STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004303	A. BUILDING: _____ B. WING _____	04/21/2023

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HERITAGE HEALTH-PERU	1301 21ST STREET PERU, IL 61354

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.1210 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. Section 300.1210 General Requirements for	S9999	Attachment A Statement of Licensure Violations	

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Nursing and Personal Care
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 regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to recognize the immediate need for transferring a Covid-19 positive resident to the hospital for necessary medical treatment for one (R26) of four residents reviewed for hospitalization in the sample of 29. This failure resulted in delay of treatment resulting in R26 expiring in the emergency room.

Findings include:

The facility's Guidelines for Physician Notification of Change in Resident Condition policy, revised 4/2019, documents: "Purpose: to define resident care situations that require physician notification. Standard: Staff observe, document and communicate to the physician changes in resident condition promptly. If the nurse is unable to contact the physician, the nurse may, by his/her informed judgment and professional discretion, transfer the resident to the hospital of record for evaluation and treatment."

On 4-19-23, at 3:10pm, R26 sat in R26's isolation

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room in a wheel chair with his head and upper body leaning over the bed with eyes closed.

On 4-20-23, at 3:30pm, V13 Registered Nurse/RN stated the following: I worked on Tuesday (4-18-23) from 6am-6:30pm. I took care of (R26) the last two days. Tuesday he was already Covid positive. No symptoms, just his blood pressure was a little lower than normal (100/60s) for his baseline. I let (V12 R26's Nurse Practitioner/NP) know. On Wednesday, (R26) got up and had breakfast, but was really tired, exhausted. I noticed (R26) was a little confused but vitals were the same; blood pressure 100/50s, no cough. I let (V12 NP) know. I noticed (R26) said he wasn't short of breath, but he looked it. (R26) was a little more confused. I told all this to (V12 NP). After spoke with (V12 NP) earlier (V12) gave an order for Lasix and IV (intravenous) fluids. Later in evening on my shift (R26) perked up and was more awake. (R26) started with a congested cough. I listened to his lungs and he had congestion to right lung and his blood pressure was 100/50. I called (V12 NP) again close to end of my shift and told (V12) this. She said to give an extra Lasix 20mg (milligrams) and order stat chest xray. This was right after I gave report. Then I put the orders in. (V15 RN) relieved me and was going to give the Lasix. I put the order in as stat for the chest xray. I told (V15) before I left that (V12 NP) wanted to be called with (R26's) xray results and a condition report. (V15) asked if (R26) was to have more fluids after this bag and I said no, that (V12 NP) would make that decision after a condition update.

R26's Progress note, dated 4-19-23 at 6:55pm by V15 Registered Nurse/RN, documents "Biotech here to do chest x-ray."

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R26's Progress note, dated 4-19-23 at 10:00pm by V15 RN "Respirations are now 36. Spo2 (Saturation of peripheral oxygen) 89% on 3L (liters). Resident complained of 'feeling anxious'. Oxygen titrated to 4L. Gave albuterol inhaler."

R26's Progress note, dated 4-19-23 at 10:00pm by V15 RN, documents "Received chest xray results. Results indicate cardiomegaly with CHF (Congestive Heart Failure), pulmonary edema, right sided pleural effusion, underlying infiltrate/atelectasis involving the lung bases. Results sent to (V12 Nurse Practitioner/NP). Awaiting call back."

