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
	IL6007447	A. BUILDING: ______ B. WING ______	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PINECREST	**414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054**

(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
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)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 300.1010 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 accident, injury or change in condition at the time	S9999		

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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.

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 Regulations are not met as evidenced by:

Based on interview and record review the facility failed to assess and monitor a resident that experienced a change in condition and failed to implement interventions as ordered by the physician resulting in the death of one of 18 residents (R93) reviewed for quality of care in the sample of 18.

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The findings include:

R93's Admission Record shows he was admitted to the facility on February 26, 2024, with diagnoses including mild intellectual disabilities, Parkinson's Disease, history of recurrent pneumonia, major depressive disorder, dementia, and dysphagia (trouble swallowing). R93's Admission Record dated May 8, 2024, shows R93 was 58 years old.

R93's Practitioner Order for Life-Sustaining Treatment Form dated March 7, 2024, shows R93 was a no CPR (cardiopulmonary resuscitation), comfort focused treatment. Comfort Focus Treatment includes maximizing comfort through symptom management. Allow Natural death. Use medication by any routes as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Transfer to hospital only if comfort cannot be achieved in current setting.

R93's Nurses Note dated April 27, 2024, at 1:25 AM shows around 1:00 AM, the CNA alerted the night shift nurse that R93 was clammy and had increased respirations. The night shift nurse went in to assess R93 and R93 stated "I feel great." The night shift nurse assessed R93's vital signs and noted his pulse and respirations were elevated. But all other vital signs were normal. V12 NP (Nurse Practitioner) was notified and stated R93 could be sent to the hospital if that was what R93's power of attorney wanted, otherwise to keep at the facility and keep R93 comfortable. A message was left on V11's (R93's Power of Attorney-POA/mother) voicemail asking to return the facility's call immediately.

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A Nurses Note entered by V10 LPN on April 27, 2024, at 9:50 AM, shows R93's lorazepam medication was held due to R93 "still sedated." At 10:29 AM, V10 documented a nurses note that indicates R93's mother returned the phone call from the facility in regard to R93's health incident prior to and stated that if R93 were to become diaphoretic, increased pulse, and respirations, to go ahead and send R93 to the local emergency room. Another Nurses Note dated April 27, 2024, at 1:08 PM entered by V10 shows R93 was coughing on food and had audible breathing sounds. R93's oxygen was 89% on room air, his respirations were 25, and V10 was not able to get R93's blood pressure with an automatic blood pressure machine. V12 NP was notified to obtain an order for a chest x ray. "At this time, [V12] asked if [R93's] mom was on board with the plan of care. This nurse [V10] informed [V12] that the mom only wanted [R93] sent to the emergency room if he were to have another episode like the previous night." V10 then placed the order for the portable chest x ray. The next nurses note entered by V10 on April 27, 2024, at 2:45 PM shows, "CNA went into [R93's] room to clean up resident for the chest x ray. CNA immediately called this nurse [V10] into the room. Resident had passed. Verified by this nurse." R93's nurses notes on April 27, 2024, shows that V12 NP was notified of R93's death at 2:47 PM and V11 R93's mother/POA was notified of R93's death at 2:50 PM.

R93's Weights and Vitals Summary shows R93's oxygen levels ranged between 91-97% on room air during the month of April 2024. R93's breaths per minute ranged 16-28 for the month of April 2024. R93's respiration rate on April 26, 2024, at 2:18 AM was 28 breaths per minute.

