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S 000	Initial Comments Complaint Investigation: 24110113/IL182381	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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.	S9999		

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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.

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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility

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failed to assess, monitor, and provide timely treatment; and failed to notify the physician of R3's change in condition and unresponsive episode for 1 of 3 (R3) residents reviewed for change in condition. In addition, the facility neglected to provide necessary medical services including assessing a change in resident's condition and recognizing when a resident needs emergent medical intervention. This failure resulted in the medical neglect of R3, who did not receive needed emergency medical treatment in a timely manner despite, over the course of five and a half hours, R3 exhibiting a significant decline in condition and subsequently becoming unresponsive. R3 experiencing a decline in Activities of Daily Living (ADLs) from 11/30 through 12/4 and subsequently became unresponsive on 12/4/24 at 9:00 AM with no medical treatment until 4:00 PM. At the time of ambulance transfer, R3 had Cardiac Pulmonary Resuscitation performed, and intubation. R3 was hospitalized with diagnosis of cardiac arrest, cause unspecified and Severe Septic Shock.

Findings include:

R3's Care Plan, dated 11/5/2024, documents Advance Directives: R3 is a full code and requests life sustaining measures.

R3's Minimum Data Set, dated October 28, 2024, documents that R3 is cognitively intact, occasionally incontinent of urine and always continent of bowel and requires assistance with activities of daily living (ADL).

R3's POLST (Physician Orders for Life-Sustaining Treatment,) dated 8/5/2024, documents that R3 indicated Yes to attempt CPR if in cardiac arrest and if not in cardiac arrest: Full

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S9999	Continued From page 3 treatment. R3's Progress Notes, dated 12/4/2024 at 2:23 PM, documents Nurses Note Late Entry: Note Text: Resident received new med order per (V4) for the following: Send resident to ER (emergency room) for evaluation and treatment R/T (related to) refusal of meds and refusal of meals. Resident POA (power of attorney) notified. Writer contacted (Local) ambulance rep who stated that a unit would be sent in 1 hour. Writer verbally notified pm nurse and told her after an hour to check back with (local ambulance company). R3's Progress Notes, dated 12/4/2024 at 5:23 PM, documents Nurses Note Text: 1632: This DNS (Director of Nursing Services) was called to resident room per emergency response due to resident noted with rapid condition decline. Crash cart requested and reported to resident room with Code called for assistance. 1634: Upon entering resident noted with 2 nurses at bedside. Crash cart and oxygen had been requested and enroute. 911 call already placed by staff nurse. This DNS took over lead duties. 1635: Resident noted in bed with HOB (head of bed) elevated, staff providing airway safety as able awaiting further equipment. Resident tachypneic with evidence of respiratory depression. Pulse present, weak and thready. Unable to obtain accurate reading on Pulse oximeter. Resident known to this nurse to have history of seizures with evidence of postictal s/s (signs/symptoms) noted. Resident diaphoretic, bilateral pupil dilation, increased oral/nasal secretions. White in color with thick frothy consistency. Resident unresponsive to verbal stimuli, tactile stimuli notes no response. Crash cart arrived. Suction set up and this DNS initiated suctioning, O2 (oxygen) initiated 5L (liters) via mask with	S9999		

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continued intermittent suctioning to maintain airway. No gag reflex noted during suction, slight secretions removed from oral cavity, no evidence of food or other particles noted to indicate aspiration. LS (lung sounds) forced but clear bilateral. Care continued until arrival of EMS (Emergency Medical Service). This DNS gave reports while care transitioned to EMS. Facility provided medical equipment transitioned to EMS medical devices (suctioning, oxygen) without further distress noted. Resident remains tachypneic, with weak thready pulse present. Unable to obtain BP (blood pressure). This DNS along with facility staff assisted EMS to transfer resident to stretcher for continued care and transfer. EMT (emergency medical technicians) reports concerns of cardiac arrest during transport. States they were having difficulty obtaining a second rig for assistance due to "shortages today". This DNS along with second nurse assisted EMS with resident move to ambulance with no loss of pulse or decreased respiration enroute to ambulance. 1700: Resident placed into ambulance with EMTs, and staff return to facility. 1708: EMTs now noted with second rig finally arrived and assistance being provided. Resident to be transfer to closest hospital due to critical status. Staff nurse contacted POA (power of attorney) and made aware of condition rapid decline and transfer status.

