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S 000	Initial Comments Complaint Investigation 2491397/IL169994 Facility Reported Incident of 5/3/24/IL173164	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1010h) 300.1210b) 300.1210c) 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. Section 300.1010 Medical Care Policies 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	S9999		

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accident, injury or change in condition at the time of notification.

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.

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:

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 interview and record review, the facility failed to properly assess a resident's change in condition after showing signs of respiratory

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distress, changes in oxygen saturation, and a low blood pressure. This affected one of three (R1) residents reviewed for quality of care and assessments. This failure resulted in R1 suffering a delay in being sent to the hospital, having a critically low blood pressure, and being tachycardic upon the paramedics' arrival.

Findings Include:

R1 is a 58 year old with the following diagnosis: hemiplegia affecting the right side following a cerebral infarction, type 2 diabetes, chronic respiratory failure with tracheostomy status, gastrostomy status, and dysphagia.

A Nursing note dated 2/11/24 at 8:39AM documents upon arriving for the morning shift, R1 was very lethargic and weak. Vital were stable (no actual vital signs were charted at this time just that they were stable) but family was concerned R1 was not in a normal state. The physician was called and ordered to send R1 to the hospital.

A Nursing note dated 2/11/24 at 9:36AM documents R1 had a change in condition per the family. R1 seems to be in distress with trying to breath and isn't talking to family. Oxygen saturations are at 93% on the trach. The physician was contacted again and ordered to send R1 to the hospital.

There is no documentation a respiratory assessment or vital signs were completed at this time when a change of condition was noticed. There is also no documentation that respiratory therapists were not notified of R1's change in condition to assist.

A Nursing note dated 2/11/24 at 7:27PM

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documents R1 was admitted to the intensive care unit for diabetic ketoacidosis.

The Ambulance Run Sheet dated 2/11/24 documents the ambulance was called at 9:34AM for a resident having a breathing problem. Upon assessment, R1 was on 5L of humidified oxygen and the crew placed a non-rebreather at 15L oxygen to the trach site. Family reported R1 was not acknowledging their presence at today visit when R1 is usually alert to them. R1's blood pressure was low at 70/46 (normal is 120/80), pulse was 140 (normal is 60-100), and respirations were 26 (normal is 12-20). The oxygen level was 90% while on the 15L of oxygen.

The Hospital Record dated 2/11/24 documents R1 was brought to the hospital for hypotension and hypoxia after the family noticed a change in mental status. R1 is toxic appearing and tachypneic. R1 is on 15L via nonrebreather mask at the trach site and there is an increased work of breath. Upon arrival the blood pressure was very low at 50/22 (normal is 120/80) and the temperature was 94.7 degrees Fahrenheit indicating hypothermia. R1 had a white blood cell count of 41.5 indicating infection in the body. Possible infection source was listed as urine vs, lungs vs abdomen. R1 was given 3L of IV fluid in the emergency room to increase the blood pressure. R1's blood sugar was 1196 mg/dL (normal is 60-100 mg/dL). R1 was in diabetic ketoacidosis likely caused by the septic shock. R1 was placed on an insulin drip for the elevated blood sugar, placed on Iv antibiotics for the septic shock, and continued with aggressive IV fluid resuscitation. R1 was admitted to the intensive care unit.

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S9999	Continued From page 4 On 5/29/24 at 1:07PM, V3 (Nurse) stated R1's family was in R1's room after V3 received report just after 7AM. V3 reported the family was thinking R1 was acting different so V3 took a set of vital signs and went back to the nurse's station to look at R1's medical record. V3 stated R1's oxygen level was at 93% on the trach collar. V3 denied calling a respiratory therapist to come assess R1. V3 reported the family then reported R1 had a difficult time breathing but V3 disagreed with the family and thought R1 was fine. V3 reported calling 911 based on what the family requested. V3 was not able to recall what R1's vital signs were when R1 was transported to the hospital. On 5/30/24 at 2:50PM, V13 (Agency CNA) stated V13 only "peeked" into R1's room that morning to check in R1. V13 reported the family was concerned and got the nurse. V13 stated R1 got sent out to the hospital for shortness of breath. On 5/31/24 at 11:48AM, V21 (Respiratory Therapist) stated residents get assessed twice a shift at 9PM and 3AM. V21 reported at the 9PM assessment R1 reported shortness of breath but the oxygen level was noted to be still above 90%. V21 stated if a resident is having shortness of breath, then the nurse should call the respiratory therapist into the room to assist. V21 reported rounding on R1 during the night but none of those assessments are documented to check in with R1 after R1 reported begin short of breath. On 5/31/24 at 12:43PM, V23 (Nurse) stated V23 has no recollection of R1 having any issues breathing the night before going out to the hospital. V23 reported R1 had no issues over night and was last seen around 5:30AM for the morning blood glucose check.	S9999		

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On 5/31/24 at 12:57PM, V24 (CNA) stated during the second shift (3-11PM), V24 took R1's vital signs and R1's blood pressure was low and R1 felt cool to touch. V24 was unable to remember what the temperature or blood pressure were but remembers then being low. V24 reported R1 was also moaning. V24 noted this was different because R1 could normally talk even with a trach. V24 stated V24 told the V23 what was happening with R1 and V23 told V24 that R1 would be assessed. V24 reported V24 was pulled to a different unit so V24 could not check on R1 the remainder of the night.