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On May 7, 2024, at 1:22 PM, V10 LPN stated on April 27, 2024, R93 was asleep in bed because R93 was still tired. V10 stated she gave R93 his morning medications and that he swallowed those without difficulty. (R93's Medication Admin Audit Report dated May 8, 2024, shows V10 LPN administered R93's morning medications at 7:04 AM.) V10 stated that when R93 woke up, V9 CNA attempted to feed R93 lunch and R93 was coughing on the liquids and food. V10 stated a chest x ray was ordered because she could hear audible breathing sounds without her stethoscope. V10 stated the second shift CNA (V13) went to clean R93 up for his chest x ray, when she came and got V10 and told V10 to bring her stethoscope. V10 stated she listened to R93's chest and could not find any heartbeat or any breath sounds. V10 stated she took R93's vital signs when he was coughing on food and liquids and V10 could hear audible breath sounds coming from R93. V10 stated that she was not able to obtain a blood pressure on R93 and V10 felt it was due because R93 was coughing so much. V10 stated she did not call and tell V11 (R93's POA/mother) that R93's oxygen was low or that she was not able to get a blood pressure.

On May 8, 2024, at 12:15 PM, V9 CNA stated she went into R93's room at about 6:15 AM and R93 was still asleep. V9 stated she went back into R93's room at about 8:00 AM and R93 was not able to be woken up. V9 stated R93 "just kind of mumbled" when V9 changed R93. V9 stated she went out of R93's room and told V10 that V9 was not able to wake R93 up. V10 told V9 that it was normal for R93 and to let him sleep until 10:00 AM or 11:00 AM and to try again later. V9 stated she went into R93's room again around 10:00 AM and R93 was still sleeping but was clean and dry so V9 did not change R93's incontinence brief. V9

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stated she then went into R93's room around 11:00 AM-11:30 AM and tried to wake R93 up again but R93 was still not arousing. V9 stated she even tried to sit R93 up, but he would not open his eyes or respond to V9. V9 stated she told V10 again that R93 would not wake up and V10 told V9 to wait for lunch time. V9 stated, "I was worried about [R93] at this time because [R93] was always up for lunch time." V9 stated she brought R93's lunch tray to him around 12:30 PM and sat R93 up in bed. V9 stated that R93 was still not awake but she tried to give him a small bite of gelato (ice cream). V9 stated that R93 just kept it in his mouth and then started coughing. V9 stated she went and got V10 and V10 came into R93's room and told V9 to give R93 another bite. V9 stated she did and R93 started coughing again and turned a grayish color. V9 stated that V10 then took over care of R93 because V9 had to get other residents back to their rooms from lunch. V9 stated she then saw R93 again around 1:00 PM and R93 did not have oxygen on. V9 stated that V10 told her she was calling 911 so V9 was surprised to still see R93 there but then V10 told V9 that R93 was getting a chest x ray instead. V9 stated she left the unit at about 2:00 PM to work a different unit. V9 stated she talked to V13 CNA at about 2:45 PM, and V13 told V9 that R93 died.

On May 7, 2024, at 2:01 PM, V13 CNA stated she came in to work her shift at 2:00 PM. V9 told V13 that R93 had been unresponsive. V9 stated she passed out ice waters and clean linens and then went to give R93 a bed bath. V13 knew that R93 was going to get a x ray. V13 stated when she went into R93's room, R93 was sitting straight up in bed with the head of the bed elevated and saw that R93's head was hanging down with drool coming from his mouth. V13 stated that R93's left

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arm had a purple discoloration to it. V13 stated she left R93's room to get V10 and told her to bring her stethoscope.

On May 8, 2024, at 10:58 AM, V12 Nurse Practitioner stated that V10 spoke with V12 on April 27, 2024, at about 1:00 PM and stated they were going to proceed with a chest x ray. V12 stated that V10 told her that R93's oxygen level was 89% on room air and that she could not get a blood pressure on R93. V12 stated she told V10 to put oxygen on R93 and to take a manual blood pressure on R93. V12 stated she received a second notification from V10 at 2:48 PM that R93 had passed away. V12 stated she would expect the nurse to notify her if a resident's blood pressure was abnormal. V12 stated she did not know why V10 could not get a blood pressure on R93 with an automatic cuff. V10 stated R93's POA should "for sure" be updated with any change in condition in R93 so that R93's POA could make the decision if she wanted R93 sent out to the hospital.