R3's Progress Note, dated 12/4/2024 at 5:57 PM, documents Nurses Note, Note Text: Time error inverted number 1632 should read 1623. Error in consecutive times caused by initial inversion: should read as follows, 1624, 1625, 1630, 1637.

R3's Progress Note, dated 12/4/2024 at 6:59 PM, documents Nurses Note, Note Text: upon writer's

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arrival to give resident her meds writer observed resident was foaming at the mouth writer immediately notified staff for help and called paramedics staff applied oxygen and suctioning to resident and elevated her head to keep her stable till paramedics arrived resident was still breathing and had a pulse, but it was faint and light paramedics arrived and suctioned resident and applied oxygen and removed resident from bed to stretcher writer sent resident out to hospital resident currently being transported to hospital by paramedics writer will continue to follow up.

R3's Progress Note, dated 12/4/2024 at 9:33 PM, documents Nurses Note, Note Text: error in time the correct time of incident was 16:23.

R3's Therapy Communication Form, documents 11/25/2024 report of change of status to NP, blood work ordered 11/26/2024 change diet to puree, 12/4/2024 educate staff re: not to feed in bed laying flat. Max (assist) without any response from patient.

R3's Local Fire Department Patient Care Records, dated 12/4/2024, documents that they received a call from local facility due to patient being unresponsive and foaming. Upon arrival patient was unresponsive and clammy surrounded by nursing staff. Nursing staff suctioning patient. Fire department took over and continued suctioning with contents of vomit. Staff not sure how long-ago patient had aspirated. Patient was agonal breathing. Faint Pulse, unable to obtain oxygen level and blood pressure. During transport to local hospital pulse was not palpable and CPR initiated.

R3's Local Hospital History and Physical, dated

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12/4/2024, documents that This 63 yrs old White Female presents to, ED (emergency department) via Unassigned with complaints of Cardiac Arrest. 12/04 Preceding the arrest, the patient was choking, was found down by nursing home staff. The arrest 17:03 occurred at nursing home. Pre-hospital course: EMS care prior to arrival: initiation of ACLS (Advanced Cardiovascular Life Support), oxygen. Per EMO patient was found "FOAMING AT THE MOUTH" BY NH (nursing home) Staff. Patient arrested upon EMS intervention en route. Patient receiving CPR upon arrival and had an IG EL (airway device) in place. It continues Exam: 12/04 17:08 Eyes: Pupils: constricted, bilaterally. Cardiovascular: Rate: tachycardic, Rhythm: Edema: pedal edema, that is very mild, ankle edema, that is very mild. Respiratory: no spontaneous respirations are appreciated, Respirations: no spontaneous respirations appreciated, Breath sounds: Unable to obtain exam due to obtunded state, patient being intubated. It also documents Procedures: 12/04 Intubation: A time-out was completed verifying correct patient, procedure, site, positioning, and intubation 16:59 set-up. The patient was pre-oxygenated using an Ambu bag and placed in a supine position. Sedation was obtained 100MG SUC. The MAC 3 blade was used and inserted into the oropharynx at which time there was a Grade 1 view of the vocal cords. A 7.5 French endotracheal tube was inserted and visualized going through the vocal cords. The stylet was removed. Colorimetric change was visualized on the CO2 meter. Breath sounds were heard in both lung fields equally. The endotracheal tube was placed at 23cm, measured at the teeth. A chest x-ray was ordered to assess for pneumothorax and verify endotracheal tube placement. Disposition Summary, dated 12/4/2024, documents

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diagnosis: Cardiac Arrest and Severe Septic Shock.

On 12/19/2024 the facility provided a 5 ways Root Cause Analysis Template, dated 12/19/2024, that documents: Clearly state the problem: Facility failed to Assess, monitor, and provide timely treatment. Nurse failed to follow up, assess resident and call MD. Nurse thought this was resident behavior. Poor assessment skills by nurse.

