| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigations:<br><br>2482687/IL171602<br>2482462/IL171324<br>2482345/IL171185 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>One to Two:<br><br>300.686f)<br><br>Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications<br><br>f) Residents who use antipsychotic medications shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these medications in accordance with Appendix F. In compliance with subsection 2-106.1(b-3) of the Act and this Section, the facility shall obtain informed consent for each dose reduction.<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to notify and obtain informed consent from a resident's (R2) representative when an anti-psychotic medication was discontinued.<br><br>Findings include:<br><br>On 04/10/2024 at 12:06pm V11 (LPN/Licensed | S9999 | | |

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Practical Nurse) stated on 3/26/2024 "I sent R2 out to the hospital" V11 stated R2 started saying that " we all have the devil in us". V11 stated R2 was making cat like noises. V11 stated R2 seemed as if she was possessed. V11 stated I called R2's psychiatrist and R2's doctor regarding the behaviors R2 was exhibiting and both doctors stated to send R2 out to the hospital for evaluation. V11 stated I called 911 and 911 came to the facility to take R2 to the hospital.

On 4/10/2024 at 2:44pm V1 (Administrator) stated in January 2024 R2 was taken off psychotropic medications. "V1 stated "I know we need consent to keep a resident on psychotropic medications. I am not sure if R2's power of attorney was notified that R2's psychotropic medication was discontinued." V1 stated according to R2's POA (power of attorney) she was not notified of R2 being discontinued off psychotropic medications.

On 4/10/2024 at 3:15pm V3 stated the power of attorney should be notified if a long-term psychotropic medication is being discontinued for a resident.

On 4/10/2024 at 3:45pm V15 (RN/Registered Nurse) stated "I am familiar with R2. I have noticed changes in R2's behavior recently." V15 stated R2 is normally quiet. V15 stated the last two weeks of March 2024 R2 was verbally abusive, hyper, and shouting at staff and other residents. V15 stated if a resident is having behaviors the nurses document on the progress note. V15 stated "I must notify the resident's power of attorney if a psychotropic medication is discontinued for the resident."

On 4/10/2024 reviewed R2's psychiatry notes

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| S9999 | Continued From page 2<br>written by V16(Nurse Practitioner) with date of service of 1/31/2024. Psychiatry notes documents in part, most recent GDR (Gradual Dose Reduction) of medication: 1/17/2024 Discontinue Aripiprazole (anti-psychotic medication) 2.5mg (milligrams) PO (by mouth) q am (every morning). 08/17/2023 decreased aripiprazole (anti-pyschotic medication) to 2.5mg (milligrams) q am (every morning).<br><br>On 4/11/2024 at 10:24am V17 (Social Service Director) stated R2 had a reduction of the psychotropic medications to see if R2 could go without the medications. V17 stated R2's power of attorney stated she was not notified of the psychotropic medication changes for R2. V17 stated I would think the power of attorney should be notified for discontinuation of psychotropic medications.<br><br>Surveyor reviewed the facility's Psychotropic Drug Therapy Policy dated 10/18, which documents in part, informed consent is not required for reductions in dosage level or deletion of a specific medication.<br><br>(C)<br><br>Two of Two:<br><br>300.610a)<br>300.1010h)<br>300.1210b)<br>300.1210d)2)3)<br>300.1220b)7)8)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies | S9999 | | |

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| S9999 | Continued From page 3<br><br>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.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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| S9999 | Continued From page 4<br>care needs of the resident.<br><br>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:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>7) Coordinating the care and services provided to residents in the nursing facility.<br><br>8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.<br><br>Section 300.3240 Abuse and Neglect | S9999 | | |

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| S9999 | Continued From page 5<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to provide emergency treatment and care for a resident (R3) with a low oxygen level, in accordance with professional standards of care, and failed to immediately contact 911 for an acute change in condition for R3 based on R3's code status of Do Not Resuscitate. The facility also failed to provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing services to ensure residents safety and to maintain the highest practicable physical, mental and psychosocial well-being for the residents. This failure resulted in R3 not receiving timely care and treatment until 6 hours after the change in condition requiring hospitalization with admission diagnosis of Acute Respiratory Failure with Hypoxia (Deficiency In The Amount Of Oxygen Reaching The Tissues), Sepsis, Metabolic Encephalopathy, Severe Sepsis with Septic Shock, Urinary Tract Infection, Acidosis, and Coagulation Defect, and subsequently expiring at the hospital.<br><br>Findings include:<br><br>R3 has a diagnosis of but not limited to Orthopedic Aftercare, Displaced Fracture of Medial Malleolus of Left Tibia, Subsequent Encounter for Closed Fracture with Routine Healing, Contusion of Unspecified Part of Head, Subsequent Encounter, Malaise, Osteoarthritis, | S9999 | | |

