Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: ______ B. WING ______	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA ON 87TH	**2940 WEST 87TH STREET CHICAGO, IL 60652**

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S 000	Initial Comments	S 000		
	Complaint Survey: 2481768/IL170502, 2482227/IL171055, & 2482286/IL171112			
S9999	Final Observations	S9999		

Statement of Licensure Violations 1 of 2

300.610a)
300.1210b)
300.1210c)
300.1210d)2
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

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 Requirements were NOT MET as evidenced by:

Based on interviews and record reviews the facility (A) failed keep one resident [R1] head of the bed elevated, and failed to provide one to one feeding assistance, (B) failed to follow their code blue policy to call 911, R1 was unresponsive and having difficulty breathing, (C) failed to notify the physician in a timely manner of an acute change in condition, and failed provide an accurate report to the physician, (D) failed to relay STAT (immediate) laboratory and diagnostic test results to the physician. These failures resulted in R1 higher level of care being delayed, R1

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experiencing an acute change in condition and subsequently expiring on 3/3/24 in the facility.

Findings Include:

R1's clinical record indicated in part; R1 was admitted to the facility on 2/27/24 with medical diagnosis of pneumonitis due to inhalation of food and vomit, dysphagia, cerebral infarction due to thrombosis of right middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, visuospatial deficit and spatial neglect, memory deficit, , protein-calorie malnutrition, muscle weakness, cognitive communication deficit, dysphagia, essential (primary) hypertension, attention-deficit hyperactivity disorder, weakness, gastrostomy, and generalized anxiety disorder.

R1's care plan dated 2/27/24:
-R1 needs the head of bed elevated 45 degrees during and thirty minutes after tube feeding.
-Monitor R1 and report to physician if noted aspiration, shortness of breath, abnormal lung sounds, abnormal lab values, nausea or vomiting.

R1's physician orders:
-2/27/24 - Aspiration Precautions:
Keep HOB elevated during and 30min after G/T Feedings and 1:1 Feed with Pureed Diet and HTL [Honey think liquid] every shift.
-2/27/24- four times a day flush enteral tube QID with 150 mL [milters] of water after feeding.
-2/27/24 - four times a day enteral feeding: Jevity 1.5 360ml bolus QID [four times per day].
-2/27/24- general diet, pureed texture, honey thick consistency with one-to-one feeding assistance.
-3/2/24 -Oxygen at 2-3L/nasal cannula as needed to maintain O2 Sat at 93% or greater every shift.

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-3/2/24 (14:42)- - Oral Suction at bedside. Suction PRN [as needed].
-3/2/24 (14:40) - Robinul Oral Tablet 1 MG, give 1 mg via G-Tube every 12 hours for drooling /excessive secretions.
-3/2/24- CBC, BMP, Magnesium level STAT
- 3/2/24 Chest Xray STAT
- 2/28/24- Monitor vital signs every shift for 30 days then daily

R1's laboratory reported dated 3/2/24 indicated the lab results were faxed to the facility on:
-Complete Blood Count [CBC] at 11:16 PM.
-Basic Metabolic Panel [BMP] at 11:47 PM.
[Lab Results was never Relayed to a Physcian]

R1's progress notes documented in part:
V8 [Speech Pathologist/Therapist] Note documented in part:
On 2/29/24- Recommendations for R1, to continue puree diet, with 1:1 assistance and to follow R1's swallowing precautions: only feed when alert, up right at 90 degrees for all meals, reposition as needed, aspiration precautions, monitor or pocketing, small bites, small sips, alternate liquids, and solids, monitor for signs and symptoms of aspiration related illness.

V3 [Nurse Practitioner] Note: 3/2/2024 at 3:51 pm CHIEF COMPLAINT: R1 is a 66-year-old male seen today for a follow-up skilled SAR visit to manage multiple medical conditions. R1 had a PEG placed on 1-04 2024. R1 stabilized transferred here from inpatient rehab to subacute rehab. Pt seen today alert, nonverbal, not following commands. Pt in NAD [No Apparent Distress]. Scattered Rhonchi and cough noted during my exam. Pt appeared to have difficulty clearing his airway. I [V3] ordered bedside suction and Robinul for excessive secretions.

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V5 nursing progress note: 3/2/24 7:19 pm
Note: R1 is breathing easy. V/S [Vital Signs] 98.7,89,18,124/80,02 R.A @ 92%. V31 instructed to maintain R1 in an upright position to prevent reflux.MD order CXR & magnesium level stat with CBC/differential. Orders carried out.

V5 [Registered Nurse] nursing progress note 3/2/2024 9:19 pm Note: V31[Certified Nurse Assistant] found R1 shaking and called nurse-observed pt having secretions coming out of nose and mouth. R1 regurgitated. Having difficulty breathing. Congestion noted on listening to lung sounds. V3 [Nurse Practitioner] was in house earlier on today and ordered oral suction at bedside PRN [as needed]. R1 was suctioned and stabilized. Respiration even non labored. [Nurse failed to document code blue was initiated]

V30 [Telehealth Physician] Note:
3/2/2024 at 9:03 pm telehealth evaluation (other)
Date of Service: 03/02/2024 8:09 PM CT
Details: Nurse Name: V24 [Nurse Supervisor/Licensed Practical Nurse]
Patient Name: R1
Primary Chief Complaint: General: Chills
History Present Illness: 66-year-old male with past medical history of dysphagia status post G-tube, hypertension. Earlier today got his bolus feed. Nurse performed bedside suctioning but has lot of secretions, mucus coming out of nose and mouth had chills per CNA [Certified Nurse Assistant-V31], no AMS [altered mental status]
Vital Signs: T [temperature]: 98.7 (°F), HR [heart rate]: 89 (bpm), BP [blood pressure]: 124/80 (mm/Hg),
RR [respirations rate]: 18 (rpm), SpO2: 92 (%), Pain Level: 0)