On 12/12/2024 at 8:46 AM V20, R3's Power of Attorney (POA), stated that she was very concerned with the care that R3 received at the facility. V20 stated she spoke with R3's roommate and was notified that R3 received CPR at the facility when being transported from the facility. V20 stated that she was notified by V5, License Practical Nurse (LPN), around 1:30 -2:00 PM that R3 was being sent out to the hospital because she was not doing well. V20 stated that she received a phone call from the facility 3 hours later telling her that the ambulance is here and R3 is being sent out. V20 stated that she didn't understand why it took so long. V20 stated that the (local) hospital called and told her that CPR had to be performed in the ambulance during transport and in the emergency room. V20 stated that she was informed that R3 was on a vent and would be transported to outlying hospital. V20 stated that she is very upset and concerned because she was told that R3 was not doing well and needed to go to the hospital 3 hours before R3 did. "Why didn't they send her?" V20 stated that for 2 weeks R3 refused to get up and laid in urine for long periods of time sitting in her own waste. V20 stated that she was informed by the hospital that R3 had an impaction the size of her hip socket. V20 stated that it's clear that R3 was

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having changes before the day she was sent out and they did not do anything.

On 12/12/2024 at 1:50 PM V7, Certified Nurse's Assistant, CNA, stated that he was not here when R3 went out to the hospital. V7 stated that he had worked with R3 the days and nights before. V7 stated that R3 had taken to the bed and would not get out. V7 stated that R3 was totally incontinent and did not eat. V7 stated that R3 would refuse to allow care but this was different from the norm. V7 stated that R3 was alert and verbal, able to stand and help with transfers, continent for the most part. V7 stated that the day before R3 went he again told the nurse that R3 was different and that something was not right. V7 stated that R3 was not able to stand, and he had to use a full mechanical lift. V7 stated that she was taken to the dining room, and she was not right. V7 stated that he informed the nurse passing pills that R3 was shaking like she had Parkinson's. V7 stated that R3 was different. V7 stated that he told the nurses and V2, DON, that there was something wrong with R3. V7 stated that the changes in R3 started 12/1/2024 and this is when he started notifying the nurses and the Director of Nursing.

On 12/12/2024 at 12:27 PM V5, Licensed Practical Nurse (LPN), stated that he was here the day that R3's change in condition occurred. V5 stated that R3 has a history of behaviors as far as refusing care and refusing to perform self-care but this was different. V5 stated that between 10:30 AM and 12:00 PM R3 was not herself and not responding to verbal stimuli and would not take her medication. V5 stated that he notified the Nurse Practitioner and got an order to send R3 out. V5 stated that he notified the power of attorney and called the ambulance. V5 stated

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that he was informed that it would be an hour before the ambulance would arrive. V5 stated that he told the oncoming nurse of this and that if the ambulance does not show after 30 to 45 minutes to call them back. V5 stated that he got the paperwork ready. V5 stated that he was not at the facility when R3 went out as he had left after completion of his shift.

On 12/12/2024 at 12:30 PM R1 stated that she and R3 were roommates. R1 stated that R3 was not herself for most of the week. R1 stated that R3 did not eat and stayed in the bed and did not eat or drink. R1 stated that the day before R3 went out to the hospital, V7, CNA, got R3 up. R1 stated that R3 didn't help much at all. R1 stated that when they put R3 to bed she was talking and that was the last time she was ok. R1 stated that R3 yells when they clean R3 but nothing during the night or following day.

On 12/17/2024 at 8:30 AM V6, LPN, stated that she was running late and got to the facility after 2:00 PM. V6 stated that she received shift report and was informed in shift report that R3 was going to the hospital and that the ambulance should be at the facility in 30 minutes, if not call the service. V6 stated that she was not informed of R3's condition and did not think it was an emergency. V6 stated that she went about, did her rounds, and started prepping for her shift and getting herself ready to pass her medications. V6 stated that around 4 to 4:30 PM the therapist (V9) reported to her that R3 needed a nurse now. V6 stated that when she entered the room R3 was in a state of distress. V6 stated that R3 was pale, not responding, shallow breathing and foam coming from R3's nose and mouth. V6 stated that she called 911 and called a code. V6 stated at that time she received help from other staff while

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she was on the phone with 911.

On 12/17/2024 at 10:21 AM V14, CNA, stated that she was not assigned to R3. V14 stated that R3 did have some changes. V14 stated that R3 was not herself. She would not talk and was spaced out, she (R3) was out of it. V14 stated that R3 does have behaviors but this was different. V14 stated that she reported it to the nurse. V14 stated that she wasn't right. V14 stated this was days before she went out.