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| S9999 | Continued From page 6<br><br>Gastro-Esophageal Reflux Disease Without Esophagitis, Chronic Kidney Disease Stage 3 And Age-Related Osteoporosis Without Current Pathological Fracture.<br><br>R3's Minimum Data Set (MDS) dated 3/29/2024 documents, in part, a Brief Interview of Mental Status score of 08 that suggests moderate cognitive impairment.<br><br>Progress note dated 4/03/2024 at 6:08am by V24 reads, in part, R3 was noted pale.<br><br>Surveyor reviewed progress notes for 4/03/2024 and there were no progress notes from V25 (LPN) on the 1st shift (6:00am-2:30pm) and V15 (Registered Nurse-RN) on the 2nd shift (2:00pm-10:30pm) regarding R3's change in condition.<br><br>24-hour Shift Report dated 4/03/2024 does not have any documentation about R3's change in condition on the 1st, 2nd or 3rd shift.<br><br>Progress note dated 4/04/2024 at 6:20am by V5 (Licensed Practical Nurse-LPN) reads at approximately 3:20 am V5 went to check on the R3 during rounds and R3's hands were cool to touch with a SPo2 of 84%. At 6 AM during rounds and med pass R3 SPo2 went to 82%. R3 DNR will continue to monitor. DON aware. V8 (Physician) notified. BP 102/55 T 96.7 SPo2 82% RA.<br><br>On 4/08/2024 at about 1:00pm surveyor reviewed the Nursing Daily Staffing Sheet that documents, in part, on 4/3/2024 there was no Registered Nurse (RN) that was scheduled or worked the 10:00pm-6:30am shift. Surveyor reviewed progress notes for 4/03/2024 and there were no | S9999 | | |

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progress notes for the 1st (6:00am-2:30pm) or 2nd shift (2:00pm-10:30pm) regarding R3's medical status. Surveyor also reviewed R3's progress notes for 4/04/2024 and V5 (LPN) does not document giving R3 oxygen when R3's oxygenation levels were 84% (3:20am) and 82% (6:00am) on 4/04/2024.

Progress note dated 4/04/2024 at 6:57am by V6 (Registered Nurse-RN) reads received R3 in bed lethargic and SOB (shortness of breath) sating at 87% O2 at 4l/nc (nasal cannula) skin cool to touch R3 able to respond to tactile stimuli. HOB (head of the bed) elevated 45 degrees. b/p (blood pressure) 96/43-24-95.5. R3 DNR will continue to monitor. DON (Director of Nursing) aware.

Progress note dated 4/4/2024 at 9:04am by V6 reads R3's vitals declining NP (Nurse Practitioner) notified with orders to send R3 to hospital. 911 called.

Progress noted dated 4/4/2024 at 9:11am V6 reads 911 Arrives R3 in route to nearest hospital.

Local hospital record dated 4/04/2024 reads, in part, R3's arrival time 9:28am with diagnosis of Sepsis, unspecified Organism and Acute Respiratory Failure with Hypoxia, Respiratory Insufficiency, Septic Shock. R3's hospital records also reads, in part, R3's discharge information that reads discharge date/time 4/05/2024 at 11:30am and discharge disposition expired.

Local hospital record dated 4/04/2024 reads, R3 presents to Emergency Department (ED) for respiratory distress and hypotension and EMS (Emergency Medical Services) reports that nursing home states that approximately 3 AM they noticed her breathing was labored and her

