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	IL6013106	A. BUILDING: _____ B. WING _____	C 08/23/2023

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BRIA OF COLUMBIA	253 BRADINGTON DRIVE COLUMBIA, IL 62236

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S 000	Initial Comments Complaint Investigation 2346622/IL163050	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1030 b) 300.1210 b) 300.1210 d)1) 300.1220 b)3) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1030 Medical Emergencies b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or	S9999		

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S9999	Continued From page 2 neglect a resident. (Section 2-107 of the Act) Based on observation, interview, and record review, the facility failed to ensure respiratory therapy is administered with a physician's order and monitored during administration for 3 of 4 residents (R1, R2 and R3) and failed to update care plans for 4 residents (R1, R2, R3, R4) reviewed for respiratory care in the sample of 7. This failure resulted in R2's oxygen blood saturation levels being low, emergency service being dispatched, and R2 being sent to local hospital for medical evaluation. Findings include: 1.R2's Physician Order Sheet (POS), dated August 2023, documents a R2 had diagnoses of Type 2 diabetes mellitus with diabetic neuropathy, weakness, need for assistance with personal care, acute on chronic systolic (congestive) heart failure, hepatic encephalopathy, acquired absence of left leg below the knee, cardiac arrhythmia, and aortic valve stenosis. R2's Physician Order Sheet did not have an order for R2 to receive oxygen. R2's Minimum Data Set (MDS), dated 7/31/2023, documents R2 was moderately impaired for cognition for decision making of activities of daily living. The MDS also documents R2 uses a wheelchair and has impairment on his lower extremity. R2's Care Plan documents R2 was admitted to the facility for skilled stay requiring physician ordered, medically necessary services, including direct therapy services, skilled nursing care, management and evaluation of the patient care	S9999		

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S9999	Continued From page 3 plan, observation, and assessment of the patient's condition and/or teaching and training activities related to the reason for stay or in preparation to transition to less care environment. R2's Care Plan, undated, was reviewed and does not document the use of oxygen or needs oxygen therapy. There were no goals and/or interventions documented for the use of oxygen. R2's Progress Notes, dated 7/24/2023 at 10:51 AM, documents, "Resident put on 2 liters of oxygen related to shortness of breath. Spoke with wife she stated she wanted resident sent out to (Hospital) for further evaluation." R2's Hospital Records, dated 7/25/2023 at 11:40 AM, documents, "Patient report chest pain and SOB (shortness of breath) on and off this weekend. Denies chest pain at this time. Plan to admit and treat for unstable angina. Patient seen and examined. Reports that his chest pain has been intermittently present over the past month and associated with some radiation to the left elbow with some shortness of breath associated." R2's Progress Notes, dated 7/29/2923 at 8:00 AM, documents, "Resident back at the facility, alert, and orientated x 3 with confusion. BP (Blood pressure) 128/69, pulse 50 and O2 (oxygen) 99% on 2 liters of oxygen." R2's Progress Notes does not document why he was on 2 liters of oxygen or if the physician was contacted. R2's Oxygen Saturations were documented as being taken on 7/30/2023 at 11:55 PM, and was documented as being 98% on room air. R2's medical record does not document when R2 was started on oxygen or when R2 was taken off of	S9999		

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S9999	Continued From page 4 oxygen. R2's Progress Notes, dated 7/31/2023 at 8:10 AM, (Written by V13, Licensed Practical Nurse/LPN) documented, "Informed by staff resident was unresponsive. Upon assessment resident noted to be in room lying in bed. Labored breathing noted with decrease spo2 (oxygen level) 69% with o2 via NC (nasal cannula). O2 increased to 4L/Nc (liters/nasal cannula). Uneven respirations noted. Resident not alert and minimal response to sternum rub. HOB (head of bed) elevated 911 called at this time. Call made to spouse no answer. 8:24 AM, 911 EMS (emergency medical service) here to assist at this time. 8:30 AM Resident transported to ER (emergency room) at this time. Attempt to call spouse regarding resident status no answer at this time." R2's Ambulance Service Report, dated 7/31/2023, documents, "Dispatched to local skilled nursing facility. For 82-year-old male (R2) patient, not responsive. Facility staff stated they found the patient in this condition with his oxygen concentrator alarming. No one was able to advise us of his first known normal or baseline orientation aside from more alert than this. They stated they checked his pulse oxygen, and it was in the 60's so they brought a portable oxygen tank and place him on 4 liters by nasal cannula with minimal improvement they called us. Patient's (oxygen pulse level) on 4 liters/pm was 88%." The Report documented his lung sounds were clear and equal bilaterally and he had strong radial pulses. R2's Hospital Records, dated 7/31/2023 at 2:38 PM, documented, "(R2) is an 82-year-old male admitted 7/31/2023 with sepsis. He is a nursing	S9999		

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S9999	Continued From page 5	S9999		

home resident and was found unresponsive by staff with an empty oxygen tank. SPO2 (oxygen) when he was found was 60 %. He was transported to hospital for further care. On arrival he was noted to be hypotensive and started on Levophed. He was seen and evaluated in the ED (Emergency Department) prior to transfer to the ICU (Intensive Care Unit)."

