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AXIOM HEALTHCARE OF MOUNT VERNON	1700 WHITE STREET MOUNT VERNON, IL 62864

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S 000	Initial Comments Complaint Investigation 2550988/IL185878 Complaint Investigation 2551135/IL186231 Complaint Investigation 2551609/IL187185 Complaint Investigation 2552215/IL188074	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4 300.610a) 300.690b) 300.690c) 300.1210a) 300.1210b) 300.1210d)6) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	S9999		

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c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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S9999	Continued From page 2 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: 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. These regulations were not met as evidenced by: Based on interview and record review the facility failed to notify the department of a serious accident resulting in death for 1 of 3 residents (R2) reviewed for accidents in a sample of 29. Findings include: R2's "Admission Record" documents as admission date of 10/18/2024, includes diagnoses of Parkinson's Disease, Type 2 diabetes mellitus, morbid obesity, dementia, and hydrocephalus. R2's "Progress Note" dated 1/31/2025 at 3:25AM, late entry at approximately 1:00AM, documents	S9999		

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"CNA (Certified Nurse's Assistant) alert this nurse that resident needed immediate assist. This nurse immediately ran into resident room and saw the resident in a compromised position. Resident appeared to be in sideways sitting position with head between grab bar and mattress. Resident was unresponsive and no pulse palpable. Resident lowered to the floor. CPR (Cardiopulmonary Resuscitation) initiated. All staff alerted (Emergency Medical Services) alerted. This nurse and other nurse continued CPR until EMS arrived. Time of Death 1:10AM. IDT (Interdisciplinary Team) notified. EMS notified coroner."

A local Fire Department report documents "1/31/2024 1:04AM call received. 1/31/2024 at 1:12 AM posture: laying, heart rate 0, respiratory rate 0. 1:13AM 3 lead Echo obtained. Patient (R2) narrative: Responded to nursing home facility for male patient (R2) unresponsive, not breathing. Upon arrival, find 82-year-old male supine on floor next to bed. Nursing staff performing chest compressions and ventilations with BVM (bag valve mask). Patient (R2) is pulseless and apneic. Skin is cold and cyanotic. Cardiac monitor applied showing asystole. Nursing staff reports possible down time 45 minutes or more. Resuscitation efforts discontinued; medical control contacted to confirm. Staff reports patient had been found with most of his body on the floor, with head and upper torso stuck between bed and bed rail. Coroner contacted via dispatch. Cleared scene with nursing staff awaiting communication with coroner. End of Report."

R2's "Medical Examiner/Coroner Certificate of Death" dated 2/11/2025, documents date of death 1/31/2025, time of death 1:15AM. The cause of

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death documents "1 a. Positional Asphyxiation, b. found in a seated position on floor beside bed, c. legs straight out and head and neck between mattress and bed rail. 2. Diabetes, hypertension, Parkinson's, dementia, and obesity." A date of injury is documented as 1/31/2025, time of injury 1:00AM, place of injury, Nursing home.

On 2/16/2025 at 7:53 PM, V11 CNA (Certified Nurse Assistant) stated she was working on 1/31/2025 when R2 expired. V11 stated she is the one that found R2. V11 stated she had done a bed check on R2 at 10:00PM, the next time she went into R2's room was around 1:00AM when she had walked by and seen his feet were not in the bed. V11 stated R2 was constantly throwing his legs out of bed and trying to get up. V11 stated when she entered R2's room at around 1:00AM, she seen him sitting on the floor beside the bed sort of sideways with his neck caught between the bed rail and bed frame. V11 stated it was like he was hung by his neck, but his body was on the ground. V11 stated R2 was not breathing, and she noted he was discolored. V11 stated she ran and got the nurse and she and the nurse had to lift him up to get his neck out from the bedrail because it was stuck. V11 stated they finally got him loose and started CPR. V11 stated there was a big gap between the mattress/ bed rail and bed frame and was big enough for his head and neck to fit in and get stuck in. V11 stated she called V1 (Administrator) and explained what had happened and she stated she told V1 that R2 was found hung in the side rail and he expired but they were doing CPR.

On 2/13/2025 at 1:34PM, V1 (Administrator) was asked for the report on R2's incident on 1/31/2025. V1 stated "we did not do one because we did not think his death was related to a fall or

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any type of injury." V1 was asked if there was an incident report made on this occurrence and V1 stated "no."

A "Report to (State Agency) Regional Office" was received on 2/14/25 from the facility to the Regional Office. The report documents R2 as the name of the resident with a date and time of incident of 1/31/25 at 1:10 AM. Under "Description of Occurrence" it documents "Resident (R2) found in room deceased in compromised position. Investigation initiated. Final to follow." The report documents V1 completed the report on 2/14/25. As of 2/26/25, the State Agency Regional Office has not received the final incident report.

"C"

Statement of Licensure Violations 2 of 4

300.610a)
300.1010b)
300.1210a)
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

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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

b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as

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S9999	Continued From page 7 applicable. (Section 3-202.2a of the Act) 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 seek emergency care for a resident with Type 2 Diabetes Mellitus who was experiencing elevated blood sugars too high for accurate readings to be obtained with facility glucose monitoring device for 1 of 3 residents (R16) reviewed for change in condition in a sample of 29. This failure resulted in R16's death with	S9999		

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cause of death listed as possible diabetic ketoacidosis.

Findings Include:

R16's "Admission Record" documents an admission date of 2/17/2022 with diagnoses of Cerebral Palsy, Type 2 Diabetes Mellitus with Ketoacidosis, without coma, Hyperlipidemia, Hyperkalemia, Epileptic Syndrome, Quadriplegia, Acute Kidney Failure, Chronic Kidney Disease, Microcephaly.

R16's MDS (Minimum Data Set) dated 12/16/2024 includes a BIMS (Brief Interview for Mental Status) assessment that suggests BIMS should not be conducted as resident rarely/never understood. R16's MDS documents R16 requires substantial/max assist with oral hygiene, putting on/off footwear, roll from left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed -to- chair transfers, and toilet transfers. R16's MDS documents R16 is dependent upper and lower body dressing.