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| S9999 | Continued From page 8<br><br>oxygen was low. On arrival of EMS patient was still hypoxic and was hypotensive. She (R3) was placed on a nonrebreather. Diagnoses this visit reads, in part, Respiratory Insufficiency (when the lungs can not get enough oxygen into the blood).<br><br>R3's hospital laboratory values at 9:51am reads White Blood Cells (WBC) 24.8 (H: higher than normal levels), Platelets 146 (L: lower than normal levels), RBC (Red Blood Cells) 3.20 (L), (Hemoglobin 10.6 (L) and Lactic Acid level of 4.9 (HH). Red blood cells measure the number of oxygen-carrying blood cells in your body.<br><br>Article titled Hemoglobin Test on website mayclinic.org documents, in part, Hemoglobin measures the amount of a protein in red blood cells. Hemoglobin carries oxygen to the body's organs and tissues when you breath in and then it carries waste gas carbon dioxide back to the lungs to be breathed out.<br><br>Article titled Lactic Acid Blood Test: What Your Levels mean from website www.webmd.com documents, in part, lactic acid is made in muscle cells and red blood cells. It forms when your body turns food into energy. (Your body relies on this energy when its oxygen levels are low).<br><br>Local hospital record dated 4/04/2024 also reads, in part, leukocytosis present, lactic acid is severely elevated, and R3 has severe metabolic acidosis (the chemical balance of acids and bases in your blood get thrown off. This can happen when your body: is making too much acid, isn't getting rid of enough acid and doesn't have enough base to offset a normal amount of acid.)<br><br>On 4/08/2024 at about 3:00pm surveyor reviewed | S9999 | | |

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R3's weights/vitals in Point Click Care software (PCC) and there were no vitals listed for 4/04/2024. Surveyor also reviewed progress notes for 4/04/2024 and there were partial vitals listed at 6:20am (BP 102/55 T 96.7 SPo2 82% RA) and at 6:57am (at 87% O2 at 4l/nc {nasal canula}, 96/43-24-95.5).

On 4/09/2024 at 12:10pm V5 (Licensed Practical Nurse-LPN) stated in interview if a person has a DNR there are no interventions that should be provided and with a DNR you should keep the R3 cleaned and comfortable. V5 stated R3's oxygenation level was 84% at about 3:20am on 4/04/2024 and that she (V5) did not place oxygen on R3 until V6 came in, which was at about 5:55am, because she (V6) assisted her (V5) with placing oxygen on R3. V5 stated that she (V5) monitored R3 (kept clean and comfortable) frequently, every thirty minutes or so, but did not chart what interventions were done. V5 stated that she attempted to contact the doctor, nurse practitioner and the Director of Nursing and no one answered the phone.

On 4/09/2024 at 2:06pm V8 (Medical Doctor-MD) stated if a patient is having shortness of breath and oxygenation is 92% or below you will place oxygen at 2 liters nasal cannula and call 911. V8 stated that care should be provided to a resident regardless of their code status (DNR or not) and timely care is necessary. V8 also stated that the nurse can use her nursing judgement to send a resident to the hospital if they are having issues with breathing and their oxygenation levels are below normal.

On 4/09/2024 at 2:31pm V3 (Director of Nursing-DON) stated if they (residents) are a DNR and they are declining, the nurses are still

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expected to provide care to the residents. DNR does not mean that a nurse does not provide care and care still needs to be provided. V3 also stated there is a standing order to give 2 Liter of oxygen via nasal canula and keep them (the resident) comfortable for someone who is having trouble breathing and I (V6) would expect for them (nurses)to use their nursing judgement and send the resident out via 911 and then the staff can call the MD, DON and the family. The nurse should be looking to see if they have labored breathing or panting, use of accessory muscles and use a pulse oximeter to determine the oxygenation level. If the oxygenation readings are in the 80's you would definitely start to give the resident oxygen 2liters via nasal cannula. It is expected for the nurse to call 911, raise head of bed, and use any measure to assist with opening the airway and not giving them water or fluids. Surveyor asked if they should wait to send resident out and V6 stated No, I would expect for them to place the resident on oxygen and immediately contact 911. The resident will continue to decline, and death could occur if oxygen is not given and the resident is not sent to the hospital.

On 4/09/2024 at about 3:41pm surveyor reviewed hospital records from 4/04/2024 that reads R3 was admitted with diagnosis of acute respiratory failure with hypoxia, sepsis, metabolic encephalopathy, severe sepsis with septic shock, urinary tract infection, acidosis, and coagulation defect. R3's hospital records reads: discharge disposition expired on 4/5/2024 at 11:30am.