On 8/22/2023 at 3:45 PM, V23, Medical Doctor from the hospital, stated R2 was not sent back to the facility with an order for oxygen on 7/29/2023 when he returned to the facility.

R2's Medical Records does not document any order for the use of oxygen and or monitoring of oxygen before 8/4/2023.

On 8/16/2023 at 3:04 PM, V5, Certified Nursing Assistant (CNA), stated, "I use to care for (R2); he was my buddy. He came here for rehab because he lost his leg. He has some heart issues, and he went downhill and passed away. He was here just last month. It makes me sad. On the day (R2's) oxygen was broken, there was no nurse working the 200-hall. I cannot say why there was no nurse that day."

On 8/16/2023 at 3:13 PM, V9, CNA stated, "I remember (R2); he was in a wheelchair and was here for rehabilitation because he lost his leg. I did not have any problems with him. He passed away here in the building. I am not aware of any issues with oxygen, but I know we were out of oxygen tanks today, and we're waiting for a delivery of new tanks." V9 stated he was not sure how long the facility had been out of tanks. V9 stated, "Maybe 24 hours or less."

On 8/16/2023 at 2:33 PM, V22, Emergency

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S9999	Continued From page 6 Medical Technician, stated, "I was told by the nurse (R2) was found unresponsive by staff with an empty oxygen tank and his SPO2 (oxygen) when he was found was 60 % and reported it to the hospital, but I cannot confirm or deny this if this was accurate, or if the oxygen tank was empty. When we hooked (R2) up to the oxygen, his oxygen stats improved. At 8:26 he was at 88 (%), at 8:31 he was at 97 (%) and at 8:51 he was at 100%." On 8/17/2023 at 1:04 PM, V15, Licensed Practical Nurse (LPN), stated, "I know why you are calling me. The facility is trying to get rid of me because on 7/31/2023 at 11:30 AM, I heard a nurse saying (V16) she was going to send (R2) out. I went down the 200-hall, which was not my hall, and I saw (R2) was lethargic and was mouth breathing. I was working the 300-hall. (V16, LPN) was working the 100 hall and (V18, LPN) was working the 400/500 hall. We found out later (V17, LPN) was a no show/no call off and did not report to work. (R2), who was on the 200 hall, was diabetic and I went and took a blood glucose level, and he was 202. I started rubbing his sternum because he was unconscious. I went and checked his oxygen level, and he was at 60%, so I turned his oxygen up, and told the nurse to go and get a crash cart. His oxygen levels did not change. (R2) was on an oxygen concentrator in his room, that was not working. The Physical Therapist was pregnant, and she came, and she brought me an oxygen tank and we hooked him up on tank since the concentrator was not working. The oxygen concentrator was broken, so we put him on a portable oxygen tank, which are also hard to find sometimes too. We had a nurse call off that day, and there was no nurse assigned to that hall because of the No show, no call off nurse. Later, (V16) the other	S9999		

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S9999	Continued From page 7	S9999		

nurse came to me and asked me if I was working that hall, and I told her no and nobody bothered to tell me that no nurse was assigned to the hall, and nobody was monitoring the residents on the 200- hall. (V16) said she was not told that either, and was not checking on the 200 hall residents either. (R2) was talking and came into the facility for therapy because he lost a leg. I went to the DON (Director of Nursing) and (V1, Administrator) and told them the oxygen concentrator was not working. They immediately went into his room and removed it. I am not going to lose my license over the facility not assigning a nurse to the 200-hall. I was really upset about (R2), and I also reported to the EMT (Emergency Medical Technician) what had happened. There was no nurse working that hall that day, and nobody was checking on (R2), and whoever put that oxygen concentrator on him should have been monitoring it, so they would have known he was not getting his oxygen with that oxygen concentrator. I know (V11, Wound Nurse) gave the medications that morning, but she was not working that hall other than giving out the medications."

On 8/17/2023 at 2:23 PM, V16, LPN stated, "I was working the day (R2) was having issues with his oxygen. He was not his normal self when I saw him. I was not working that hall that morning. I am not sure who was supposed to be working the 200-hall, but it was not me. I was assigned to a different hall. I went to help (R2), and we (V15, LPN) and I were getting low oxygen saturations levels on him, and I called the EMT (emergency medical team), and we had him sent off."