On 4-20-23, at 1:28pm, V15 RN stated the following: I worked 6pm-10:30pm (4-19-23) last night. I took care of (R26) and got report from (V13 RN). (V13) told me (R26) was dehydrated, getting a liter of fluid and a chest xray, and had increasing edema. (V13) said (R26) had a cough and was confused on day shift. (R26's) chest xray results came back at 10pm. I gave report to (V14 Licensed Practical Nurse/LPN). (V14) took a picture of the results and texted it to (V12 R26's Nurse Practitioner). I did not listen to (R26's) lungs. At 8pm (R26) seemed alert and oriented talking to me. I did hear (R26) coughing kind of congested sounding. I did not listen to (R26's) lungs then or on my shift. At shift change at 10pm his breathing was faster and his oxygen saturation dropped to 89-90%. I upped (R26's) oxygen from 3 to 4lpm (liters per minute) and gave (R26) Ventolin inhaler. A CNA (Certified Nursing Assistant) said (R26) was asking for an anxiety pill but it was too soon. I reported off to (V14 LPN). Maybe I should have listened to (R26's) lungs. I told her about these things in report. I did read the chest xray results. We did not hear back by the time I left around 10:30pm. I

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thought (V14) was going to call (V12 NP) if (V14) hadn't heard back from the text (to V12 NP). That's what I would have done. I would have waited 20 minutes or so then called (V12 NP) or the doctor.

On 4-20-23, at 12:33pm, V14 LPN stated the following: I took care of (R26) for four hours from 10pm till 2am. I got report from (V15 RN). (V15) said (R26) had Covid. (V15) gave (R26) an anxiety pill about 8:30pm. (R26's) oxygen saturation had dropped so (V15) bumped it up to 4 liters. After report maybe around 10:45 or 11pm I think, (R26) had put (R26's) call light on. CNAs said (R26) was feeling anxious and didn't know where (R26) was at earlier when I got report, (V15) said that (R26's) chest xray results just came in. I saw the results and sent it to (V12 R26's NP). I sent it by text to (V12's) work phone shortly after 10pm. I did not hear back from (V12). I did not try (V12) again and didn't think there was reason to (R26) called CNAs a lot and wanted fan turned on then a little while later wanted it off, then back on a little while later (V15) did report to me that (V15) gave (R26) Albuterol and that (R26's) oxygen saturation was 89%. (V15) said (V15) bumped him (R26's oxygen) up to 4 and he (R26's oxygen saturation) went up. I don't recall (R26's) respirations being at 36. (R26) fell asleep and was asleep when I left - it seemed like anxiety to me.

R26's Progress note, dated 4-20-23, at 3:38am by V11 LPN, documents "Resident is noted to be yelling out multiple times starting at 0300 (3:00am). At 0325 (3:25am), O2 (oxygen) 96% 3L, no abdominal breathing at this time, head of bed elevated and resident repositioned. Resident is verbalizing that he is SOB (short of breath) and can't breath and wants to go to hospital. Resident

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denies pain at this time; PRN (as needed) Norco given at 0043 (12:43am) and Hydroxyzine given at 2037 (8:37pm) 4/19/23. Resident verbalized 'Just give me something to sleep or be able to breath, just send me to hospital!' 911 called at 0331 (3:31am), MD (Medical Doctor) notified at 0333 (3:33am). On call notified at 0334 (3:34am), POA (Power of Attorney) called and notified at 0335 (3:35am) and verbalized understanding and would like to be updated with any news, EMT (Emergency Medical Technicians) arrived at 0341 (3:41am). When entering room with EMTs resident is noted to be abdominal breathing and verbalizing 'I feel like I'm dying'. EMTs left with resident at 0355 (3:55am)."

R26's Progress note, dated 4-20-23, at 4:57am by V11 LPN, documents "Nurse at (local hospital) notified this nurse at 0445 (4:45am) that resident passed away in ER. Nurse at ER verbalized that she would call and notify (R26's) POA (Power of Attorney). (V1) Administrator notified at 0455 (4:45am). (V12 R26's NP) notified at 0500 (5:00am) and verbalized understanding."