On 4/10/2024 at 12:34pm by V6 (Licensed Practical Nurse) stated that R3 did not have oxygen on when she arrived at 5:50am on 4/04/2024 and her skin was cool to touch and R3

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was responding to me by opening her eyes. V6 (LPN) stated that V5 (LPN) told her that she spoke with V3 (DON) who asked her about R3's code status, which was DNR, and V3 (DON) told V5 (LPN) to monitor R3. V6 (LPN) stated that V5 (LPN) did not know where the oxygen was and from the time, she (V6) placed the oxygen on R3 her oxygen levels began to fluctuate. V6 stated she (V6) placed an oxygen mask on R3 but R3 kept trying to pull it off, so I switched it over to a nasal canula and opened it all the way up (give 4 liters of oxygen). I had the CNA (Certified Nursing Assistant) to put R3 back in the bed and I checked her oxygen levels again, which were fluctuating, and decided it was time to send to the hospital because the levels were not approaching the normal limits. V6 stated that she thought she charted what R3's saturation levels were. Surveyor did not see a progress note from V6 indicating R3's saturation levels after V6 placed R3 on 4 liters of oxygen.

On 4/10/2024 at 3:36pm V15 (Registered Nurse-RN) stated R3 was pale and requested to be put in bed early on 4/04/2024 during her (V15's) shift (2:00pm-10:30pm) and R3 was not really drinking the supplements and she only consumed 50% of the supplement and I (V15) offered it twice on my shift. V15 stated there was no issues with R3's blood pressure and R3 was ok at that time and her temperature was a bit cold, I took R3's temperature and it was on the lower end of normal, so I gave her a blanket. V15 said I did not check her oxygenation status because I did not have my pulse oximeter.

On 4/11/2024 at 9:27am V8 (MD) stated that he did review R3's chart briefly and that he had missed a call from the facility at around 3:30am on 4/4/2024 but spoke with someone briefly early

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that morning around 7:00am. Stated that he spoke to the facility that morning, but he does not recall the details of the conversation, but I (V8) told them to apply oxygen and to monitor R3. Stated he did not hear back from the facility regarding R3. V8 stated he (V8) would expect for them (the nurses) to monitor R3 at least every 15 minutes to 30 minutes depending on how she (R3) is doing. V8 also stated that R3's DNR status and co morbidities does not change his answer that the nurse should apply oxygen (2Liters nasal cannula) and send R3 to the hospital via 911. V8 also stated that R3 had a change in condition quickly (oxygen saturation) and that it was not something he was treating her for.

On 4/15/2024 at 10:24am V3 (DON) stated after the orientation is done the new nurse shadows with an experienced nurse and are shown everything that needs to be done when they are working and some of other things that are explained are the med pass and the knowledge of the medicine that is given, the code status and the process if someone is found unresponsive and they are a DNR that you really don't do anything, but you notify the provider, DON and family.

On 4/15/2024 at 10:50am-V3 (DON) stated she (V3) believed did receive a call from V5 and it was at 3:23am, but it was a missed call. V3 stated "I spoke with the nurse (V5) at 6:14am and the conversation was about the R3's oxygen saturation, she read the vitals to me, and I advised V5 to put the R3 on oxygen and call 911." V3 stated "I do remember asking V5 if she put R3 on oxygen and was told No, and when I asked why I was told that she (R3) was a DNR. Nurse said that she did not put her oxygen because she

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did not have an order and she is a DNR." V3 continues, "I expect them to follow the standing order and for oxygen it's 2liters via NC (nasal canula) and also call 911. "

R3's POLST (dated 3/18/2022 reads, in part, A: Do Not Attempt Resuscitation/DNR, B: Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment (relieve pain and suffering through the use of medication by any route as needed; use oxygen), use medical treatment, IV (Intravenous) fluids and IV medications as medically appropriate and consistent with patient preference.
Undated policy titled Do Not Resuscitate reads, in part, 4. When faced with a possible DNR order situation: If the order is valid and the physician does not order otherwise, follow the terms of the DNR Order, thoroughly document the circumstances following the use of the DNR Order.

On 4/12/2024 at 12:06pm surveyor reviewed V5's employee file and V5 had an undated Nursing Skills Check List that confirms her orientation with V6 (LPN). Surveyor reviewed V5's General Orientation Checklist for All New Employees that is partially completed. Instructions state to initial beside each area when completed. Have manager to sign each. V5's did not initial any areas. V5 did not have a Self-Competency Packet in her (V5's) employee file.