R16's Physician Orders dated 12/1/2024 to 12/31/2024 documents orders for Humalog Kwikpen (insulin) 100 units/3 milliliters, inject 6 units subcutaneous three times a day (8:00AM, 11:00AM, and 4:00PM) with meals. Lantus (insulin) 100 units/milliliters, inject 23 units subcutaneous once daily (8:00AM). Fingerstick glucose monitoring three times a day (8:00AM, 11:00AM, and 6:00PM) with meals with sliding scale insulin including parameters: less than 150 =0 units, 151-200= 2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and over 400 give 12 units and call the physician. R16's December medication administration Record (MAR) documents orders

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for Fingersticks Glucose Monitoring: TID (three times a day) with meals with sliding scale insulin at 8:00AM, 11:00AM, and 6:00PM.

The Blood Glucose Monitoring System, User Instruction Manual on page 53 documents your blood sugar is more than 600mg/dl (milligrams per deciliter). Instructions to repeat test with new test strip. If the message shows, again contact your healthcare professional right away. If blood sugar is over 600mg/dl the monitor will read "HI."

On 3/5/2025 at 11:59AM, V20 (Certified Nurse Assistant/CNA) stated we got R16 up that morning and he was acting ok but seemed tired. As the day progressed, he didn't seem right like yelling at us, so we told the nurse. V19 (Agency Licensed Practical Nurse/LPN) was the nurse, and she checked R16's BS (blood sugar) and it was high. We told the nurse that he needs to be sent out to the hospital, but V19 did not listen and said she was going to try some things first. V20 stated V19 would not listen to the CNA's and the nurse is just temporary and does not know the residents like we do. V20 stated R16 didn't eat much that day. Right before lunch is when R16 started getting worse. V20 stated in the evening V19 kept checking R16's blood sugar and it kept reading "high." V20 stated V19 had never worked dayshift before so she did not know how R16 was during the day.

On 3/4/2025 at 11:59AM, V19 (LPN) stated she was working the dayshift 6A-6PM on 12/22/2024. V19 stated she was the charge nurse for R16. V19 stated R16 was mostly fine through the earlier part of the day. V19 stated she really didn't know R16 that well. V19 stated around 3:00-3:30PM the CNA's reported to her that R16 wasn't acting right, and he looked bad. V19 stated

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she checked R16's blood sugar around 3:30PM and the glucometer just read "HI." V19 stated she gave R16, 12 units of regular insulin at this time and called the on-call physician but had to leave a message. V19 stated at 4:00PM she gave 6 more units of regular insulin as scheduled. V19 stated R16 was a little sluggish and was acting tired. V19 stated as she was waiting for the return call from the physician, she called V2 (Director of Nursing/DON) and V2 informed her that this has happened before with R16 and sometimes they send him to the hospital if the physician orders to send to the emergency room. V19 stated that V2 said to just wait on the physician to call back and see what the physician wants to do. V19 was asked if she has had training at the facility on change in condition, blood glucose monitoring such as how high does the glucometers read, and V19 stated she has not had any kind of any training at the facility. V19 stated she had no idea of how high the blood sugar is when it read "HI." V19 stated R16's vital signs were within normal limits, and she did not receive a return call from the physician during the remainder of her (day) shift that ended at 6PM.

On 3/6/2025 at 2:00PM, V19 stated she was not sure what number she called for the on-call physician on 12/22/24, it was on a note at the nurse's station. V19 stated she doesn't know about the facility's (electronic communication system) and communication like that. V19 stated, "I was advised by V2 to wait for the physician to call back and if V2 would have said send R16 to the ER (Emergency Room), I would have sent him to the ER." V19 stated she gave report to V22 (Agency Registered Nurse/RN) when she came in at 6PM with information about R16's high blood sugars and a call placed to the on-call physician.

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S9999	Continued From page 11 On 3/6/2025 at 11:04AM, V22 (Agency Registered Nurse/RN) stated she worked on 12/22/2024, 6AM -6PM. V22 stated she received in report that R16 had been running high blood sugars and insulin per orders was given and the on-call physician was called, and a message was left for a return call. V22 stated she went to R16's room around 6:30PM to check on R16, she stated she could arouse R16, and he would answer yes or no to questions. R16's blood sugar was checked at this time and the reading was "HI." V22 stated she had put in another call to the on-call physician and left a message. V22 stated she received a call back from a physician around 7:30PM and received orders to give another dose of 12 units of insulin, in addition to the scheduled dose of 6 units and recheck "in a little while." V22 said that she was not sure who the physician was that called. V22 stated she did not document the physician's name in the medical record and did not write the orders given to her on the Physician Order Sheet. V22 stated she was the only nurse in the facility for that shift. V22 stated she could arouse R16 at that time and he was unchanged from previous assessment at around 6:30PM. V22 stated she remembers rechecking R16's blood sugar about 45 minutes later, approximately 8:15PM and the blood sugar was down to 488. V22 stated, " I thought we were finally going in the right direction with the blood sugar going down." V22 stated, "Sometime around 10:00 PM, I was called to R16's room by a CNA, upon entering room R16 was having a hard time breathing, heart rate was irregular, color was bad and R16 was nonresponsive." V22 stated at this time she and the CNA lowered R16 to the floor to prepare for CPR (Cardiopulmonary Resuscitation), when lowering R16 to the floor, R16 stopped breathing. V22 stated CPR was	S9999		

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started and help was called for from the other CNA's. When the other CNA entered the room V22 asked her to call 911 and the CNA stated, "CNAs are not allowed to call 911," so that CNA took over chest compression and V22 went to call 911 and check R16's chart for code status. V22 stated code status was found and R16 was a DNR (Do Not Resuscitate) so she went to the room and stopped CPR. V22 stated EMS (Emergency Medical Service) arrived and pronounced death around 10:30ish. V22 stated she remembers R16 having a strong sweet fruity smell as they were transferring him to the floor. V22 stated she has had no training at the facility on policies or resources to look up policies.

