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S 000	Initial Comments Complaint Investigation: 2469362/IL180985	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.610c)2) 300.1030a)1) 300.1030b) 300.1035a)2 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. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including	S9999		

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laboratory and x-ray);

Section 300.1030 Medical Emergencies

a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:

1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.

Section 300.1035 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:

2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions,

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and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated.

These regulations were not met as evidenced by:

Based on interview and record review the facility failed to provide timely emergency airway management and suctioning for a resident in respiratory distress during a medical emergency. This failure affected one of three residents (R1) reviewed for emergency airway management and has the potential to affect all 77 residents residing in the facility. This failure resulted in R1's subsequent death.

Findings Include:

R1's Progress Note dated 9/19/24 documents R1 was diagnosed with Esophageal Cancer, Dysphagia, Choking in Adult, and History of Esophageal Stricture.

R1's Minimum Data Set dated 8/15/24 documents R1 is severely cognitively impaired, requires partial/moderate assistance with eating, holds food in his mouth, and coughs or chokes during meals.

R1's Physician Order Sheet dated September 2024 documents R1 is prescribed a regular diet, pureed texture, and thin liquids.

R1's Care Plan dated 10/17/23 documents R1 is at risk for aspiration due to difficulty eating and coughing noted with meals. Staff are to monitor for choking or coughing with meals or liquids. The same Care Plan documents on 9/11/24 R1 was

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placed on a Regular diet, Pureed texture, Thin Liquid consistency. Resident placed on a puree diet temporarily related to mucus, choking, and Barrettes Esophagus. The same Care Plan documents R1 had a Do Not Resuscitate (DNR) order in place. Staff are to follow advance directives on R1's chart, honor R1's choices, and notify the physician of changes in R1's condition.

R1's Practitioner Order for Life Sustaining Treatment (POLST) form dated 10/12/23 documents R1 wished to have no Cardiopulmonary Resuscitation performed however did wish to have Selective Treatment including but not limited to non-invasive forms of positive airway pressure, intravenous fluids, antibiotics, vasopressors, or antiarrhythmics. R1 wished to be transferred to the hospital if indicated.

R1's Progress Note dated 9/19/24 documents R1 was observed in the dining room during the noon meal, unable to cough up phlegm or verbalize words.

R1's Progress Note dated 9/19/24 documents R1 expired with family at the bedside in the facility. Time of death was 5:55 PM.

R1's Progress Note: Skilled Nursing Facility Acute Note dated 9/19/24 documents at 12:30 PM that day, R1 was found coughing and choking on secretions. V7 Family Caregiver was with R1 at the start of the incident. V18 Advanced Practice Registered Nurse went into R1's room to find staff attempting oral suction for R1. R1 was in his wheelchair and hypoxic with oxygen at 50%, heart rate at 120, respiratory rate at 40. R1 was pale and diaphoretic with grossly congested lungs. V18 APRN took over suctioning, switched to

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nasotracheal suctioning and retrieved copious amounts of dark tan secretions. R1 however did not improve. R1 was placed on oxygen support at 10 liters via non-rebreather mask.

R1's Death Certificate dated 9/24/24 documents R1's expired on 9/19/24. R1's cause of death listed: Acute Hypoxic Respiratory Failure, Acute Aspiration of Stomach Content, Esophageal Dysphagia/History of Esophageal Cancer.

At 11/22/24 at 8:09 AM V7 Family Caretaker stated she arrived at the facility around 11:50 AM on 9/19/24. R1 was propelling himself down the hall in his wheelchair. V7 stated she came up to R1 and could audibly hear phlegm rattling in the back of his throat. V7 stated she took R1 to the dining room and he was served his lunch tray. V7 stated R1 took one bite of his mashed potatoes. V7 stated he was having trouble with all the extra phlegm in his throat and V7 then took him to V5 Licensed Practical Nurse (LPN) for some "cough" medicine. V5 gave R1 cough medicine and V7 took him back to the dining room. V7 stated R1 sat at the table for a few minutes not eating or drinking when she saw him start to struggle to breath. V7 stated she took off with R1 in his wheelchair to the nurses station and found V5 LPN. She told V5 R1 was choking on his phlegm and needed suctioning. V5 told V7 to take R1 back to his room. V7 stated R1 was struggling to breath, was visibly scared, was gasping for air, had audible gurgling sounds, and was anxiously flailing his arms around. V5 LPN could not find the suctioning equipment. V7 stated V5 asked other staff to assist and help find the suctioning equipment. V13 Certified Nurses Assistant (CNA) brought in the suctioning machine. V7 stated more staff came into R1's room and multiple staff were attempting to get the suctioning equipment