V23 was interviewed again at 1:11PM to confirm V23's previous interview and to ask questions regarding V24's interview. V23 did not deviated from the original statement of R1 being "fine." V23 stated if something was wrong with R1 then V23 would have sent R1 out via 911.

On 6/12/24 at 11:37AM, V59 (Nurse Practitioner) stated if a resident is having a change of condition, then staff should notify the physician or nurse practitioner immediately so new orders can be given. V59 reported when someone is septic, they tend to have a low blood pressure, a fever, and have tachycardic. V59 also noted there could also be some respiratory issues involved if that is the system that is infected. V59 stated if staff notice it changing condition with the resident or a family is saying that there has been a change then V59 would expect the nurse to get a set of accurate vital signs and assess the resident so V59 can know more of what is going on with the resident. V59 reported hypothermia would be a later stage of sepsis. V59 said, "I can't really say exactly when it occurs, but I can say that blood pressure and fever along with tachycardia usually

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present first and then overtime the body will develop hypothermia in order to compensate for whatever infection". V59 reported telling the nurses to notify V59 immediately if something's going on and make sure they chart it so we can be getting a basis or a trend going and what's happening. V59 stated if an accurate set of vitals aren't obtained then staff can't accurately let anyone know what's going on. V59 reported, "The patient might look OK on the outside, but if they're vital signs are showing something different than they need to be sent out immediately." V59 reported if a resident isn't sent out immediately when it changes are noticed then the sepsis is likely to get worse. V59 stated any indication of a resident being septic V59 would order at minimum a chest x-ray and urine with possible labs. V59 reported if the resident is in anyway unstable then call 911.

On 6/12/24 at 1:43PM, V2 (DON) stated a resident needs to be assessed and the vitals should be done if there is a change in condition. V2 reported the next step is to call to notify the doctor and administer oxygen if needed. V2 stated if the resident is in the vent unit, then respiratory therapy is called for additional support. V2 reported if a resident is having respiratory issues, then 911 should be called immediately.

The Ventilator Flowsheet dated 2/10/24 documents R1 was noted using accessory muscles with inspiratory breaths. R1 was suctioned with noted improvement. The oxygen level increased to 96% after suctioning. R1's breath sounds were diminished on both sides. There is no documentation what the oxygen level was before being suctioned. There is no documentation from the respiratory therapist that R1 was assessed again after experiencing

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S9999	Continued From page 7 labored breathing during the first assessment. The vital signs were reviewed for 02/2024. Vital signs (blood pressure and heart rate only) are charted for 2/11/24 at 11:10AM after R1 had left the facility. There is no documented respiratory rate or oxygen saturation level the morning of 2/11/24. The Care Plan that is not dated documents R1 has a potential for difficulty breathing related to COPD and acute respiratory failure. Interventions include: assess respiratory status to include rate, depth, pattern, and skin color; monitor vital signs and lung sounds; and observe for changes in breathing pattern. The policy titled, "Emergency Management," dated 09/2017 documents, "General: Emergency guidelines refer to actions given to residents with urgent and critical needs. When emergency situation arises, emergency procedures are initiated, which includes sending the resident to the closest emergency room. Policy: 1. The object of the emergency management of a resident is to administer necessary care until the paramedics arrive ... 5. Monitor and treat as much as possible the following areas: f. Take vital signs and provide reassurance to the resident. Vital signs should be taken every 10-15 minutes based on resident need until the resident is stable or transferred ... Guidelines for specific medical emergencies: 1. Acute respiratory distress ... c. Take record, vital signs, including pulse oximetry ... g. Document events in the medical record." (A) Statement of Licensure Violations (2 of 2):	S9999		

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300.610a)
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)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.

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.

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

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S9999	Continued From page 9 following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to put interventions in place for a resident with a behavior of leaning to the side while in bed. This affected one of three (R14) residents reviewed for fall prevention interventions. This failure resulted in R14 suffering a laceration to the head that required a staple to repair while hospitalized.	S9999		

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Findings Include:

R14 is a 63 year old with the following diagnosis: hemiplegia following a cerebral infarction, nontraumatic intracranial hemorrhage, laceration of the head, and cirrhosis of the liver.