On 3/5/2025 at 1:20PM, V21 (Certified Nurse Assistant/CNA) stated, she came into work on 12/22/2024 at 6:00PM and shortly after getting to work she saw R16. V21 stated R16 was not responding to the staff and his color was not good. V21 described R16's color as not a good color and sort of gray. V21 stated, "As the evening went on there really was not many changes with R16." V21 stated, "I was working on another hall when I heard someone yell and when I got down there, the nurse was doing chest compressions on R16." When another CNA got in there, she took over chest compressions and the nurse went to check the chart to see if R16 was a DNR or a Full Code. The nurse returned stating R16 was a DNR, so the CPR stopped. When EMS arrived, they checked R16 and stated to leave R16 in the floor until cleared by the coroner." V21 stated, "When I got report from the day shift CNA's, the CNA's reported that R16 was not doing good at all and the CNA's tried to get the dayshift nurse to send him to the Emergency Room, but she wanted to try some other things first. V21 stated this was an agency nurse and

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they do not know the residents like we do.

On 3/4/2025 at 4:20PM, V25 (CNA) stated she was working the night R16 passed. V25 stated she worked 6PM -6AM that day. V25 stated she had checked in on R16 a few times and R16 was sleeping. V25 stated when she went in to do bed check on R16 she noted he was gray in color and not responding. V25 stated she was unsure of the time. V25 stated she yelled for help, and everybody came. V25 stated they moved him to the floor and started CPR. V25 stated they did CPR for about 15 minutes until EMS arrived then they stopped CPR. V25 stated R16 had been out to the hospital multiple times in the past because of his blood sugars.

On 3/5/2025 at 12:18PM, V2 (DON) stated she remembers the phone call she received from V19 LPN on 12/22/2024. V2 stated it seems like it was somewhere around 5:00PM. V2 stated V19 was an agency nurse that informed her that R16's blood sugar was reading "HI" and that she had followed doctor's orders and had given him insulin and was waiting on the physician to call her back. V2 stated she asked how R16 was doing, and the nurse stated his vital signs seemed to be normal. V2 stated the nurse stated she thought he was acting ok to her. V2 stated she told the nurse that if she felt like he needed to be sent out that she could do that or just wait on the physician to call back with orders. V2 was asked if she had investigated R16's death records. V2 stated, "I read the nurses notes because she didn't see anything really concerning." V2 stated she talked with the night nurse V22 after R16 passed. V2 stated the night nurse said R16 acted fine at 6:00pm when she arrived at work and then V22 was called to his room later and she called 911. V2 stated she thought V22 had called back the

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doctor or the doctor called her and order more insulin. V2 stated she had seen where his blood sugar went down a bit after V22 gave the ordered insulin. V2 stated his blood sugar was down in the 400's after that. V2 was asked if she would have sent him out with the high blood sugars, V2 stated, "If he was not acting right, I would have." V2 stated his blood sugars reading high meant it was over 500. V2 was asked how high the glucometers reads and V2 stated, "I believe 500 or 550 but I would have to read the book on that to make sure. V2 was informed the Owners' Manual to the glucometer states these glucometers read up to 600 then automatically go to read "HI." V2 stated "Wow!" V2 stated she would have sent him out knowing his blood sugar was over 600. V2 stated she feels it was a long time for the physician to get back with the facility and this is unusual, and she would have sent him out. V2 stated R16 had started making a pattern of having DKA (Diabetic Ketoacidosis) and he had been placed in ICU (Intensive Care Unit) with an Insulin drip over the last several months, with the last time was 12/12/2024. V2 stated R16 was normally very active, talking to the staff, V2 stated he had the mind of a child, and we all loved him. V2 was asked if the (Nurses Agency Staffing Organization) nurses receive any or are required to complete any training at the facility level, V2 stated the only requirement is a valid nurse's license. V2 stated she doesn't like to have agency nurses in her facility working because they don't know the residents usually, but we don't have a choice right now.

On 2/28/2025 at 1:45PM, V1 (Administrator), stated she has been employed at the facility for 5 years and she was very familiar with R16. V1 stated she had not investigated R16's death. V1 stated R16 had been sent to the hospital several

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times for elevated blood sugars, DKA, and R16 would get treated and return. V1 was handed R16's progress notes from the day he expired. V1 was asked to read the progress notes. V1 then stated, " I would have sent him out at 488 but I would have sent him out before that when the blood sugar was too high to read on the glucometer." V1 stated she and V15 (Nurse Practitioner/NP) had talked about this after his death and R16's life expectancy was only to live until his 20's, he was in his 50's and he had many health issues. V1 stated the nurse that was working that day was an agency nurse. V1 stated, "I would have sent him out and if they would have sent him out when it was high, he would still be alive, but I was very familiar with R16 and knew his medical issues."

On 3/6/2025 at 1:50PM, V23 (R16's sister/Power of Attorney) stated R16 was her brother, and he had resided in the facility for a few years. V23 stated up until the last several months the care was good and R16 was thriving, but the last several months had been bad. The facility has a lot of nurses that only work occasionally, and they do not know the residents or how to care for them. V23 stated on 12/22/2024 she came to visit R16 in the afternoon and R16 did not seem himself and seemed very tired. V23 stated she thought maybe he was just sleepy as no staff said anything to her about his blood sugars or anything being wrong. V23 stated, "The next thing I knew I got a call between 10:30PM and 11:00PM that my brother had passed." V23 stated R16 was in the hospital recently with Ketoacidosis on 12/12/2024. V23 stated if R16 doesn't get his insulin right his blood sugars get too high.