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Physical Exam: Exam findings per nurse Physical Exam - Notes: GEN NAD [No apparent distress] Respiratory: congested on room air, Diagnosis, Assessment/Plan: Chills (without fever) (Primary) The patient's condition is stable. This is an acute new problem. Nurse performed patient concern is aspiration pneumonia although he is not having any respiratory stress at time of this evaluation. Will order labs and chest x-ray. Technology Used: Audio and video with patient and nurse present. Statement of Medical Necessity.
[V24 failed to tell the Physician: Code Blue was initiate, R1 was found laying flat, R1 was self-feeding, R1 has an emesis with food particles projecting out of his nose and mouth, and started on supplemental oxygen to sustain oxygen levels of 92%.]

V29 [Agency Registered Nurse] Nurse Progress note: 3/3/2024 07:50 AM
Note: Received R1 in bed awake and alert lying upright in bed verbally responsive. Notified by CNA [V31-Certified Nurse Assistant] that R1 was unresponsive patient found lying upright in the bed pulselessness code blue called, CPR initiated and 911 called, blood sugar 171 BP 111/54 CPR continued until fire department arrived.

There was no documentation on (3/2/24) 7AM-11PM from V4 [Licensed Practical Nurse] no progress note, no vital signs.

There was no documentation on (3/2/24) 11PM-7AM V36 [Agency Registered Nurse], no progress note, no vital signs.

Interviews:

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On 3/26/24 at 4:21 PM, at V6 [R1's Family Member] stated, "On 3/2/24 I went to the facility approximately 5:30 PM. Upon arrival to the facility R1's door was closed; I thought the staff was changing his under brief at the time. Then I saw nursing staff going in and out of his room running pass me and no one said a word to me. A few seconds later, I heard over the intercom speaker code blue for R1's room number. I asked V5 [Registered Nurse] coming out of R1's room what was going on. V5 told me that R1 was lying flat down in bed eating and aspirated. When V5 went back into the room I went in the room with him. I saw R1 foaming at the mouth and nose, not responding with his eyes closed and V4 [Licensed Practical Nurse] was suctioning R1. Another young lady brought in oxygen and V4 started oxygen on R1. A few minutes later R1 opened his eyes and was looking around. V4 and V5 left out the room, and I asked R1 was he okay, he turned his head side to side meaning no. R1 can usually say simple words like yes or no, but R1 could not talk. After staying with R1 for a few hours, he continued coughing, drooling, and I can hear his chest rattle when he breaths in and out. I asked V5 at the nursing station was my father going to be alright, V5 said yes, he will be okay, for me to go home and rest. On 3/3/24 at 8:42 AM, a nurse called me from the facility and said she was sorry R1 passed away 45minutes ago."

On 3/26/24 at 12:44 PM, V8 [Speech Pathologist/Therapist] stated, "I completed R1 speech evaluation and worked with him. R1 had a medical diagnosis of dysphagia with moderate oral phase. R1 would have oral phase trace residue 4 out of 4 exercises. R1 would have a little food left on his tongue. With drinking honey thick liquid, R1 would have some liquid come out of his mouth that he did not swallow. My

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recommendations for R1 were to continue puree diet, honey thick liquid, one-to-one feeding assistance and follow aspiration precautions. On 2/29/24, I placed R1's aspiration precautions at the head of his bed under a privacy cover. The top cover read 'Please see attached swallowing precautions', underneath I listed the following: [only feed when R1 is alert, feed him in an upright 90-degree position, and reposition as needed, due to R1's past stroke he would lean to the side, small bites, and small sips of liquid]. During mealtime if R1 was noted coughing, chest congestion, rattle, or difficult breathing staff was notified to stop oral intake and notify R1's provider for further instructions."

On 3/26/24 at 6:26 PM, V5 [Registered Nurse] stated, "On 3/2/24 around 5PM, V4 [Licensed Practical Nurse] yelled out for my help and said code blue in R1's room. V4 was the assigned nurse for R1. When I went into the R1's room I saw R1 lying flat down in the bed throwing up food, out of his nose and mouth, with his dinner tray in front of him, not responsive and having a hard time breathing, R1 was weak and limp. V4 sat R1 up in bed, and I ran and got the crash cart while V4 was suctioning R1. I sent V31 [R1's Certified Nurse Assistant] to get the oxygen tank. R1's oxygen level was reading in the 70's percentile. After suctioning and started oxygen R1 started to come back around. R1 started breathing and looking around. R1 continued to cough, and I could hear chest congestion, but he was back breathing and stopped vomiting. I did not call 911 when R1 was unresponsive because R1 was left lying down in bed and aspirated, that situation could be managed by nursing interventions. When I left out the room, V6 [R1's Family Member] asked me what was going on with R1. I explained R1 was left flat and

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aspirated, but he was okay now. I spoke to V31 and gave her education that no one with a gastric feeding tube should ever be laid flat in bed, and R1 was a one-to-one feed assist, R1 was not to receive a dinner tray to eat alone. V31 said she understood, and that she did not see the sign above R1's head. I documented a brief note in R1's chart to help out V4, because she [V4] was having a rough night with her set of residents. I documented vital signs after R1 was stable in my progress note, not on the electronic medication sheet. I did not document the vital signs during his code blue. I thought V4 would chart a complete progress note and assessment to what happened with R1, V4 was his assigned nurse. I worked 3/2/24 night shift, but I did not have R1 on my assignment."

