

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012835	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2023
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NAME OF PROVIDER OR SUPPLIER RIVER CROSSING OF JOLIET	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE JOLIET, IL 60435
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S 000	Initial Comments Investigation of Facility Reported Incident of 03-01-2023/IL157379 Extended Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3)6) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to initiate immediate cardiopulmonary resuscitation (CPR), failed to correctly provide emergency interventions, and failed to initiate 911 timely.</p> <p>These failures resulted in the delay of efforts to revive R3 and has the potential to affect 43 residents (R2, R7, R13-R53) at the facility who are full-code status.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>The Order Listing Report dated 3/29/23 documents 43 residents residing at the facility with an advanced directive of a full code.</p> <p>Findings include:</p> <p>R3's Admission Record dated 3/1/2023 documents R3 as an 84-year-old admitted 7/1/2008 with diagnoses to include Cerebral Vascular Accident, Chronic Ischemic Heart Disease, Cardiomyopathy, Hypertension, and Diabetes.</p> <p>R3's Practitioner Order for Life-Sustaining Treatments dated 1/9/2020 documents if R3 does not have a pulse and is not breathing, attempt CPR and provide full treatment to sustain her life by medical means.</p> <p>On 3/28/203 at 11:10 AM, V14 (Nurse) stated he was working on the same side of the building as V3 (R3's assigned Nurse). At around 4 AM V3 urgently summoned V14 to assist her in R3's room and he immediately responded. V14 stated when he entered the room R3 was partially on the floor and partially on the bed, which was an air mattress. R3's head was on the floor at the foot of the bed, her trunk was partially off of the bed and her legs still on the bed. V14 stated he quickly realized a code needed to be called and he left the room to overhead page the code to alert other staff for assistance. At 11:32 AM, V14 stated after making the overhead page, he then went back into R3's room and assisted with placing R3 back in bed, then left to get the crash cart which he brought to R3's room and then left again to call 911 and did not return.</p> <p>On 3/28/2023 9:30 AM, V17 (Agency Nurse) stated she was working on the nursing unit on the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>opposite side of the building when an overhead announcement was made for a code blue. V17 stated she arrived to R3's room approximately 4 minutes later after securing narcotic drugs she was in the process of preparing. When V17 entered R3's room the crash cart was in the room and V3 was the only staff member present. V17 stated CPR had not been initiated by V3, and R3 was in the bed with blood to the right side of her face from the top of the skull to her neck from a fall. V24 (Agency Nurse) then entered the room, R3 was placed back onto the floor from the bed and CPR was started. V17 further stated, V3 had to be instructed where to obtain the manual resuscitator (ambu bag) mask, to provide ventilation's (breaths) with the manual resuscitator, and to tilt R3's head up from a chin tucked position to open her airway for ventilation. V17 stated V3 was using the manual resuscitator that was hooked to oxygen but was not keeping the manual resuscitator mask on R3's face while compressions were being done to provide additional oxygen.</p> <p>On 3/29/2023 at 12:11 PM, V3 stated CPR was initiated between 3-5 minutes after V3 found R3 on the floor and continued for 20-25 minutes until the Emergency Medical Technicians (EMT's) arrived and took over. V3 was unable to provide an exact time R3 was found on the floor, but stated it was between 3:45-4 AM.</p> <p>On 3/29/2023 at 2:21 PM, V24 stated she and V17 are agency nurses that were working on the opposite side of the building that R3 resided at the time of this incident. V24 stated she was administering medications to a resident via a feeding tube and did not clearly hear the overhead page calling a code blue. V24 stated as she was exiting the resident's room another page</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>came overhead for a code blue and V24 saw V17 heading towards R3's room and V24 entered R3's room right behind V17. As V24 entered R3 was on the air mattress and V24 instructed the staff present to move R3 to the floor to provide effective CPR. After R3 was placed back on the floor CPR was started.</p> <p>A Progress Note dated 3/1/2023 documents 911 was contacted no later than 4:10 AM and EMT's arrived at approximately 4:30 AM. The EMT's ceased CPR at 5 AM and R3 was pronounced dead at 6:45 AM by V23 (Coroner).</p> <p>On 3/28/2023 12:30 PM V15 (Nurse Practitioner) stated R3 should not have been put back to bed on her air mattress after the fall to perform CPR and should have been left on the floor. V15 stated R3 was a full-code and CPR and life saving measures are to be started immediately in hopes to revive them. V15 further stated, delays in initiating life saving measures can reduce a person's chance of survival.</p> <p>The Police Department Case Report documents the 911 call received by dispatch as occurring at 4:09:42 AM.</p> <p>The Code Blue and CPR Policy revised on 3/27/2021 documents the facility standard as: This facility will honor the resident/resident's representatives wishes either with the provision or withholding of CPR. To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including CPR, to any resident requiring such care prior to the arrival of EMT's in accordance with related physician orders and the resident's advanced directives. CPR Guidance includes the sequence to provide CPR as to check the resident for</p>	S9999		

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S9999	Continued From page 5 responsiveness, if unresponsive call for help and activate 911 or direct others to do so, check for breathing and pulse and if no pulse and not breathing, begin CPR. (A)	S9999		