On 3/7/2025 at 9:25AM, V24 (Medical Director),

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was asked if he was familiar with R16. V24 stated, "That name does not ring a bell, I don't know him." V2 was asked how the on-call services work and V24 stated, "The nurses have to use (facility notification system) to reach the nurse practitioner and on weekends from 9PM to 6AM there is a number to call and usually I am the one on call." V24 was asked if he received any calls on 12/22/2024 or after midnight on 12/23/2024, V24 checked his records and personal phone and stated, "No I did not." V24 was explained the condition of R16 and his high blood sugars. V24 stated, "We can sometimes manage high blood sugars in the facility but if we give treatment and the condition doesn't change then they need to be sent to the hospital." V24 stated he believes the problem is with the nursing staff and some of them only being in the facility a few times. V24 was asked if he thought that hindered communication with physicians and he stated, "Yes if they do not know our system." V24 was asked when the last time he made rounds in the facility to see the residents and V24 stated, " I do not see the patients, the Nurse Practitioners see the patients and they work through me. I only come per requirement quarterly for the meeting." V24 stated "the facility should have done a better job with R16, and I am sorry for his death." V24 stated education needs to be done and corrected.

On 3/6/2025 at 12:04PM, V15 (NP) stated she was looking for messages on 12/22/204 on the call log and on her cell phone and no messages were left and there were no missed calls for this facility for 12/22/2024.

On 3/6/2025 at 2:20PM, a call was placed to the Physician Service office and spoke with the receptionist/secretary (V35) who stated she would send a call log for the date of 12/22/2024 for this

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facility. The call log was received and did not show that the Physician Service office received any calls from the Facility log on 12/22/2024.

R16's Nurses Notes authored by V19 dated, 12/22/2024 at 5:50PM, documents, right before dinner had started it was time for me to check R16's. I checked his blood sugar, and the monitor said high. So I check it again on another finger and it still said high. I looked at his chart to see his sliding scale, I followed the sliding scale and called the on-call doctor like it stated on his order. I called and left and voicemail for the on-call doctor letting him know what was going on and what he would like for me to do next. I checked R16's vital signs before I called the doctor, and his vital signs were wnl (within normal limits). While waiting on the call back I checked R16's blood sugar again 40 minutes later after given insulin, and it still said high. So, I called the DON and told her what was going on and she said he had issues with his blood sugar being high before. While doing shift change, I informed the on-coming nurse about what was going on and that she should receive a call from the doctor soon. I also charted what was going on, on the shift change sheet.

R16's Nurses Notes authored by V22, dated 12/23/2024 at 1:00AM, documents report received at approximately 6PM from the day shift nurse that resident's blood sugar had been running high today and most recent blood sugar reading prior to evening meal read hi on the blood glucose monitoring machine. Dayshift nurse reports calling provider on call for further insulin orders. Call back from PCP (Primary Care Provider) received at approx. 7:30PM with new orders for additional 12 units insulin x 1. Insulin given per orders RUQ (right upper quadrant) abd

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(Abdomen). At that time resident able to respond yes/no to questions asked. No active distress. Respirations even and unlabored, heart RRR (regular rate and rhythm), BS (Bowel Sounds) per 4 quads. Skin color WNL. Recheck of blood sugar at approx. 8:30PM with result of 488. No change in condition from an hour ago. No acute distress. During med pass CNA's notified this nurse that resident looked "terrible." Upon entering resident's room, he was laying in bed color pale resp uneven and labored, fruity/sweet smell odor noted to resident's breath, unresponsive, heart irregular rate and rhythm. V/S (Vital signs) 56/32, 56, 28, 96.2 unable to obtain O2 (Oxygen) sat. Resident moved to the floor in anticipation of CPR if required, while this writer and CNA moved resident to floor, he stopped breathing, chart checked for code status and rescue breaths given. POLST (Physician's Order for Life Sustaining Treatment) form - DNR (Do Not Resucitate). No further breaths given. Emergency responders/fire department arrived at facility at approx. 10:33PM. Time of death 10:33PM. This writer called sister/guardian at 10:35 PM and 11:15, sister returned call to facility and spoke with this nurse with situation relayed. Sister began crying and stated she was glad for being able to see him this morning for a visit and was thankful to all facility staff for care given to brother. On-call after hours MD (medical doctor) called x2 awaiting call back. This nurse called local funeral home and body removed from facility at approximately 12:45AM.

R16's December 2024 MAR (Medication Administration Record) documents on 12/22/2024, R16's blood sugar at 8:00AM has numbers that are scribbled out but looks like 200 written beside the scribbles with V19's initials. On 12/22/2024 at 11:00AM, the MAR documents

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blood sugar of 272 with initials of V19. There was no amount of sliding scale insulin documented to be given at that time, however the scheduled Humalog Kwikpn 6 units at 11:00AM and initialed by V19. On 12/22/2024 4:00PM, the MAR documents 6 units of Humalog Insulin was given as scheduled and initialed by V19, and at 6:00PM fingerstick glucose monitoring is initialed by V19 and results were scribbled out.

On 3/6/2025 at 2:00PM, V19 was asked about the blood glucose monitoring checks being scribbled out on MAR and V19 stated she did not do that.

R16's December MAR contains no documentation that 12 units of Humalog insulin were given around 4:00PM on 12/22/24. The MAR does document at 7:30PM on 12/22/2024 R16 received 12 units of Humalog due to blood sugar reading Hi on Blood Glucose monitoring machine.

R16's State of Illinois Certificate of Death includes a date of death for 12/22/2024, and cause of death Probable Diabetic Ketoacidosis. Time of death 10:33PM.

Facility Physician- Family Notification-Change in Condition Policy with a revision date of 11/13/2018, documents in part: "The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is:...(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

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S9999	Continued From page 20 Life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before). (D) A decision to transfer or discharge the resident from the facility." "AA" Statement of Licensure Violations 3 of 4 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999		

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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 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:

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.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement new fall

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interventions for a resident who was a high risk for falls for 1 of 3 residents (R25) reviewed for falls in the sample of 29. This failure resulted in R25 being sent to the hospital for a fall that that resulted in a new hyper density in the posterior right globe and swelling/hematoma to the right scalp.