On 3/26/24 at 1:01 PM, V9 [Certified nurse Assistant] stated, "I worked with R1 on 3/2/23 morning shift. R1 was alert but nonverbal, he understood what I would say by following commands and nodding his head yes or no. R1 had a gastric feeding tube, and he received a food tray. I did not remember if I fed R1 on 3/2/23. R1 had a post at the head of his bed with his feeding instructions. R1 needed to be sitting up, fed slowly one to one, with small bites of food. I do remember R1 being congested, I could hear a rattle in his chest, and I notified the nurse [V4-Licensed Practical Nurse]. The next day, I worked with R1 on 3/3/24 day shift. During rounds, I notice R1's breathing was off, with his lips curled back in his mouth and his mouth was open. I reported my findings to the nurse [V29-Agency Registered Nurse]. V29 told me R1 was lying down in bed and aspirated on his food yesterday evening (3/2/24), and he was awake all night needed suctioning throughout the night, and R1 was okay he was just tired. After I passed the

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breakfast trays, I went to collect the trays around 9AM. I went to collect R1 breakfast tray and noticed he was not breathing. I ran and got the nurse. V29 [Agency Registered Nurse] started CPR, I called the code, and other nurse called 911. Then I went out in the hallway assisting other residents. I did not attempt to feed R1 any breakfast, because he was sleeping."

On 3/26/24 at 12:10 PM, V7 [Physician] stated, "I am R1's physician, V3 [Nurse Practitioner] and I manages R1's care. The rule from the facility and Third Eye, told me if I receive a phone call from the facility staff not to answer the phone after 7PM during the weekdays and not to answer after 7PM on Friday until Monday morning. I only seen R1 one time, he was alert and non-verbal on a pureed diet. R1 also received nutrition via gastric tube due to poor oral intake. I was notified on 3/2/23, there was mild episode of R1 coughing earlier that day, but R1 lung sounds were clear, and R1's oxygen level did not drop, he was not receiving supplemental oxygen. The second episode later that evening (3/2/24) when there was a code blue for R1 due to him vomiting, coughing and need suctioning. R1 became stable with 3-4 liters of oxygen and suctioning, R1 was okay to remain in the facility, with the chest x-ray ordered. A chest x-ray would have ruled out aspiration pneumonia or any mechanical issues. I was not made aware of R1's blood work results or chest Xray that was ordered from V30 [Third Eye Physician]. However, If R1 continued to cough, could hear chest rattle congestion sounds, and need frequent suctioning that lasted at least four hours, then V30 should have been notified and R1 should have been sent out the hospital emergency room for further evaluation."

On 3/27/24 at 2:50 PM, V31 [Certified Nurse

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Assistant] stated, " I took care of R1 on 3/2/24 during second shift. I made rounds and R1 was resting in bed. Dinner trays came up and I passed out the food trays, and I gave R1 a dinner tray as well. I did not reposition R1 or raise the head of bed up. Approximately around 5:30 PM, I was walking down the hallway picking up the dinner trays. I went into his room and saw half of his food missing from the food tray and he was making gurgling gasping sounds with vomiting coming from his nose and mouth. The vomit looked like it was his dinner, with food particles. R1 was lying down in bed and leaning on his side, shaking like he was having a seizure, and his eyes was rolled back into his head. I ran out and got the nurse V4 [Licensed Practical Nurse]. V4 went into R1's room and yelled out for help. V4 said R1's is aspirating and get the crash cart. V5 [Registered Nurse] came running into the room to help with the crash cart. V5 called over the speaker system code blue to R1's room, and other nurses came to help. I passed R1 his dinner tray, I did not know R1 needed one to one feeding assistance. I thought he could feed his self. After the code, V5 asked me if I gave R1 a food tray and did R1 feed himself alone. I told V5 I did give R1 his food tray, but I did not know R1 was a one -to-one feed assist. V5 told me that R1 was lying down too far and aspirated on his dinner while eating alone. V5 told me that R1 should have sitting up 90 degrees due to his aspiration precautions, and I needed to feed R1."
[Survey showed V31 the sign that read 'Please See Attached Swallowing Precautions']
V31 stated, "I saw the sign that was on the wall, above R1's head of bed after R1 coded, I did not pay attention to the sign before he aspirated. I did not read the swallow precautions."

On 3/27/24 at 3:50 PM, V24 [Nurse

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Supervisor-Licensed Practical Nurse] stated, "I was working on the second floor and heard code blue to R1's room around 5PM. When I peeped my head into R1's room V4 and V5 was working on R1. I did not go into R1's room. I went back to my floor. A few minutes later there was another code blue called for another room on the first floor. I went to that code and assisted with CPR. I do not remember video calling Telehealth physician for R1. I do not remember what happened to R1."
[Surveyor showed V24 her progress nursing note dated 3/2/24 at 8:09 PM with the Telehealth physician.]
V24 stated, "I see the documented progress noted dated 3/2/24 at 8:09 with my name, but I cannot remember. To access a call with a Telehealth physician, each nurses have their own individual log in and passwords to access the video call. No one could document or call the Telehealth Physician under my name; I must have called the Telehealth Physician. I am so confused, and I do not recall the code for R1 on 3/2/24. I do not know why I called the physician three hours after the code blue, and V4 did not call, she was R1's nurse not me. I am not trying to give you [surveyor] a hard time, I just cannot remember. It does not make any sense that I would call the physician and did not know what happened to R1, I had no information. I don't know what to say, because I was not in the room with R1's code. I have no more information to give you."