A Nursing note dated 5/3/24 documents the CNA observed R14 lying face down on the floor in R14's bedroom. 911 was called and paramedics arrived and picked R14 up off the floor and transported R14 to the hospital.

A Nursing note dated 5/4/24 documents the nurse called the hospital for a status update and R14 was admitted to the hospital with a diagnosis of intracranial hemorrhage and scalp laceration. R14 had one staple place on the on the right parietal scalp from a 1 cm laceration. R14 also had swelling to the right eye. The CT scan could not rule out a hemorrhage so a follow up CT scan will be obtained.

The Fall Risk Evaluation dated 4/15/24 documents R14 is a high fall risk due to the score on the evaluation being 14. Any score 10 and over is considered a high fall risk. R14 is a high fall risk due having decreased mobility, impaired memory or judgement, is over 65, is incontinent, and takes medications that increase the risk for falls. The Functional Abilities and Goals dated 4/15/24 documents R14 is dependent with self-care and functional cognition. R14 needs substantial/maximal assistance with bed mobility and is dependent with transfers. R14 is not able to walk at the time of this assessment.

On 6/7/24 at 12:04PM, V44 (Agency Nurse) stated V44 was not able to remember R14 or R14 fall due to being an agency nurse. V44 reported

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being told in report what residents are fall risks but was not able to remember if R14 was a high fall risk. V44 stated if a resident is exhibiting behavior that might contribute to a fall, then an intervention should be put in place as soon as possible to help prevent any falls. V44 was unaware of any interventions in place for R14 at the time of the fall or after the fall.

On 6/11/24 at 2:02PM, V60 (CNA) stated V60 was alerted by V27 (CNA) that R14 fell. V60 reported R14 was lying face down on the floor with R14's legs still in the bed. V60 stated seeing blooding coming from R14's head. V60 reported not being aware of R14 was a high fall risk and denied R14 having any fall mats in place at the time of the fall. V60 stated R14 was not able to move but since working with therapy had begun to lean to one side of the bed over the "past couple weeks." V60 confirmed R14 had a habit of leaning to the same side R14 fell out of the bed. V60 reported "putting some pillows" under R14 to help keep R14 from leaning. V60 stated V60 told V44 about R14 leaning but V60 was unaware what V44 did after that. V60 said, "I'm guessing she just leaned out of the bed and fell."

On 6/12/24 at 11:37AM, V59 (Nurse Practitioner) stated if a resident is having a specific behavior that could cause them to fall then that needs to be addressed through rounding and appropriate interventions. V59 reported the facility is responsible for putting in interventions that best fit the residents for falls. V59 stated if interventions aren't being put for the resident, then a fall is likely to occur and the resident has a higher chance of being injured.

On 6/12/24 at 12:25PM, V16 (Restorative Nurse) stated R14 was sent to the hospital after a fall

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and had to get one staple to the head after suffering a laceration. V16 reported R14 was a high fall risk. V16 stated basic fall interventions are put in place when a resident is admitted but other interventions can be added over time if needed. V16 reported if a resident is leaning then an intervention should be put into place for better alignment. V16 denied ever being told about R14 leaning in bed. V16 stated if V16 was told then V16 would have assessed R14 and ordered a wedge to help R14 stay upright in bed. V16 stated the air mattress inflates to a certain percentage and changes for less mobile residents. V16 reported there is a risk for slipping out of bed if she is leaning and has an air mattress that moves by itself.

The Functional Abilities and Goals dated 4/15/24 documents R14 is dependent with self-care and functional cognition. R14 needs substantial/maximal assistance with bed mobility and is dependent with transfers. R14 is not able to walk at the time of this assessment.

The Care Plan with no dated documents R14 is at high risk for falls and requires assist with daily care needs related to a diagnosis of non-traumatic subarachnoid hemorrhage with left sided weakness, cirrhosis of the liver, and end stage renal disease. Per V16's interview, R14 has basic interventions in place at the time of the fall such as low bed and keeping items within reach. The interventions of floor mats and bolsters were added to the care plan after the fall on 5/3/24.

The Minimum data Set (MDS) dated 4/15/24 documents a Brief Interview for Mental Status score of 8 (severe cognitive impairment). Section GG of the MDS documents R14 needs substantial/maximal assistance with bed mobility

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	IL6010086	A. BUILDING: _____ B. WING _____	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF PALOS HILLS	10426 SOUTH ROBERTS PALOS HILLS, IL 60465

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 and is dependent with transfers. The policy titled, "Fall Prevention and management," dated 10/2018 documents, "General: ...the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Guideline: Upon admission ...Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk." (No Violation issued)	S9999		