Findings include:

R25 's document titled "Admission Record" documents R25 was admitted to the facility on 4/4/2022 with diagnoses including Anemia, Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, History of Falls, Unspecified Dementia, History of Transient Ischemic Attack, Legal Blindness, and Cerebral Infarction without residual deficits. R25's MDS (Minimum Data Set) dated 12/17/24, documents under section "C" (cognition patterns) that R25 has long term and short-term memory problems, cognitive skills for daily decision-making are marked severely impaired, and no BIMS (Brief Interview for Mental Status) was completed due to resident unable to participate. Section "GG" documents, functional limitation in range of motion shows impairment on both sides, of lower extremities. R25 has mobility by wheelchair. MDS documents R25 is, upper and lower body dressing, putting on/taking footwear, rolling left and right, sit to lying, and chair-bed-to chair transfer. Section "H" Bladder and Bowel documents always incontinent of bladder and always incontinent of bowels. Section "J" health condition, under Fall history/any falls since on Admission/Entry or Reentry or prior assessment, documents R25 has not had any falls since admission/entry or the prior assessment. Number of falls since admission/Entry or Reentry or Prior Assessment is left blank. Section "M" Skin Condition

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documents resident is on a turning and repositioning program. Section "P" Restraints and Alarms documents R25 had no alarms such as bed alarms, chair alarms, floor mat alarm, motion sensor alarm, or wander/elopement alarm.

R25's Care Plan documents under Focus, resident is at risk for falls related to cognitive impairment and unaware of safety needs, 3/7/2025 resident unwitnessed fall out of bed, scoop mattress placed on bed, date initiated 7/18/2024, Revision date on 3/13/2025, with same date for canceled. Interventions: Resolved (with no date) ½ side rail to help with bed mobility and improve safety per POA (Power of Attorney) request. The residents call light is within reach and encourage the resident to use it for assistance as needed, anticipate and meet the resident's needs, follow fall policy, observe nonverbal signs of restlessness that may precipitate movement and attempts to stand /walk unattended, OT (Occupational Therapy) to evaluate and treat as ordered, review information on past falls and attempt to determine cause of falls, record possible root cause, after remove any potential causes of possible and up ad lib with 1 assist.

R25's "Fall Risk Assessment" dated 9/16/2024 documents score of 21 which instructions read: 10 Points or More = High Risk Score. R25's, 7/17/2024 fall risk assessment documented a score of 24, and R25's 5/21/2024 assessment documented a score of 12.

R25's "Unwitnessed Fall" report dated 3/7/25 documents, at 4:00PM, Incident description: Unwitnessed fall from bed. 4:00PM resident's roommate came to Admin office stating that a resident was in the floor next to her bed. Resident

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was hoyer lifted from floor to bed by nurse and CNA's. Resident is unable to give description. Immediate action: POA (Power of Attorney) declined to send to ER (Emergency Room) to eval and treat. Scoop mattress placed on bed. Neuro checks initiated. Approx 4:00AM on 3/8/2025, resident was sent to ER related to change in condition/change in neuro assessment. Injuries observed at time of incident Bruise to top of scalp and face. Predisposing Environmental Factors is marked "none." Predisposing Physiological Factors is marked "none." Predisposing Situation Factors is marked "none."

On 3/14/2025 at 1:20PM, V31(Certified Nurse Assistant/CNA) stated she was working the day R25 had a fall. V31 stated she and V21 had laid R25 down around 2:00PM that afternoon. V31 stated R25 was incontinent of bowel and bladder and required 2 people to transfer because R25's legs were bent. V31 stated R25 did not ever move very much in the bed. V31 stated R25 used to have a small siderail but it was removed recently. V31 stated the rail had been there a long time but R25 had not been able to use the rail for bed mobility for quite some time. V31 stated the rail was there to keep R25 in the bed but it was taken off. V31 stated R25 's family requested that the bed be moved up against the wall as well. V31 stated R25 had fallen one other time a while back but she was unaware of the intervention that was put into place. V31 stated when he had laid R25 down, R25 was facing the wall on her right side, and closer to the wall. V31 said when she entered the room when she heard that R25 had fallen, R25 was lying in the floor in the same position, on her right side with knees bent. V31 stated R25 had her eyes open but was not screaming and yelling like she normally does when someone touches her. V31 stated she has

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no idea how R25 fell out of bed as she normally never moves.

On 3/14/2024 at 2:12PM, V20 (CNA) stated she was working on the day R25 fell. V20 stated she and V31 laid R25 down around 2:00PM and they positioned her on her right side facing the wall and about in the middle of the bed. V20 stated she had never seen R25 move by herself. V20 stated as they were making rounds between 3:30PM -4:00PM to get residents up for supper we found R25 lying on the floor facing the wall on her right side. V20 stated in the past if R25 would get mad she would move her legs from side to side. V20 stated R25 used to have a side rail and her bed against the wall to keep her from falling, but the rail was removed recently. V20 was asked if any other fall interventions were put into place like alarms, lower bed, or a fall mat and V20 stated not that she knew of. V20 stated R25 was not able to get out of bed by herself as her knees were contracted. V20 stated R25 always screamed and yelled when anyone touched her as she did not like to be bothered. V20 stated they summoned the nurse to R25's room and the nurse assessed R25, then R25 was hoyer lifted back to the bed with 2 assists. V20 stated R25 was totally dependent on the staff for all her care.

On 3/14/2025 at 2:29PM, R9 who was alert to person, place and time, stated she was in the room on the evening R25 fell out of bed. R9 stated R25 never moved much at all anymore. R9 stated, she was snoozing and reading, remembered looking up and R25 was lying on the floor on her left side facing R9. R9 stated she always tried to check on R25 frequently as she was old. R9 stated she went to tell V1 (Administrator) as fast as she could that R25 was on the floor. R9 stated the nurses came and got

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the hoyer and lifted her back to bed. R9 stated she believed R25 slipped out of bed, and she couldn't stand at all.