On 3/27/24 at 4:48 PM, V30 [Telehealth Physician] stated, "I received a request for telehealth visit at 8:09 PM for R1. V24 explained that R1 had some mucus, chills, with stable vital signs, no fever, and no respiratory distress. V24 told me she had concern of aspiration

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pneumonia, but R1 was stable without any respiratory distress noted, I ordered blood work and a chest x-ray to be completed as soon as possible, meaning STAT. I knew the test would be completed by an outside agency to perform the test, so STAT would mean to complete soon as possible. I was not made aware that code blue was called in the facility for R1 at 5PM, three hours prior to calling me. I was not made aware that R1 was found lying flat in bed, unresponsive, oxygen level in the 70's percentile, threw up food particles out of his nose and mouth, having difficulty breathing, needed to be suction, started oxygen, and needed continuous oxygen to sustain a blood oxygen of 92%. If V24 gave me a complete accurate report of R1's condition, I would have given an order to send R1 to the hospital. I did not know R1 labs came back, and his white blood count was 15, and chest Xray showed early infiltrates in the right lung base. No one from the facility notified me or my staff at the Telehealth of the test results. Those results indicated R1 aspirated, and now developing pneumonia. If I would have received the test results, I would have sent R1 to the emergency room."

On 3/27/24 at 1:22 PM, V29 [Agency Registered Nurse] stated, "I worked on 3/3/24, with R1 and received in report from V36, that R1 had aspirated the day before [3/2/24]. During making rounds at the start of my shift, R1 was awake, and alert sitting upright in bed. A little while later, V9 [certified nurse assistant] came and told me R1 was not looking right. I went immediately and noted R1 was sitting up in bed, nothing coming from his mouth or nose. R1 was not breathing and did not have a pulse. I started CPR, called code blue, and 911. I notified the physician, and family. 911 was unable to resuscitate R1. 911 did

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not remove the body, R1's family had the funeral home pick up R1."

On 3/27/24 at 3:20 PM, V3 [Nurse Practitioner] stated, "R1 has a gastric feeding tube and oral pureed diet with honey thick liquids. I assessed R1 earlier in the afternoon on 3/2/24, I was in the facility, he had some rhonchi and coughing. I did not order a chest Xray because R1 had the same symptoms in the hospital, it was his baseline. I ordered a medication called Robinul for excessive secretions, and a suction machine at the bed side. I felt the medication would assist with drying up the secretions. The evening of 3/2/24, was on a Saturday, the facility policy is during the week after 7PM, and on weekends the nursing staff is to call 'Third Eye Physicians' on call service for assistance and change of conditions with residents. I was not notified on 3/2/24, that code blue was initiated for R1. If the facility staff called code blue, and R1 oxygen decreased in the 70's percentile, 911 should have been called. I did not receive any test results from R1's labs or chest x-ray from 3/2/24."

On 3/27/24 at 1:45PM V2 [Assistant Director of Nursing] stated, "Residents with a gastric feeding tube should never be lay down flat, the head of bed should be elevated at all times at least 45 degrees. R1 had a gastric feeding tube and received oral diet with specific swallow aspiration precautions. R1's physician order dated 2/27/24, aspiration precautions, to keep head of bed elevated during and 30-minutes after gastric tube feedings and 1:1 feed assistance with all meals. The speech therapist places an instruction sheet on the wall above resident's bed that is on swallowing precautions as a reminder for staff. 1:1 feed assistance means R1 needed to receive assistance with all meals, R1 needs to be fed by

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a nursing staff member and to follow the swallow aspiration precautions. If a resident with a gastric feeding tube lays flat in bed, the resident could potentially aspirate. If a resident with 1:1 feed assists with meals, self-feed the resident could potentially aspirate. Whenever the nursing staff calls a code blue, 911 should have been phoned. Any change of condition, once the nurse cares for the resident, the nurse should call the physician right away. If a change of condition occurs around 5PM, it is unacceptable for the nurse to notify the physician 3-hours later at 8PM. STAT Labs (blood work), and chest Xray abnormal results, should be relayed to the physician right away. Not relaying results, is delaying potential treatment. The agency nurses and our staff nurses all have access to look up the lab results. If the results were not available, the nurse could call the lab for the results. Each nurse has their own Third Eye log in username and password. No one should share their passwords, log in information with anyone it is against HIPPA."