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put together and working. V7 stated after about 15 minutes R1 stopped moving around and went "limp" in his wheelchair however he was still gasping for air. V7 stated one staff member (V22 Registered Nurse) went in and out of the room multiple times to get items the suction machine was missing. V7 stated eventually V3 Registered Nurse was called from another unit to come and help get the suctioning machine working. V3 RN came and got the machine working and began to suction R1 orally however nothing much came out. A couple minutes later V18 Advanced Practice Registered Nurse (APRN) came into the room and assessed R1 and requested a different suctioning catheter. Staff ran out of the room again to retrieve what she had requested. V18 APRN was then able to suction R1 and got quite a lot of phlegm out however R1 did not seem to improve at all. V7 stated R1 was left in his wheelchair the entire time and was only placed in his bed after V18 had suctioned him. V7 stated forty minutes passed between the time she realized R1 had aspirated in the dining room until V18 Advanced Practice Registered Nurse began to suction R1. V7 stated R1's status never improved and he passed away later that same evening. V7 stated R1 was very scared of choking and it was horrible to witness someone so scared of choking end up aspirating and then no one was able to provide him the help he needed for such an extended period of time. V7 stated she had asked V24 Director of Nurses at the time if anyone had called for an ambulance and V24 stated R1 was not supposed to be transferred to the hospital. V7 stated that was not true.

On 11/21/24 at 3:50 PM V4 Licensed Practical Nurse (LPN) stated V7 (R1's Caregiver) came up to her with R1 in the wheelchair and told her R1

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had aspirated and was having trouble breathing. V7 took R1 back to his room and V4 called for help. V4 stated she did not know where the suctioning machine was located and V13 Certified Nurses Assistant located the suctioning machine for her and brought it to R1's room. V22 and V23 MDS Nurses came into R1's room and attempted to help get the suctioning working. V24 (DON at the time) also came into the room. V22 had to run in and out multiple times to get supplies needed for the suctioning equipment. V4 stated even when they had all the equipment needed they could not get the machine to work. V4 stated she called V3 Registered Nurse from another unit to come and help. V3 came over and was able to get the suctioning working and suctioned R1 orally. V18 APRN came in the room and asked for a different suctioning catheter. V18 then began to suction R1 and asked for a non-rebreather mask and oxygen. V4 stated she went to retrieve the oxygen supplies. V4 stated during the entire incident R1 was was struggling to breath, he was diaphoretic, and anxious. V4 denied calling for emergency services or alerting V18 APRN.

On 11/20/24 at 2:35 PM V3 Registered Nurse stated on 9/19/24 she was working on another unit when she got a phone call from V4 LPN stated R1 is in respiratory distress and they needed help with the suction machine. V3 stated she ran to R1's room and the staff (V24 DON at the time, V22 and V23 MDS coordinators, and V4 LPN) were having issues with the tubing and how to place it onto the suction equipment correctly. V3 RN stated she hooked up the suctioning tubing correctly and it worked. V3 stated she did the initial oral suctioning but couldn't get much out, then V18 APRN came in and did a deep nasotracheal suctioning then asked for a

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non-rebreather mask and high flow oxygen and V3 left the room to get it. V3 RN stated staff should know how to use the suctioning equipment.

On 11/20/24 at 3:32 PM V23 Minimum Data Set Nurse confirmed on 9/19/24 she attempted to assist in providing emergency care to R1 when he was in respiratory distress. V23 stated R1 was in his wheelchair and was diaphoretic, had labored breathing, audible gurgling, and was in severe distress. R1 oxygen saturation was very low and he was not getting enough air in and out. I was attempting to assist in getting the suctioning equipment working but the kit was missing pieces and we could not get it to work. V22 MDS Nurse was making trips in and out of R1's room to get what we were missing and we still could not get it working. V3 RN was called over and she was able to finally get the suctioning working and she began to suction R1. V23 stated she was never trained on the suctioning unit that was being used and did not know how to use it. V23 stated V18 APRN came in the room and performed nasotracheal suctioning however R1 was not responding to her efforts and had no eye contact, was not verbal or talking and continued with labored breathing post suctioning and oxygen administration. V23 stated as far as she knows 911 was never called.