On 4-20-23, at 9:28am, V11 LPN stated the following: I came on duty at 2am today. I got report from (V14 LPN).. After that (R26) was call light happy - on the call light every 5 min. I asked the CNAs each time what he needed. I asked if he seemed more anxious than usual and they said yes. (R26) wanted the fan on then off then back on again. At 3:25am (R26) started complaining of shortness of breath, his oxygen saturation was 95-96%, oxygen was running, bubbler was fine. No abdominal breathing. Head of bed was elevated. It was just verbal that he was short of breath. I said I could send (R26) to the hospital, he agreed and didn't refuse. I offered (R26) prn (as needed) Albuterol inhaler and (R26)

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refused and just wanted to go to the hospital. I saw the chest x-ray results after my assessment at 3am sitting on the desk. I knew (R26) had one done but didn't know we had the results back until I saw them. I did not know they had been reported to (V12 NP) already. I didn't have time to notify (V12) because I was trying to get (R26) out to the ER (Emergency Room).

On 4-20-23, at 9:50am, V12 (R26's Nurse Practitioner) stated (R26) probably should have been sent out yesterday. (V13 RN) called me yesterday (4-19-23), not sure what time (10am?), and said (R26) seemed confused, weak, his blood pressure was still low, and his lungs and urine were clear. I ordered one liter of fluids at 125 lpm (liters per minute) and to monitor (R26's) blood pressure. I also ordered Lasix 40mg oral in addition to his usual Lasix 40 dose. (V13) called back later around 6pm and said (R26) seemed perkier but (R26's) right lung is congested. I ordered a chest x-ray. (V13) said (V13) would put it in stat. (V14 LPN) texted the results to me at 10:10pm but I was sleeping. I woke up at 12:30am and saw the results. I did not text back or call them. (V13 RN) was worried. (V13) said (R26)was weak, confused and not himself. That isn't like him, but I thought (R26) was dehydrated and kidney function was failing. (V14 LPN) texted me at 10:10pm with xray results but I was sleeping and saw them at 12:30am. I didn't' know (R26's) respirations were 36 and oxygen saturation was 89% at 10pm...I'm hesitant to send residents out. They are sending them here really sick then expect me to keep them out of the hospital. I totally trust (V13's) assessment. If (R26) had been sent out earlier (R26) would have gotten more diuretics but was urinating. It's a hard line.

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S9999	Continued From page 7 R26's X-ray Patient Report, dated 4-19-23, documents "Impression: Postop changes in the chest. Cardiomegaly with CHF (Congestive Heart Failure), as well as early/subtle interstitial pulmonary edema. Right-sided pleural effusion. Obscured lung bases may be secondary to pleural fluid, but underlying infiltrate/atelectasis involving he lung bases would also have to be considered. Follow-up chest radiographs recommended after medical management." On 4-20-23, at 3:53pm, V2 Director of Nursing/DON stated the following: V2 was unaware of (R26's) 10pm condition of rapid respirations and low oxygen saturation when the xray results were received. I think they should have phoned (V12 R26's Nurse Practitioner/NP) with results. They normally would call. (V12 NP) likes the text. The nurses shouldn't wait very long before calling (V12NP) to be sure (V12) got the results. On 4-21-23, at 8:59am ,V16 Medical Director stated the following: I think they should have called the nurse practitioner. Texting does not replace a phone call. Technically they should have an order to have an ER (Emergency Room) visit, but (V15) could have sent him out without it. An ER visit at 10pm would have been warranted. The nurse is trained to send patients to the ER. It's possible they could have done more for (R26) and tried other things. ER generally prefers to get people before they crash. V16 confirmed that knowing R26's condition and xray results, the nurse (V15 RN) should have reached (V12 NP) by phoning. R26's Emergency Department Note, dated 4/20/23, documents "Exam Narrative: Patient having agonal breathing, is ashen, and his	S9999		

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S9999	Continued From page 8 respirations are down to 10. He is not alert. He is not responding. Chest has fairly decent air movement when he takes in a breath. Pupils are still reactive. Discharge Patient Disposition: Expired. Probable Cause of Death: Pulmonary Embolism. Expired Date/Time: 4/20/23 04:37am." (AA)	S9999		