On 3/28/24 at 4:48 PM, V4 [Licensed Practical Nurse] stated, "I worked with R1 on 3/2/24, I worked first shift 7AM to 3PM and second shift 3PM-11PM. Around 5:30 PM, V31 [Certified Nurse Assistant] came to me in the hallway and said R1 was not breathing and was throwing up food out of his nose and mouth. I entered the room and R1 had difficulty breathing, not responsive, eyes were half open his eyeballs were rolling up and he was vomiting lying down in bed. V5 [Registered Nurse] came in to help me and called code blue. I pulled R1 up in bed and started to suction him and V5 applied oxygen. I did not remember R1's blood oxygen level, or his vital signs during the code I did not write them down or input the vitals in R1 electronic chart, I was busy. After suctioning and giving him

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oxygen, R1 came back around, alert, and looking around, R1 became stable and was okay. I did not chart on R1, V5 and V24 [Nurse Supervisor] help me chart that day because there were a couple of code blues on the same day and same time. I did not call the Telehealth Physician, V24 called telehealth and spoke with the physician. I do not know what time V24 called the physician. V24 called in labs and chest x ray to be completed STAT. No, I did not receive any test results, maybe the results came in on 11PM-7AM shift." [Surveyor asked V4 why she did not call 911.] V4 stated, "I did not call 911, because R1 was stable after I suctioned him and started him on oxygen. I was able to handle the situation."

On 4/9/24 at 1:05 PM, V2 stated, her investigation showed V24 did call the Telehealth Physician and gave report to V30.

On 4/9/24 at 12:11 PM, V38 [Certified Nurse Assistant] stated, "I been working at the facility for five months. I worked on 3/2/24 from 10PM to 6AM. R1 was cleaned and changed twice that shift. During ADL incontinent care, I left R1 head elevated, he was never laid down flat. R1 was woke through the night, coughing, and I could hear chest congestion like a rattle, and V36 [Agency Registered Nurse] kept suctioning him. R1 looked normal but was sweating and clammy. Other than R1 sweating, he looked okay, and R1 was non-verbal as usual. I did not take R1's vital signs, the night shift aides don't take the vital signs the day shift aides take the vitals."

On 4/9/24 at 11:50 AM, V36 [Agency Registered Nurse] stated, "I worked at the facility twice. I've been a registered nurse for ten years. On 3/2/24 I worked 11PM to 7AM, and that was my last time working at the facility. I got report from V4. She

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[V4] told me, on second shift, R1 aspirated while lying flat in bed feeding himself, and she suctioned R1 very well, the physician was notified, order blood work and chest x-ray. I received R1 sitting up in bed, awake, alert, non-verbal and he was sweating. I kept a cold face towel on his forehead to keep him cool and removed the cover off his feet. I made sure R1 was sitting straight up in bed, because he was coughing, I could hear chest congestion, and secretions coming out of his mouth. R1 needed frequent suctioning, at least a couple times per hour. I did not call the physician because V4 said she already called the physician. I did not receive R1's blood work or chest x-ray report. I am an agency nurse and do not have access to check the results. It did not occur to me to ask another staff nurse to print of R1's results, I was so busy with the other residents and suctioning R1 that I did not have time to ask another nurse. I did not chart on R1 because I was too busy taking care of the other residents. I took one set of vital signs, but I did not place the vital signs in R1's electronic chart, I just ran out of time and forgot to put them into the system. I do not remember the vital signs; I am sure they were normal. On 3/2/24, was my last time working at that facility. V2 placed me on the DNR [Do Not Return] list. V2 did not give me any reason why I could not return to the facility. I did not go back into the system and place in any vital signs later after I left the facility on 3/2/24, I did not have access to the facility's system."

On 4/9/24 at 10:26 AM, V9 stated, "I started work on 3/3/24 at 6AM. I started making rounds around 6:15-6:30 AM. When the food trays came to the floor, all staff assist with passing out food trays. I did not pass R1 his breakfast tray, but someone gave him a breakfast tray. When I was walking

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on the unit to collect the breakfast trays around 9:30 AM, R1 was sitting up in bed, leaning to the side and was not breathing. R1 was not throwing up, nothing was coming up from his mouth or nose. I called for the nurse, and she started CPR, called code blue, and called 911. R1's food tray was untouched. R1 was in deep sleep and did not wake up to eat anything."

On 4/9/24 at 11:01 AM, V3 stated, "During the weekdays from 7PM to 7AM, and from Friday 7PM to Monday 7AM the Third Eye Physicians are on call. If a nurse reaches out to the Third Eye Physician on call service, that physician is responsible for the resident's care. Any resident that is lying flat down that has a gastric tube feeding, has the potential to aspirate. If any resident that has high risk for aspiration, swallowing precautions, and must have one to one feeding assistance, is given a meal tray and the resident self-feed alone, has a potential to aspirate."

On 4/9/24 at 10:48 AM, V7 stated, "Third Eye Physicians are responsible for that resident's care and making health decisions during that on call time. If R1 was feeding himself alone, and he was on swallowing precautions one to one feed it could potentially cause R1 to aspiration. If R1 was lying flat, he has a potential to aspirate."

On 4/9/24 at 12:26 PM, V37 [Director of Nursing] stated, "I been working here since 4/1/24. I been a registered nurse since 2007, and six years of director of nursing experience. If nurse calls out code blue, the nursing staff should check advance directives, start CPR, and to call 911. If a resident that has a gastric feeding tube lays flat, they could potentially aspirate. The staff should never give or place a food tray to a resident that

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is 1:1 feed assist, due to aspiration swallow precautions, the resident could potentially aspirate. The laboratory can call or fax the lab results. The nursing staff can also call the lab for results as well. Our nursing staff and agency nurses all have access to the computer system to look up lab results as well. When there is a change in condition, the assigned nurse should notify the physician to give a accurate report of the resident's condition and document the change, orders, and vital signs."