On 12/17/2024 at 10:28 AM V17, CNA, stated that she got to the facility between 3:30 to 4:00 PM. V17 stated that she was not assigned to R3 that day and maybe saw her in passing as V17 walked past R3's room but did not look at her. V17 stated that she let the ambulance in and got the oxygen when told to do so. V17 stated that R3 has been having some changes and requiring more assistance than normal. V17 is normally alert and able to make her needs known. V17 stated that R3 hadn't been doing that and the other CNAs were needing help with her which is unusual.

On 12/17/2024 at 10:32 AM V15, CNA, stated that she did not have R3 the day she went out. V15 stated that she helped transfer R3 onto the gurney and got the oxygen tanks and things to help R3 breathe. V15 stated that R3 has behaviors and refuses care. V15 stated that prior to this R3 was not herself and stayed in the bed, went from standing and verbalizing her needs to dependent on staff, not eating and increase incontinence. V15 stated that the nurse was notified.

On 12/17/2024 at 10:39 AM V18, CNA, stated R3 was having changes days before she went out.

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V18 stated that R3 was crying a lot and not eating. V18 stated that R3 wouldn't stand up. V18 stated that this was different for R3 and that R3 was alert and able to stand and help. V18 stated that R3 did have behaviors and would refuse care. V18 stated that this was different.

On 12/17/2024 at 10:50 AM V9, Speech Therapist, stated that Speech Therapy was seeing R3 due to cognitive changes and eating. V9 stated that R3 did not have any difficulty with swallowing but did have some changes in her ADLs within the last week or so. V9 stated that because of this she went in to see R3 at 9:00 AM to see if she had eaten. V9 stated that she entered R3's room and R3 was lying flat in the bed with food tray on table next to the bed. V9 stated that she called out to R3 and there was no response. V9 stated that she went to raise the head of the bed and it did not work and R3 did not respond to movement. V9 stated that she noticed at that time that R3 was unresponsive. V9 stated that she performed a sternal rub and R3 did not respond. V9 stated that she notified the nurse and was informed that this was a behavior and no to worry about it. V9 stated at that time she did some in servicing with the staff about feeding R3 with bed being flat and raise the head of the bed. V9 stated that at about an hour later she again noticed that R3 was unresponsive and notified the nurse asking for vitals. V9 stated that she was informed that the vitals could not be taken because the battery was dead in the machine. V9 stated that at about 4 PM she entered R3's room and it was the scariest thing she has seen. V9 stated that R3 was lying in bed unresponsive with foam coming out of her nose. V9 stated that she told the nurse and was informed that the nurse on days said R3 was going out but was waiting on an ambulance. V9

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stated that she informed the nurse that R3 needed help now.

On 12/18/2024 at 10:46 AM V10, CNA, stated that she took care of R3 on 12/4/2024. V10, CNA, stated that she came in and went to R3's room and she didn't look herself. V10 stated that she asked what's going on with R3, she doesn't look right. V10 stated that she was informed that R3 was having some problems and to leave her in for breakfast and so she did. V10 stated that she went back in R3's room around 10:00 AM and provided incontinent care. V10 stated that R3 was not responding and was incontinent of a small amount of liquid stool but not wet with urine. V10 stated that R3 does have behaviors when she refuses care and not wanting to get up. V10 stated that this was different. V10 stated that this was not like R3 at all. V10 stated that she left the room and let V5 the nurse know. V10 stated that she provided incontinent care at 1:30 PM and R3 was unresponsive. V10 stated that R3 again had a small amount of liquid stool. V10 stated that this was different, this was a big change for R3. V10 stated that R3 was alert and able to tell you when she needed to toilet. V10 stated that R3 was continent in the day and incontinent at night. V10 stated that R3's change in condition started about 3 to 4 days prior to the unresponsive episode. V10 stated that R3 went from standing and taking steps to using a sit to stand and then not transferring at all and not eating at all. V10 stated that she let the nurse know.

On 12/18/2024 at 4:00 PM V3, Regional Clinical Nurse, stated that the Change in Condition and Physician Notification Policy was all in one and had been provided.