On 11/21/24 at 2:00 PM V22 Minimum Data Set Nurse confirmed on 9/19/24 he attempted to assist in providing emergency care to R1 when he was in respiratory distress. V22 stated entered R1's room and he could not breath- it appeared as though he had aspirated. R1 was gasping for air and trying to clear stuff from his throat but was unsuccessful. V22 stated the suctioning equipment was brought to the room however it

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was not complete and he had to run in and out of the room 3-4 times to retrieve the necessary pieces for the suctioning. V22 confirmed that they still could not get the machine to work until V3 RN came over from another unit and was able to get it working. V3 then started suctioning R1. V18 APRN also came into the room and started suctioning R1. After V18 APRN suctioned R1, I moved him to his bed. R1 did not recover and passed away later that evening.

On 11/22/24 at 9:18 AM V24 Registered Nurse (Previous Director of Nurses DON) confirmed on 9/19/24 she was called into R1's room to assist in caring for him. V24 stated R1 had aspirated and was struggling to breath. V24 stated when she arrived in R1's room V22 and V23 Minimum Data Set Nurses were attempting to put together the machine and get it working however pieces were missing and V22 had to leave the room a few times to get different things. Even after V22 retrieved the missing pieces they could not get the machine working and ended up calling for V3 Registered Nurse who was working on another unit to come and assist. V3 RN arrived and was able to get the suctioning machine to start working and began to suction R1. V24 stated soon after that V18 APRN came into the room and requested a different suctioning catheter, which had to be retrieved, and V18 then suctioned R1 herself. V24 confirmed many errors occurred during the incident and R1 was not able to get the suctioning/care he needed timely because of the missing suctioning pieces and that they could not get the machine working right away. V24 stated R1's primary nurse V4 Licensed Practical Nurse should have called 911, R1's Power of Attorney, and V18 APRN.

On 11/22/24 at 10:11 AM V18 Advance Practice

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Registered Nurse (APRN) stated on 9/19/24 R1 had a massive aspiration episode. V18 stated she was in the building and was notified V24 DON at the time would be late or the meeting because she was assisting in an emergency with R1. V18 stated she jumped up and ran to R1's room to see what was going on. V18 stated when she entered R1's room, V3 RN was performing oral suctioning but it was not doing any good. R1 was hypoxic and in severe distress. V18 stated she asked for a different suctioning catheter and performed nasotracheal suctioning on R1 retrieving copious amounts of thick secretions. V18 stated despite her efforts R1's status was not improving and the suctioning was not going to relieve his distress. V18 stated she spoke with R1's POA (V6) who requested at that point they keep R1 comfortable. V18 stated R1 was provided with comfort measures and medications to keep him comfortable until he expired later that evening. V18 stated the facility nursing staff knew she was in the building and should have notified her immediately when it was first noticed that R1 was in respiratory distress. V18 stated she was not aware that initially the nursing staff had issues finding the suctioning equipment or issues with getting it working. V18 confirmed nursing staff should know where to locate suctioning equipment and how to use it.

On 11/21/24 at 2:16 PM V6 (R1's) Health Care Power of Attorney/Niece stated even through R1 had a DNR order in place she would have wanted the facility to call EMS when R1 began having trouble breathing. V6 stated she feels the facility was negligent. V6 stated she was only called concerning the situation by V7 (R1's Personal Care Taker) a little before 1:00 PM. V6 stated she could hear all the commotion in the background and V7 told R1 V6 was coming. V6 stated she got

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there about ten minutes later. V6 stated when she arrived in R1's room, R1 was still struggling to breath but he was no longer able to speak, he was not making eye contact, or acknowledging her presence. V6 stated she knew he was not going to make it at that point. V6 stated she made a comment in the past (when he seemed to be declining naturally) that if R1 was comfortable and calm, they did not need to send him to the hospital but V6 stated- that does not mean that if there was an emergency situation, and R1 was gasping for air and needed emergent care that they should not get him the help he needed. V6 stated R1 deserved better than this and the facility should have done better.

The undated Oropharyngeal Suctioning policy documents the purpose is to maintain an unobstructed airway and prevent aspiration of mucus secretions. Staff are to place a resident in semi fowlers or side lying position and proceed with suctioning procedure.

The Facility Assessment, last reviewed on February 2024 documents the facility will ensure staff are educated and have competencies in the areas that are necessary to provide the level and type of support and care needed for their resident population. This includes specialized care such as oxygen administration and suctioning. The same assessment documents the facility on average within an typical month has eight residents requiring oxygen respiratory services and one resident requiring suctioning. (This is a typical month, not taking into an account emergency medical situations.)

The facility resident roster dated 11/20/24 documents 77 residents reside in the facility.

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