R1's care plan dated (2/27/24) documents in part:
-R1 needs the head of bed elevated 45 degrees during and thirty minutes after tube feeding.
-Monitor R1 and report to physician if noted aspiration, shortness of breath, abnormal lung sounds, abnormal lab values, nausea or vomiting.
Facility's Policy "Code Blue" dated (1/10/24) Documented in part:
-A code is initiated for all residents requiring emergency medical attention
-If a resident requires emergency medical attention, then a code blue should be announced
-As staff arrive staff should, call 911, notify the physician and family

Facility's Policy "Change in Resident Condition: dated (1/10/24) documents in part:
-It is the policy of the facility, except in a medical emergency, to alert the resident's physician and resident's responsible party of a change in condition.
-Nursing will notify the resident's physician or nurse practitioner when there is a significant change in the resident's status; when there is s significant change in the resident's status, when it is deemed necessary or appropriate in the best interest of the resident.
-Communication with the physician will be

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documented in the resident's medical record

Facility's Policy "Documentation" dated (1/24)documents in part:
-Documentation should include any change of condition of the resident
-Any communication with the physician, or nurse practitioner should also be documented.

Facility Assessment Tool dated (1/24) documents in part:
Licensed Staff: Identification of resident changes in condition - identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life.

Facility policy "Critical Lab Results Reported" dated (1/10/24) documents in part:
The facility will communicate the results of test considered critical to the patient care to the responsible licensed caregiver in a timely and reliable manner.

(AA)

Licensure Violations 2 of 2

300.610a)
300.1210b)
300.1210d)5

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

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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.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility staff failed to provide necessary treatment and services to promote healing and prevent infection of an existing pressure ulcer for 1 (R2) of 4 (R4, R7, R8) residents. R2 was admitted to the facility on 03/04/24 with a pre-existing pressure ulcer, however the facility was unable to provide consistent documentation that the physician ordered treatments for R2's sacral pressure ulcer was documented on from 03/06/24 through 03/11/24 and 03/12/24 through 03/17/24. The deficient practice resulted in R2 sacral wound becoming infected.

Findings Include:

During record review R2's sacral wound initial assessment documentation dated 03/05/24 with the second assessment dated 03/12/24 during which time R2 sacral wound evolved with no further wound documentation. R2 was admitted to the hospital on 03/17/24 with a diagnosis of Infected Decubitus Ulcer and received IV (Intravenous) antibiotics.

R2 was admitted to the facility on 03/04/24 with diagnosis not limited to Paroxysmal Atrial Fibrillation, Essential (Primary) Hypertension, Hyperlipidemia, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Dysarthria Following Cerebral Infarction, Fall, Ataxia, Cerebral Infarction, Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Chronic Atrial Fibrillation, Acute Kidney Failure, Repeated Falls, Encounter for Other Orthopedic Aftercare, Muscle Weakness, Dysphagia, Difficulty in

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S9999	Continued From page 22 Walking, Cognitive Communication Deficit, Weakness, Urinary Tract Infection, Pressure Ulcer of Sacral Region, Unstageable, Pressure-Induced Deep Tissue Damage of Left Heel, Disruption of External Operation (Surgical) Wound, Pressure induced Deep Tissue Damage of Right Ankle and discharged to the hospital on 03/17/24. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 13 indicating intact cognitive response. Order Summary Report document in part: Complete weekly skin checks to ensure no new skin alterations are present. Sacrum/Xeroform one time a day every Tue, Thu, Sat cleanse with ns (normal saline) pat dry apply treatment cover with dry dressing order date 03/05/24. Sacrum/Medihoney & Silver Ag (Alginate) one time a day every Mon, Wed, Fri cleanse with ns pat dry apply treatment cover with dry dressing order date 03/13/24. Cefdinir Oral Capsule 300 mg (milligram) give 1 capsule by mouth every 12 hours for 7 days order date 03/11/24. Collagenase Ointment 250 Unit/GM (gram) Apply to sacrum topically as needed for itching order date 03/12/24. Collagenase Ointment 250 Unit/GM (gram) Apply to sacrum topically everyday shift for itching cleanse with ns (normal saline) pat dry apply treatment cover with dry dressing order date 03/12/24. Treatment Administration Record: document in part: Sacrum/Xeroform one time a day every Tue, Thu, Sat cleanse with ns pat dry apply treatment cover with dry dressing -D/C (discontinue) Date- 03/17/24 with missing initials on 03/09/24 and 03/16/24. Sacrum/Medihoney & Silver Ag one time a day every Mon, Wed, Fri cleanse with ns pat dry apply treatment cover with dry dressing -D/C Date- 03/17/24.	S9999		

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Care Plan document in part: Focus: Nutritional Status: Focus: Skin: At risk for skin complications. Focus: R2 is at Risk for alteration in skin integrity R/T (related/to) self-care deficits, Impaired mobility, and comorbidities. Interventions: Remind/Assist resident to reposition frequently. Provide peri-care after each incontinent episode and apply barrier cream. Focus: R2 has a pressure injury R/T self-care deficits, Impaired mobility, and comorbidities. Site: Sacrum Site: Left heel Site: Right medial knee Date Initiated: 03/06/2024. Focus: R2 has an alteration in skin integrity R/T self-care deficits, Impaired mobility, and comorbidities Date Initiated: 03/06/24.

Patient Risk Profile dated 03/05/24 document in part: Braden score 14 (Moderate Risk).

Most Recent Risk Assessment: Braden Score: 14 (Moderate Risk) dated 03/11/24.