On 12/18/2024 at 9:26 AM V2, Director of

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	IL6010441	A. BUILDING: _____ B. WING _____	C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

(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
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Nursing, stated that she was up in front of the building and was called to R3's room. V2 stated that she ran down to R3's room. V2 stated that when she entered the room it looked like R3 had a seizure. V2 stated that R3's pupils were dilated and R3 was foaming at mouth and nose. V2 stated that there were nurses at the bedside. V2 stated that R3 had slow shallow breathing and a weak pulse. V2 stated that the foam was frothy, and she was almost post ictal. V2 stated that they were unable to obtain a pulse ox and O2 applied. V2 stated that 911 had been called. V2 stated that they were keeping R3's airway safe. V2 stated that EMTs came and took over and R3 was transferred to the stretcher and left facility. V2 stated that she had not seen R3 that day. V2 stated that she passed R3's room but did not actually see R3 prior to this event.

On 12/18/2024 at 1:35 PM V4, Nurse Practitioner, stated that on 12/4/2024 at 10:30 AM she received a message that R3 was refusing medication and food, facility attempted to get a urine and was not successful and R3 was shaking. V4 stated that at 12:30 PM she responded to send to R3 to the ER for eval. V4 stated that she was not notified of R3 being unresponsive with sternal rub being performed at 9:00 AM. V4 stated that if she would have been notified, she would have expected them to send R3 to hospital immediately. V4 stated that they know that this would be an emergency and with nursing judgement R3 should be sent out with 911 called. V4 stated if the nurse thought this was a behavior, then there still should have been an assessment. V4 stated that she was not aware of R3's change of condition and decline days before.

On 12/19/2024 at approximately 11:15 AM V5 stated that he was notified of R3's change of

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conditions prior to R3 being unresponsive and thought it was behavioral. V5 stated that R3 would refuse care and have behaviors in dining room.

On 12/19/2024 at 3:10 PM V21, Physician, stated that he was not notified of R3's change of condition. V21 stated that he was not aware that R3 was found unresponsive at 9:00 AM and then foaming from nose at 4:23 PM and went out to hospital in an ambulance. V21 stated that he was not aware that R3 went into cardiac arrest and received CPR. V21 stated that if he was notified that R3 was unresponsive to a sternal rub, attempts to arouse R3 had failed; he would have considered that an emergency and would have sent R3 to the hospital with lights and sirens. V21 stated that he would expect an assessment to be done and vitals. V21 stated that these are things he would have wanted to know. V21 stated that he was not aware that R3 was having change in condition prior to the event, not eating, taking to the bed and not allowing staff to care for her for days. V21 stated that these are red flags and V21 would have wanted to look further. V21 stated that he would have wanted to know what the assessment was. V21 stated that a resident needing minimal help to dependent, alert and then not is an emergency and V21 would have wanted R3 to be seen at the emergency room. V21 stated that he would expect to be notified of the changes of condition prior to the unresponsive episode with assessment including vitals.

On 12/23/2024 at approximately 11:30 AM V2 stated that they had a QA meeting on 12/19/2024 concerning the change of condition to try to find out what was the cause of the delay in treatment. V2 stated this was transcribed to the 5 ways Root

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Cause Analysis Template. V2 stated that their findings were transcribed to the form. V2 stated that the Facility failed to Assess, monitor, and provide timely treatment, Nurse failed to follow up, assess resident and call MD, Nurse thought this was resident behavior and Poor assessment skills by nurse was the root cause of the delay in treatment.

On 12/23/2024 at 1:19 PM V36, Restorative Nurse, stated that she is a part of Quality assurance team (QA). V36 stated that there was QA meeting, and they went over the deficiency and tried to figure out what happened. V36 stated that they found that they did not respond timely and appropriately with R3's change in condition. V36 stated that they have been in servicing staff related to the Change in Condition policy and if they feel the nurse is not responding then to go above them.

The facility's Notification of a Change in a Status Change in Condition policy, dated 11/17, documents PROCEDURE: 1. Guideline for notification of physician/ responsible party (not all inclusive): a. Significant change in /or unstable vital signs (Temperature, B/P, Pu Ise, Respiration) ... h. Repeated refusals to take prescribed medication (for two days). i. Change in level of consciousness. k. Unusual behavior. 2. Document in the Interdisciplinary Team (IDT) notes: a. Resident change in condition. b. Physician/physician extender notification. c. Notification of responsible party.

The facility's Abuse Prevention Policy, revised 10/22/24, documented "Neglect: A failure of the facility, its employees, or service providers to price goods and services necessary to avoid physical harm, mental anguish, emotional

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S9999	Continued From page 16 distress or pain." (A)	S9999		