On 3/13/2025 at 2:30PM, observed R25 lying in bed on right side, facing the wall, in fetal-like position. At that time the right side of bed was up against the wall with no side rail noted but concave mattress in place. R25 had noted bruising/swelling noted to right eye and right side of head with noted hematoma. R25 was not responding to verbal stimuli. Hospice nurse present at time of observation.

R25's document titled "Nurses Notes" documents on 3/7/2025 at 5:57 PM, resident roommate came out of room and notified CNA that resident was in the floor and had rolled out of bed. Resident was found lying on right side with hematoma to right side of head and swelling and bruising to right eye. Notified POA due to this nurse feeling like resident wound need to go to Emergency Room for eval due to resident being on Eliquis (blood thinner). POA stated to hold off that he was going to come up here and check on R25. POA showed up about 10 minutes later and stated he did not want her sent to the Emergency Room at this time. Provider notified. On 3/8/2025 at 2:47 AM, upon taking residents vital signs blood pressure decreased to 92/50, pulse 58, respirations 16, temperature 97.7 and Oxygen saturations at 89-91% room air, resident not responding to blood pressure cuff being applied or tough. Called POA and updated POA on resident's condition, stated we recommend R25 being seen at the Emergency room, possible brain bleed related to blood thinners and fall. POA stated to monitor her and call him back in 1 hour with vital signs after redoing them, will continue to monitor. On 3/8/2025 at 3:40AM, went to check on resident,

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resident's vital signs are as follows: blood pressure 87/42/ pulse 63, respirations 16, temperature 97.7, oxygen saturations 85% on room air, resident is still not responding to touch. Bruising, swelling remains to right eye and right side of head. Called POA back with new vital signs per POA requested update, had to encourage POA for resident to be seen. POA stated to send R25 to local emergency room for eval and treat. Notified MD on electronic messaging system, called ambulance for transport and called local hospital to give report on R25. On 3/8/2025 at 9:30AM, resident returned to facility from local hospital via ambulance. POA at bedside. CNAs assisted with repositioning resident for comfort. On 3/8/2025 at 9:40AM, Vital signs Oxygen saturations 96% on room air, pulse 86, respirations 24 and blood pressure 98/58. The only medication change/orders when resident came back from local hospital, were to stop taking Eliquis (blood thinner). Bruising and swelling, and hematoma continues to right peri orbital and scalp area. Bruising noted to right hand and bilateral arms and right leg. Resident is on a scoop mattress. POA present at bedside and updated V15 NP (Nurse Practitioner) of readmit.
Documents from local hospital titled "CT (Computerized Tomography) Head without Contrast" dated 3/8/2024 at 6:10AM, documents under Impression: No CT evidence of acute intracranial abnormality. There is new hyper density in the posterior right globe. Can not exclude acute hemorrhage. Recommend ophthalmologic evaluation. Right frontal scalp and right periorbital soft tissue swelling/hematoma.

Document titled "Nurses Notes" dated 3/9/2025 at 7:38PM, spoke with POA about V15 asking if family wanted hospice and POA stated it would

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be a good idea. POA chose hospice team and to consult tomorrow.

Document titled "Hospice Admission Summary" dated 3/11/2025, documents terminal diagnosis of: Cerebral Atherosclerosis with code status documented of DNR (Do Not Resuscitate).

Policy titled "Fall Prevention Program" with revision date of 11-21-2017, documents purpose as: To assure the safety of all residents in the facility, when possible. The program will include ensures which determine the individual needs of each resident by assessing the risk of falls and implantation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Program will monitor the program to assure ongoing effectiveness. Section titled "Fall/safety interventions may include but are not limited to" documents, to inform family of risk factors and reinforce interventions a needed.

"A"

Statement of Licensure Violations 4 of 4

300.1210a)
300.1210b)
300.1210d)2)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to provide safe administration of peritoneal dialysis by qualified trained staff as ordered by a physician for 1 (R22) of 3 residents reviewed for

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dialysis in the sample of 29. This failure resulted in R22 experiencing severe shortness of breath requiring transfer to local hospital, R22 receiving intubation and mechanical ventilation for respiratory failure to prevent imminent deterioration and further organ dysfunction from hypoxia and hypercarbia.

V29 (Registered Nurse/RN) and V30 (Licensed Practical Nurse/LPN) manually infused 2.5 liters of dialysate fluid into R22's peritoneal space (totaling approximately 4 liters of dialysate fluid in R22's peritoneal space) causing R22 to experience shortness of breath and be transferred to the hospital for further treatment.

Findings include:

R22's New Admission Information documented an admission date of 9/10/24. R22's Cumulative Diagnosis Log documented diagnoses that included sepsis, peritonitis, and dependence on dialysis. R22's Minimum Data Set (MDS) dated 9/17/24 documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.

On 3/11/25 at 2:45 PM, V33 (Regional Reimbursement) said the facility was not able to produce R22's Care Plans due to a change of ownership and was now unable to access the electronic medical records.

On 3/12/25 at 2:14 PM, V2 (Director of Nursing/DON) said when she came into the facility on 10/22/24 the nursing staff were having some issues with R22's Peritoneal Dialysis (PD) infusion due to the PD cycler alarming through the night. V2 said she was told by V30 (LPN) that due to R22's PD cycler alarming, V30 had called

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V28 (Dialysis Company Registered Nurse). V2 said around 9:30 AM to 10:00 AM, V28 called the facility requesting to speak with V2 to give new orders for R22. V2 said the facility did not have the bag of dialysate that V28 gave an order for and had to go to the dialysis company to pick up the bag of dialysate. V2 said she returned to the facility and V29 (RN) was the nurse caring for R22. V2 said she gave V29 the order for a 1.5 liter PD manual fill and asked V29 if V29 was familiar with how to set and infuse a PD manual fill because V2 was not familiar with infusing PD solution with gravity. V2 said V29 said she was used to completing PD manual fills and had completed them in the past. V2 said R22 received 2.5 liters of PD dialysate, started to have some shortness of breath, and was sent to the hospital for further evaluation. V2 said she had never completed a PD manual fill of dialysate at that time. V2 said she had received training from the dialysis company for PD but the training only included how to hook a resident up to the PD cycler.