On 4/15/2024 at 10:24am V3 (DON) stated she provides orientation to each nurse on each floor for a least 5 days on everything that falls under their job description and onboarding which is computer training, on abuse, nursing care and

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other topics. V3 stated that ideally the nurse will get a total of 5 days of orientation and more if needed. After this orientation is done the new nurse shadows with an experienced nurse and are shown everything that needs to be done when they are working and some of other things that are explained are the med pass and the knowledge of the medicine that is given, the code status and the process if someone is found unresponsive and they are a DNR that you really don't do anything, but you notify the provider, DON and family. V3 also stated that there is another Nursing Skills Orientation Checklist that is given to the new employee and that the checklist that I have (V5's checklist) is for (workforce education training) and that the employee must initial the boxes and have the supervisor signs off from each department and the form has to be completed before the floor orientation starts. V3 said, "No, we don't have charge nurses for each shift and if it is after hours they can call me and they know to ask for help from other experienced nurses and the RN's who are always in the building on the third shift (10:00pm-6:30am)".

On 4/15/2024 at 11:15am surveyor reviewed V22's (LPN) employee file and there were a Self-Competency Packet that was incomplete. Surveyor reviewed V23's (LPN) employee file and did not find a Self-Competency Packet or Nursing Skills Orientation Checklist.

On 4/15/2024 at about 12:15pm V3 stated that the facility did not have any other Self Competency Packets or Nursing Skills Orientation checklist for V5, V22 or V23 if it was not in their (V5, V22 and V23) employee file.

On 4/16/2024 at 12:44pm V23 (LPN) stated that

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she was hired about the end of December 2023 and had about 6 weeks of orientation. V23 stated I did have another nurse that was available for questions, but I had to pass meds by myself on one side of the hall and the nurse I was shadowing was passing meds on the other side of the hall. V23 stated on about the 3rd or 4th day of orientation I had to work by myself, while still in orientation, but she (V23) did not take the other side of residents. V23 stated she was questioned why, and she told administration that she (V23) did not feel comfortable taking care of 40 residents by herself. V23 stated that she had been scheduled to work by herself, while in orientation, on more than one occasion and that was the reason she (V23) left that job. V23 stated that she did not have to complete a Nursing Skills Orientation checklist or anything like that and she did not have to submit anything to the Director of Nursing.

On 4/16/2024 at 1:40pm V6 (LPN) said I was V5's preceptor when she first started and I only precepted her one shift on the first floor sometime in December of 2023 and I did complete R5's orientation checklist for the one time I precepted R5.

On 4/16/2024 at 6:31pm via email V1 (Administrator) stated No, we do not have a policy on training/orientation of nurses.

On 4/17/2024 at 11:55am by V3 (DON) via email that reads a new nurse with previous nursing experience gets a minimal 2 days "classroom" orientation doing paperwork, being in-serviced on various topics and watching educational videos and then a minimal 3 days orientation "shadowing" with another facility Nurse and a new grad nurse will typically get a minimal of 2 weeks

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| S9999 | Continued From page 16<br>of "shadowing" another Nurse and same 2 days of "classroom" orientation. V3 also stated no new Nurse is to be scheduled solo (to work alone) to work a floor and be responsible for a group of residents during the above listed orientation period.<br><br>Policy titled Respiratory Distress: Emergency Procedure date 5/2014 reads, in part, Residents exhibiting signs of respiratory distress will be assessed and treated immediately, 1. Elevate HOB, 2. Oxygen 2-3 L per nasal cannula, 3. Take and record vital signs, 8 Notify physician and 9. Call paramedic and transfer to hospital if indicated.<br><br>Policy titled Physician Orders dated 6/2017 reads, in part, these guidelines are to ensure that 1. Changes in resident status/condition are assessed and physician notification is based on assessment findings and is to be documented in the medical record and 2. Any orders given by Physician are carried out.<br><br>Policy titled Change in Condition Physician Notification Overview Guidelines dated 4/2014, documents, in part, 3. Medical care emergency problems are communicated to attending physician and family immediately (generally within two (2) hours or sooner), A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received and E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification (phone calls) of changes in condition.<br><br>Undated job description titled LPN Job Description reads, in part, the primary purpose of your job position is to provide direct nursing care | S9999 | | |

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| S9999 | Continued From page 17<br>to the residents, 2. Ensure that resident care procedures are followed in rendering nursing care, 4. Perform administrative duties as charting, 12. Chart nursing progress notes in an informative and descriptive manner that reflects the care provided to the residents as well as the resident's response, and 23. Make independent decisions concerning nursing care.<br><br>(A) | S9999 | | |