff in attendance shall follow nursing directions/protocol until EMT (Emergency Medical Technician) arrives. Coroner's Office Case Report, dated 10/19/22 documents, "Z5 reported that R1 had stated to other residents last night, Tuesday 10/18/22 that he was not feeling well." E1's Witness Statement, dated 10/19/22 includes, "I received a text from the PM staff stating that R1 did not want to go to work tomorrow. Staff stated she had just check on R1 and he had just got done using the bathroom. She stated R1 stated he almost got sick, she	Z9999		

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Z9999	Continued From page 10 stated R1 said his stomach hurt, time noted of the PM staff text was 10:00 pm staff. E1 responded at 10:58 pm 10/18/22." E3 Witness Statement, dated 10/19/22 includes, "On the morning of 10/19/22, R9 walked in the office where I was sitting and stated that R1 was sick last night and needed help getting a shower from staff. R9 also stated that R1 was sick and complaining about sweating. I checked therap to make sure if there was any documents on it. I found nothing. Maybe 30-45 minutes later staff called out for me to check on R1 and there is where I found him unresponsive." Interview on 10/20/22 at 11:09 am, E5 (Registered Nurse Trainer/RN-T) was asked are you aware of anything regarding R1. E5 stated, "Yes, his muscle spasms." E5 was asked are you aware of his illness on 10/18/22 or his death on 10/19/22. E5 stated, "No, oh my goodness. No one called me. When did he die? Oh my goodness." E5 was informed by surveyor that he passed on 10/19/22. E5 stated, "They even called me this morning about the computer system. What time did this happen?" Surveyor informed E5 between 6:30 am-6:45 am staff found him unresponsive. E5 stated, "Oh my goodness." On 10/20/22 at 11:35 am, E1 was asked if the nurse should be notified if an individual is unresponsive or if they die. E1 stated, "If that's what the policy is saying." d) R1's 30 Minute Bed Check Time Tracking Sheet for 10/19/22 shows no documentation from 5:00 am-6:00 am. On 10/20/22 at 2:47 pm, E4 confirmed that on	Z9999		

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Z9999	Continued From page 11 R1's Bed Check Time Tracking Sheet, the 10/18/22 11:30 pm through 10/19/22 4:30 am bedchecks were all documented on 10/19/22 at 4:46 am by E2. 2) R2's ISP (Individual Service Plan) of 4/22/22, R2 is a 22 year old ambulatory non-verbal female who functions in the Profound Range of Intellectual Disabilities with Autism OCD (Obsessive Compulsive Disorder), Anxiety, and Bipolar Disorder. R2's ISP documents, "Recently, I began leaving the facility without staff knowledge or running out the door with the intent to be outside more. It is important that staff know my whereabouts at all tames and ensure that I am being engaged in a manner that allows me to go outside weather permitting from time to time. I am non-verbal and reply on gesture or pulling on others." R2 has attempted to leave the facility on 7/15, 8/18. 8/19 and 8/24. The alarm door was activated and staff followed her out the door and prompted her back in the facility. Elopement was added to R2's Behavior Plan on 6/10/22, with intervention that consist of decrease proximity, provide structure activities and redirection. R2 has had 3 incidents of leaving the building without staff knowledge. Review of facility GER (General Event Reports) documents: *"On 4/14/22 at 1:15 pm, Staff completed a walk through because the alarms were off due to a phone being in the build. R2 was sitting in the TV room playing with her doll. At 1:33 pm staff notice that R2 had gotten quiet and staff notice R2 was	Z9999		

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Z9999	Continued From page 12 not in the room. A search of the building and the facility grounds were completed. One staff drove the street to search for R2 and was found down the street in a church park lot." *"On 8/11/22 at 7:00 am, R2 was sitting at the dining room table. 10 minutes later, staff notice R2 was not at the table. The building and facility grounds were check. E1 (Home Manager) got into the facility vehicle and R2 was found down the street." *"On 9/28/22, R2 received medication at 6:35 am and went to sit in the living room. Staff last laid eyes on her around at 6:45 am prior to going into the kitchen to prepare breakfast. A past staff called the facility at 6:50 am to ask if R2 was in the building. Staff checked the building and the facility grounds. E1 searched the neighborhood and R2 was located in a subdivision down the street." The facility incident reports does not indicate whether the exterior door alarms were activated at the time R2 left the facility. Observation on 10/25/22 at 3:52 pm, "Surveyor exited the door near the girls side of the facility, when exiting no door alarm sounded." Interview with E4 (QIDP/Administrator) on 10/26/22 at 2:00pm, E4 was asked if there has been any revision with R2's behavior program. E4 responded, "No." E4 was also asked if there has been any specific retraining on R2's Behavior Program since it was developed on 6/10/22. E4 responded, "No." (AA)	Z9999		