On 3/13/25 at 10:13 AM, V30 (LPN) said R22's peritoneal cycler machine "messed up." V30 said she called the dialysis company and was unable to fix it when the dialysis company said to come to the dialysis facility to get a bag of dialysate solution for R22. V30 said V2 brought R22's dialysate solution back to the facility. V30 said V29 (RN) asked V30 if V30 could walk V29 through how to put the fluid into R22's peritoneal space. V30 said V2 did not speak to V30 about R22's peritoneal dialysis order when she returned from the dialysis facility. V30 said V29 was the staff that approached her to assist with infusing R22's dialysate fluid. V30 said she did not check R22's orders because R22 was not her patient and V30 was only there to tell V29 how to hook

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up the manual dialysate tubing to R22 because V29 had not been trained. V30 said she had not received any training by the dialysis company on how to manually fill or drain a peritoneal dialysis patient. V30 said after R22 had been hooked up to the bag of dialysate fluid V29 infused the whole bag (2.5 L). V30 said R22 became short of breath and was transferred to the hospital. V30 said when she was on the phone with the dialysis company earlier in the day the dialysis nurse had not told V30 how much dialysate fluid to infuse. V30 stated the dialysis nurse "just said come get a bag to put in."

On 3/7/25 at 11:53 AM, V29 (RN) said she was caring for R22 on 10/22/24. V29 said she had received information in report from the night shift nurse R22's Peritoneal Dialysis (PD) cycler had been alarming throughout the night and V29 would need to follow up with the dialysis company to make sure R22's PD cycle had completed and ask if there were any new orders if it hadn't. V29 said she called the dialysis company and told them R22 had trouble with the PD cycler and V30 (LPN) took over the phone call. V29 said V2 came into the facility with a box from the dialysis company and placed it in R22's room. V29 said she was hard of hearing and deaf in one ear. V29 said she did not know what V2 said to her. V29 said she and V30 went to R22's room and V29 hooked R22's PD catheter up to the bag of dialysate and V30 unclamped the tubing infusing R22 with the dialysate. V29 said she was not sure how much dialysate was supposed to be infused. V29 said the dialysate bag was a 2.5-liter bag and if only 1 liter "or however much was supposed to be put in" was ordered why would V2 not have told the nurse (V29) who was going to be completing the treatment. V29 said after the dialysate was infused into R22, R22 looked like

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R22 was in fluid overload. V29 said R22 became hypotensive and short of breath with very low blood oxygen saturations. V29 said she put oxygen on R22 and called an ambulance to transport R22 to the hospital. V29 stated "I was just observing. I didn't hook (R22) up. I just connected it. (V30) unclamped it and the fluid started going in." V29 said the whole 2.5 liters of dialysate was infused in R22 and no orders were written so V30 could not have known how much to infuse. V29 said she had not received any training on dialysis. V29 said training was completed through the dialysis company and due to V29 being a float nurse from a sister facility no dialysis training was ever offered to V29. V29 said she thought V30 was certified in dialysis. V29 said during the facility's investigation V29 was told R22 was supposed to receive 1.5 liters of the manual fill dialysate solution but nothing was written in R22's medical record. V29 said she had been in communication with V28 (Dialysis Company RN) and V29 had given V28 some of the readings from R22's PD cycler but when V28 started asking more questions she handed the call off to V30. V29 said she was not sure if there were any infusion directions in R22's Medication Administration Record.

On 3/14/25 at 4:31 PM, V32 (Nephrologist) said overfilling of dialysate fluids can cause lung problems and discomfort with breathing. V32 said extra fluid in the abdomen pushes on the diaphragm and causes discomfort with breathing and can make it difficult. V32 said he knew R22 and R22 was already compromised respiratory wise as R22 just had pneumonia and had pulmonary edema. V32 said the normal amount of fluid left in the abdomen is 1.5 liters. V32 said the facility is supposed to follow the orders from the dialysis center. V32 said the dialysis center

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faxes over the orders to the facility and the facility should not be doing dialysis without current orders. V32 said if a nurse does not know how to perform or was never trained in peritoneal dialysis they should not perform the dialysis and should call the dialysis center.

On 3/13/25 at 10:42 AM, V36 (Emergency Department Physician) said he was the Physician treating R22 on 10/22/24. V36 said he was not made aware by the facility R22's peritoneal space had been overfilled. V36 said the more fluid in the abdomen would push up on the diaphragm making it difficult to breathe. V36 said R22's CT (Computed Tomography) scan documented moderate volume ascites (fluid in the abdomen). V36 said, looking at R22's CT scan, they called it moderate, but it looks like a lot. V36 said the fluid in R22's abdomen would have made it harder to breath. V36 said R22's CT scan of the lungs did show pneumonia with consolidations in bilateral lungs, but the extra fluid would have made it even harder to breath.

R22's dialysis company's Progress Note dated 10/22/24 at 8:30 AM documented in part " .... Patient had been discharged from the hospital on 10/21/24. RN unaware of discharge from the hospital back to SNF (Skilled Nursing Facility). (V30/LPN) ... called and states 'We are having trouble with the patient's machine. It has been alarming for 20-30 minutes and it has not completed the last fill. The whole treatment is done but it hasn't done the purple bag' Writer advised (V30) to terminate the treatment and instructed to do a manual last fill. Discussed with (V30) supplies that were needed and would need to be picked up from dialysis facility ... spoke with (V2/DON). Discussed with her the conversation of the above with (V30). And RN concerned

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supplies had not been picked up. (V2) then asked about a manual last fill that should be put into the peritoneum. Writer gave instructions at this time. Last fill would be 1.5L or 1500ml. It would not have to be manually drained, that it would drain during the initial drain with treatment this evening ..."