On 8/17/2023 at 2:41 PM, V19, Occupational Therapist (OT), stated, "I remember going into (R2's) room. He had been a patient here off and

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S9999	Continued From page 8 on over the years and we all liked him. When I went into his room, he was breathing different, he had shortness of breath. I immediately went and got the nurse. I do not remember who the nurse was. The nurse began changing the tank, so I left. That is all I remember." On 8/22/2023 at 3:43 PM, V21, Medical Director, stated, "I would expect a resident on oxygen to have a working oxygen tank and for staff to be checking the oxygen levels and post oxygen/saturations ensuring the resident is 94% or higher, resting comfortable. If a resident is lower than 94%, I would expect the facility to contact me and send the resident out. I am not aware of any issues with oxygen tanks not working." 2. R1's August 2023 POS documents R1 has diagnoses of acute and chronic respiratory failure with hypoxia, chronic kidney disease, stage 3, congestive heart failure, and dementia. R1's MDS, dated 7/6/2023, documents she was cognitively intact for decision making of activities of daily living. R1's Care Plan, undated, was reviewed and does not document she is on oxygen or needs oxygen therapy. There were no goals and or interventions documented for the use of oxygen. R1's Nurse's Notes, dated 8/16/2023 at 5:02 PM, documented, "This nurse was in dining room and noted (R1's) oxygen wasn't in place reporting that she was waiting for a new tank as her previous tank wasn't working correctly. (R1) was talking with ease with respirations between 18-20. (R1) denied any difficulties and continued conversation with other resident."	S9999		

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S9999	Continued From page 9 On 8/17/2023 at 4:50 PM, R1 was in the dining room. R1's oxygen tank was on the back of her wheelchair, but the tubing was in the back not within reach of R1. R1 was not wearing any nose cannula and was not getting any oxygen. On 8/17/2023 at 5:05 PM, R1 stated, "My tank is not working. They are supposed to be getting me another one. I am supposed to be on oxygen 24 hours, seven days a week. I have a machine at my bed and that works okay but this portable one does not work. I am not wearing it because no air is coming out. They don't seem to care that I am not wearing my oxygen, but I am not wearing it because it is not working. This is not a one-time thing. It happens a lot when I leave my room." On 8/17/2023 at 12:47 PM, V14, Nurse Practitioner, stated, "I was in the facility yesterday and I observed (R1) without an oxygen tank on while she was in her room and was only on room air. When I asked staff why, I do not remember the names of the staff, but they told me the facility was out of oxygen tanks. I would expect the facility to always have oxygen tanks available for residents 24 hours a day, seven days a week. I would expect staff to monitor residents especially residents on oxygen. They told me they were expecting some tanks to be delivered later that day. If a resident needs oxygen but is not getting that oxygenj that can lead to hypoxia. Hypoxemia is a below-normal level of oxygen in your blood, specifically in the arteries and can cause significant harm if left untreated." 3.R3's August 2023 POS documents R3 had diagnoses of Respiratory failure and sleep apnea. R3's MDS, dated 7/11/2023, documents R3 was	S9999		

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S9999	Continued From page 10 cognitively alert for decision making. On 8/16/2023 at 10:33 AM, R3 stated the facility had run out of oxygen, and they were waiting for some tanks to come in today. She was not sure how long, but it had been a few days now. It was not uncommon for the facility to run out of tanks, and she needs the tanks so she can do therapy. On 8/16/2023 at 10:39 AM, V20, Physical Therapist, stated, "I have had to replace the tanks on (R3) when she came in to do therapy. She is the only resident on the top of my head that I have that uses oxygen. I know sometimes when she comes in here, she does not always have a full tank of oxygen." 3. R3's August 2023 POS documents a diagnosis of Respiratory failure and sleep apnea. R3's MDS, dated 7/11/2023, documents R11 was cognitively alert for decision making. On 8/16/2023 at 10:33 AM, R3 stated the facility had run out of oxygen, and they were waiting for some tanks to come in today. She was not sure how long, but it had been a few days now. It was not uncommon for the facility to run out of tanks, and she needs the tanks so she can do therapy. R3's Care Plan, undated, was reviewed and does not document the use of oxygen or needs oxygen therapy. There were no goals and or interventions documented for the use of oxygen. 4. R4's Face Sheet documents diagnoses of heart Failure and Pulmonary Embolism and hypertension. R4's August 2023 POS documents, "oxygen at 2	S9999		

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S9999	Continued From page 11 LPM per nasal cannula every day and night shift for COPD and Chronic Respiratory Failure." R4's Care Plan, undated does not document R4 is receiving oxygen therapy. On 8/15/2023 at 12:02 PM, V2, Director of Nursing stated, "I expect all care plans to be current and up to date." The Oxygen Administration Policy, with a revision date of 9/2022, documents, "It is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care." The Facility Resident Right Policy undated documents, "The right to participate in the planning process including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care." (B)	S9999		