Wound Assessment Details Report assessment date 03/05/24 document in part: Wound: Sacrum, Status: Active, Type: Pressure, Classification: Ulceration, Source: Present-on-admission, Date identified: 03/05/24, Clinical Stage: Deep Tissue Pressure Injury. Tissue Types: Deep Maroon = 65%, Bright Pink or Red = 25%, Slough loosely Adherent 10%. Size: 8.50 x 15.00 x unknown. Resident is incontinent of b/b (Bowel/Bladder) and able to verbalize needs.

Wound Assessment Details Report assessment date 03/12/24 document in part: Wound: Sacrum, Status: Active, Type: Pressure, Classification: Ulceration, Source: Present-on-admission, Date identified: 03/05/24, Clinical Stage: Unstageable. Tissue Types: Bright Pink or Red = 20%, Slough

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loosely Adherent = 80%. Size: 8.00 x 14.00 x unknown. DTI (Deep Tissue Injury) evolved, wound site 70% slough and 30% non-granulation.

Progress note dated 03/04/24 18:21 document in part: Nursing Note: Uses Condom foley. Incontinent of bowel.

Progress note dated 03/04/24 19:48 document in part: Medical Practitioner Note HPI: Pt (patient) seen today to manage multiple medical conditions. Sacrum 03/05/24 Pressure Ulceration Active Unstageable Sacral wounds - Consult wound care.

Progress note dated 03/11/24 14:37 document in part: Skin/Wound Note Text: Received call from (R2 family member) gave a wound update, advised (R2 family member) that writer would know more on tomorrow after assessment is complete.
Progress note dated 03/13/24 16:38 document in part: Social Service Note: IDT (interdisciplinary team) met with (R2 family member) via phone. Wound nursing and MD (Medical doctor) reviewed wounds, treatments, stage (unstageable).

Progress note dated 03/17/24 17:51 document in part: Nursing Note: Brought to writer's attention by residents' (family members) that they want their father sent out of the facility because R2 wound is not healing to them and that they feel like R2 got an
infection in the wound.

Progress note dated 03/17/24 19:35 document in part: telehealth evaluation (other) Date of Service: 03/17/24 6:34 PM CT Primary Chief Complaint: Skin: Pressure Wound History Present Illness:

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Family believes that patient is not getting good care and think the wound has worsened. They want R2 transferred back to the hospital. They believe it is infected and do not want to wait to talk to primary or wound care. Physical Exam: Exam findings per nurse and video observation. SKIN: Patient with large sacral wound Diagnosis, Assessment/Plan: - Pressure ulcer of sacral region, unstageable (Primary) The patient's condition is worsening. Transfer patient to hospital per requests of family.

Hospital record dated 03/17/24 document in part: Specimen Information Culture: wound collected 03/18/24: Moderate Corynebacterium species. Moderate Escherichia coli. ESBL (Extended Spectrum Beta-Lactamase) positive status. Skin: Comments: Stage 2 ulcer across his (R2) sacrum, warm tender, erythematous margins with purulent discharge. History of Present Illness: Patient's ulcer does appear infected. Clinical Impression 1. Infected decubitus ulcer. The patient was started on antibiotics in the ED (Emergency Department). Assessment: Sacral Decubitus/gluteal ulcer wounds, present on admission, with concern for skin and soft tissue infection/cellulitis. Principle Problem: Soft tissue infection. Assessment: Infected sacral decubitus ulcer.
On 03/26/24 at 10:43 AM V11 (R2's Family Member) stated "R2 was admitted to the facility on 03/04/24. On Tuesday 03/05/24 we spoke to two certified nurse assistants and when they flipped R2 over he had an area on his buttocks. R2 wound traveled and on the last day 03/17/24 last day the wound ended up with an infection, was sore, spreading, and full of pus. R2 is now on IV (intravenous) antibiotics."

On 03/26/24 at 12:19 PM V7 (Physician) stated

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"R2 had a wound, but I am not sure where it was or if there was drainage.

On 03/27/24 at 08:55 AM V16 (Wound Care Doctor) stated "I saw R2 one time. R2 had a pressure relate wound from the sacral extending to the buttock. When R2 was admitted he had a DTI (Deep Tissue Injury) and it had evolved and progressed. It was unstageable. On 03/13/24 the sacral wound was unstageable pressure with a combination of tissue types; a quarter granulation tissue, a quarter to a third slough tissue, and half of the area was still epithelial. R2 sacral tissue was damaged on admission and evolving over the next week or two. Some DTI's resolve and some become stage 4. There were no signs of infection when I saw the wound. Physiologically when you get a DTI the tissue has been damaged and it can take a while to break down because the tissue has to necrose. The thing is if someone is wet and there is pressure that has the potential for causing further damage to the wound. If those things happen that will make the wound worst. The protocol is there to prevent those factors from convening." When showing V16 the hospital records V15 responded, "Cultures show that there are bacteria present. E. coli is part of the flora of our gut because it is in proximity of the anus. The erythema will indicate an infection if the hospital says the sacral wound was infected it was infected. If the hospital had R2 there and there was a change in the wound, warm tender, and purulent drainage it evolved and became infected. If R2 was incontinent of stool and urine it is possible for the sacral wound to become infected."

On 03/27/24 at 09:23 AM V17 (Certified Nurse Assistant) stated "When we would come in the morning R2 would tell us the night shift did not

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come in the room. I did witness R2 being wet or soiled."