R22's 10/21/24 through 10/22/24 dialysis company's Treatment Summary Report documented a cycler total on 10/22/24 at 8:48 AM of 1552 ml being in R22's peritoneal space.

On 3/13/25 at 9:00 AM, V1 (Administrator) said the facility was unable to produce any orders for R22 from the dialysis company. V1 said after reviewing R22's medical record no orders for what peritoneal dialysis solutions were being administered was ever written on R22's September 2024 or October 2024 Physician's Order sheets. V1 said she did not know how staff were completing R22's peritoneal dialysis with no written orders.

R22's Physician's Orders documented a 10/22/24 order documenting in part " ... T.O. (Telephone Order) Administer 1.5 L (Liters) of purple bag ... manually. Hold purple bag night of 10/22/24 ..."

R22's Nurse's Notes dated 10/22/24 at 11:15 AM and completed by V2 (DON) documented in part " ... This nurse received a call from (V28 Dialysis Registered Nurse) at (dialysis company) who gave T.O. to do a manual fill of 1500 ml (1.5L) to (R22). This nurse was instructed to come to (dialysis company) and pick up bag needed for manual fill ..."

R22's Nurse's Note dated 10/22/24 at 11:50 AM completed by V2 documented in part " ... This

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(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 36	S9999		

nurse returned to facility with dialysis bag needed for manual fill ... this nurse placed unopened box in (R22's) room and explained to (R22) what (dialysis company) wanted (V29/RN) floor nurse to do for her next appointment on 10/23/24. This nurse spoke to (V29) about what orders (V28) at (dialysis company) gave and what supplies were brought back ..."

R22's Physician's Orders dated 10/1/24 through 10/31/24 included a 10/22/24 order documenting in part " ... Administer 1.5 L (1500 ml) of purple bag (dialysate fluid) ...manually ..." No other orders for peritoneal dialysis were documented.

R22's Medication Administration Record (MAR) dated 10/1/24 through 10/31/24 documented no orders for peritoneal dialysis other than the 10/22/24 order for 1.5 L manual fill.

R22's Nurse's Note dated 10/22/24 at 12:30 PM completed by V29 documented in part " ...(R22) was doing well this AM had visitor, awake, conversating. No (signs/symptoms) of distress. Was called to room by staff. (R22) was noted to be in respiratory distress (blood oxygen saturation) in the 70's placed on (oxygen at 5 Liters via nasal cannula oxygen saturation) wouldn't go above 81. States 'I can't breath' (Blood pressure) 88/42 ... Lung fields sound "tight" to auscultation ... Sending to (hospital emergency department) ..."

R22's Nursing Home to Hospital Transfer Form dated 10/22/24 completed by V29 documented in part " ... Additional Relevant Information ... Just completed (peritoneal dialysis) last bag by gravity she said she feels like her stomach is about to blow up. Unable to breath (blood oxygen saturation) in the 70's. Placed on (5 Liters of

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	IL6004881	A. BUILDING: _____ B. WING _____	C 03/25/2025

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S9999	Continued From page 37 oxygen blood oxygen saturation) 70's-81 ..." R22's Emergency Department Encounter dated 10/22/24 documented in part " ... presents to the (Emergency Department with) severe shortness of breath ... is dusky and diffusely cyanotic (oxygen saturation) 80's on (15 liters of oxygen via non-rebreather) on arrival, panting ... abdominal distention noted ... repeating help me ... (R22) was intubated due to respiratory distress ..." R22's Progress Notes & Medical Decision Making form dated 10/22/24 documented in part " ... Seen and assessed on arrival, weak inspiratory effort, dusky and mottled on arrival. Intubated due to severe respiratory failure ..." R22's hospital Progress Note dated 10/22/24 at 6:00 PM by dialysis nurse documented in part " ... Initial drain >3900 ml abdomen is no longer firm ... Reported (initial drain) volume to primary RN ..." R22's ICU (Intensive Care Unit) Progress Note dated 10/23/24 documented in part " ...Assessment and Plan ... Pulmonary: Acute hypoxemic respiratory failure: intubated due to respiratory distress. Continue managing the mechanical ventilation for respiratory failure to prevent imminent deterioration and further organ dysfunction from hypoxia and hypercarbia ... Renal: ... Nephrology is following. ?excessive (sic) dialysate instillation at NH (Nursing Home) as 4L removed overnight ..." R22's ICU Progress Note dated 10/26/24 documented in part " ...Assessment ... Acute respiratory failure with hypoxia status post intubation on mechanical ventilation, extubated	S9999		

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S9999	Continued From page 38 10/25/24 ..." R22's hospital Discharge Summary dated 10/4/24 through 10/21/24 documented a 10/21/24 chest Xray documenting in part "... Impression: Suggestion of small bilateral pleural effusion with bibasilar atelectasis or pneumonia ..." The facility's 10/30/24 final report regarding R22's 10/22/24 incident documented in part " ... On 10/22/24 at approximately (3:00 PM) this administrator was notified that (R22) was noted to be in respiratory distress and was being sent to the (hospital) for evaluation ... Investigation reveals that (R22) was connected to the dialysis cycler at approximately (8:00 AM). The cycler continued to alarm, was turned off and (dialysis company) notified. At approximately (11:15 AM) the facility received orders from (dialysis company) for a manual fill of 1.5 L bag. (V2) picked up supplies from (dialysis company) which were (sic) 2.5 L bags. (V29) and (V30) connected (R22) to the manual fill bag at approximately (12:00 PM). At approximately (12:30 PM) (V29) was notified by staff (R22) appeared to be in (respiratory) distress ... sent to (hospital) for evaluation ... In conclusion, the facility was able to substantiate that (R22) experienced an adverse reaction secondary to receiving a manual fill during peritoneal dialysis ..." "A"	S9999		