On May 8, 2024, at 1:00 PM, V10 stated that V12 did not give her any other orders beside the chest x ray. V10 stated that V12 did not tell V10 to take a manual blood pressure nor to apply oxygen. V10 stated she did not take a manual blood pressure on R93, did not apply oxygen, and did not attempt to suction R93.

On May 8, 2024, at 3:00 PM, V12 stated she was not told that R93 had a change in skin color. V12 stated she depends on the nurse's assessments for her orders as to what to do. V12 stated she is not at the facility, so she relies solely on the nurse and what the nurse reports to her. V12 stated she was not aware that V10 did not follow the orders she gave V10 to take R93's manual blood

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pressure and place R93 on oxygen.

On May 8, 2024, at 10:39 AM, V2 DON (Director of Nursing) stated if the nurse gets report that a resident is not arousable, she would expect staff to do an assessment, notify the provider, and send the resident to the hospital. V2 stated she was not aware of R93's change in condition. V2 stated that R93 "probably needed to go out to the hospital." At 1:25 PM, V2 stated if the nurse cannot get a blood pressure with an automatic blood pressure machine, then she expects the nurses to try a different extremity or perform a manual blood pressure. If a resident is having trouble breathing and oxygen saturation is lower than normal, the nurse should place the resident on oxygen and call the nurse practitioner and see what the orders are.

R93's State of Illinois Certificate of Death Worksheet shows R93's date of death as April 27, 2024. R93's cause of death is listed as Respiratory Failure, Aspiration Pneumonia, and Developmental Delay.

The facility's Notification of Changes policy dated December 1, 2023, shows, "The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. Resident incapable of making decisions: The representative would make any decisions that have to be made."

The facility's Change in a Resident's Condition or

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NAME OF PROVIDER OR SUPPLIER: **ALLURE OF PINECREST**

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Status policy revised May 2020 shows, "Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."

(AA)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210d)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide nutritional supplements as ordered for one of three residents (R64) reviewed for weight loss in the sample of 18. This failure contributed to R64 experiencing a 11.41% weight loss in the last six months.

The findings include:

R64's Order Summary Report dated May 7, 2024, shows she was admitted to the facility on October 13, 2022, with diagnoses including wandering, generalized anxiety disorder, history of falling, depression, alzheimer's disease, dementia, need for assistance with personal care, and difficulty walking. R64 has pudding with lunch ordered on December 15, 2023, and health shake three times per day ordered on October 3, 2023.

R64's meal ticket shows for R64 should have received a mighty vanilla shake and a pudding

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cup at lunchtime.

On May 7, 2024, at 12:10 PM, R64 was sitting at the lunch table for her lunch meal. R64 had a general diet food tray in front of her and was eating small bites of food with her fingers. There was a cup of water and cup of apple juice for R64's fluids. R64's apple juice was half gone. There was not a vanilla shake nor a pudding cup at R64's table. R64 left the dining room at 12:25 PM.

On May 7, 2024, at 12:28 PM, V19 CNA (Certified Nursing Assistant) said health shakes and pudding is kept in the unit refrigerator. V19 said the dietary staff typically hand out the supplements to the residents.

On May 7, 2024, at 12:29 PM, V14 Dietary staff said she passes out resident's health shakes when she hands out the resident's drinks. V14 said she didn't pass out R64's health shake because R64 was not sitting down and another resident that sits near R64 likes to grab things.

R64's monthly weights show that R64 weighed 147.2 pounds on November 28, 2023, and weighed 130.4 pounds on May 7, 2024. This is a 11.41% weight loss in six months.

On May 9, 2024, at 11:34 AM, V18 Dietitian said health shake and ice cream is ordered to increase R64's caloric intake because she has lost weight. V18 said if R64's supplements are not provided, then R64 may not be getting the calories she needs and may continue to lose weight.

The facility's Weight Monitoring Policy revised on December 1, 2023, shows, "The facility will utilize

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S9999	Continued From page 11 a systemic approach to optimize a resident's nutritional status. This process includes developing and consistently implementing pertinent approaches. Interventions will be identified, implemented, monitored and modified consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status." (B)	S9999		