On 03/27/24 at 09:30 AM V18 (Licensed Practical Nurse) stated "I was here the day that R2's family members came and said R2 has a wound that is not getting better. I called the third eye zoom call and the doctor offered to do a culture, but the family refused. I did not remove R2's sacral wound dressing. I never physically saw or smelt R2's sacral wound. At times I had to reinforce R2's dressing because it was draining through with a light pink in color drainage. R2 had a bowel movement, and I changed the dressing one time."

On 03/27/24 at 11:33 AM V13 (Wound Care Coordinator) stated "R2 was admitted to the facility on 03/04/24. I did R2 initial skin assessment on 03/05/24. When R2 first got here R2 had a DTI (Deep tissue injury) to the sacrum. A DTI and ulceration are under the same category. R2 had 25% granulation which is more healthier pinkish reddish tissue. 65% deep maroon where the epidermis is not open but there is something going on underneath and 10% slough, bad tissue until you clear away the slough you don't know what is going on underneath. The slough tissue was within the open area. The treatment R2 started with on 03/05/24 was Xeroform. The Xeroform is like a Vaseline gauze 3 times a week. The only time documentation that is done is every 7 days when the wound assessment I done. I saw R2 a couple of times between the assessments and there was nothing major going on. I can't remember the other days that I saw R2. The Xeroform order was discontinued on 03/12/24. With the Xeroform we wanted to remove the deep maroon tissue and remove all the tissue on top of the wound. The 20% granulation was the good tissue and the

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80% slough was the bad tissue. The sacral wound was not close to R2's rectum. The meaning of the wound evolving is until the maroon tissue breaks away the wound is changing. It is an expectation of the wound evolving/changing. We expected for the wound to look like it did on 03/12/24 compared to 03/05/24. Unfortunately, we are to document every 7 days on the assessment. There is no further documentation after 03/12/24. The last time that I saw R2 wound was on 03/13/24 with the wound care doctor." While showing V13 the hospital records V15 responded, "E. coli is related to stool. Purulent discharge would be signs of infection."

On 03/27/24 at 02:23 PM V32 (Certified Nurse Assistant) stated "R2 was incontinent of both bowel and bladder and was a total assist. R2 had a dressing on his bottom, it was brown/tan like a band aid. The last time I saw R2 his (R2) daughter peeled off the sacral wound dressing. I held R2 so that the daughter could go get the nurse. V5 (Registered Nurse) came in the room and helped me change R2. I had not seen R2's wound before. The dressing had a little red drainage on it with no odor. V5 cleaned the wound and put another dressing on."

On 03/27/24 at 03:06 PM V5 (Registered Nurse) stated "I don't remember what R2's wound look like or if there was any drainage. On 03/17/24 I do recall putting the dressing back on R2 sacral wound."

On 03/27/24 at 03:30 PM per telephone interview V3 (Nurse Practitioner) stated "I did not see R2's wound aside from seeing pictures from the wounds nurse. The picture with slough, redness around sacral area, the buttocks with an open

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area where it was kind of pink and slough. The family was concerned that R2 did not have any wounds. The goal is to remove eschar and slough, keep the pressure relieved, and turn every 2 hours. There is a high probability that E. coli could have been in R2 sacral wound. Given the position of the wound the E. coli lives near the butt. The purulent discharge is indicative of an infection. If the hospital found R2's sacral wound was infected upon being admitted the sacral wound became infected at the facility."

On 03/27/24 at 04:06 PM V35 (Certified Nurse Assistant) stated "I change R2 and sometimes I did the wound dressing. The gauze dressing was dirty with stool and wet. I changed R2 sacral wound dressing 2 or 3 times. I did not see the nurse, so I changed the dressing.' When asked by the surveyor was, she (V35) trained to do wound dressing changes V35 responded "the nurse went for her break, and I was changing R2. I looked for nurse and just managed to do the best I can to protect R2's wound. I work the night shift and R2 was always urinating. R2 would urinate 2 - 3 times while I was changing him."

On 03/27/24 at 04:33 PM V2 (Assistant Director of Nursing) stated "my expectations for wound care and prevention are upon noticing any skin breakdown to notify the family and physician. My expectation for documentation is for the nurse to document correctly and what treatment that they are providing."

On 03/28/24 03:03 PM V25 (Wound Care Nurse) stated "R2 came to us admitted with a DTI to the sacrum. It evolved if I am not mistaking to an unstageable covered in mostly yellow to white slough. I don't recall what R2 wound looked like. I don't know what the wound care order was. R2

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wound did not have any signs and symptoms of infection or drainage that I can recall. We don't document as we do a bandage change and do not do daily documentation. The facility protocol is to turn and reposition the residents as needed, and it depends on the patient. R2 is incontinent of both bowel and bladder."

Policy:

Titled "Skin Care Prevention" reviewed 01/24 document in part: All residents will receive appropriate care to decrease the risk of skin breakdown. Guideline: 2. Dependent residents will be assessed during care for any changes in skin condition including redness, (non-blanching erythema), and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. 3. All residents will be evaluated for changes in their skin condition. 5. All residents unable to reposition themselves will be repositioned as needed, (minimum of every 2 hours). 9. Clean skin at time of soiling and at routine intervals.

Titled "Skin Management: Monitoring of Wounds and Documentation" reviewed 01/24 document in part: It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. General Guidelines: An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); The status of the area surrounding the PU/PI (Pressure Ulcer/Pressure Injury) (that was observed without removing the dressing); General Monitoring Guidelines: With each

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S9999	Continued From page 31 dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), and evaluation of the PU/PI should be documented. At a minimum, documentation should include the date observed and: location and staging: (A)	S9999		