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S 000	Initial Comments Complaint Investigation: 2543903/IL191528	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

These Requirements were not met evidenced by:

Based on interview and record review the Facility failed to assess and treat a change of condition for 1 of 3 residents (R2) reviewed for change of condition. This failure resulted in R2 having a significant change in condition for several hours without interventions that ultimately required an emergency transfer in which her family called 911 and R2 experienced respiratory distress, was intubated en route to the hospital and placed on a mechanical ventilator.

The Immediate Jeopardy began on 5/2/2025 when R2 began to experience respiratory/breathing issues and was not sent to the hospital in a timely manner. On 5/8/2025 at 12:43 PM, V1, Administrator, V2, Director of Nursing (DON), V3, Assistant Director of Nursing (ADON), V17, Regional Nurse Consultant/ VP Clinical Services and V18, RDO/CEO (Regional Director of Operations) and CEO were notified of the Immediate Jeopardy. The surveyor confirmed by observations, record review and interview, that the Immediate Jeopardy was removed on 5/9/2025 but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in-service training.

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Findings include:

R2's Physician Order Sheets (POS) for May 2025 document, a diagnosis of Urinary tract infection, site not specified; Type 2 diabetes mellitus with diabetic neuropathy, unspecified; End stage renal disease; Dependence on renal dialysis; Heart failure, unspecified; Presence of cardiac pacemaker; and Essential (primary) hypertension. R2's POS also documents an order with a start date of 4/23/2025 for Oxygen up to 4 L (liters) Continuous.

R2's Minimum Data Set (MDS) dated 2/11/2025 document R2 was cognitively intact for decision making of activities of daily living.

R2's Care Plan does not address any oxygen use and/or respiratory issues or her dialysis.

R2's Progress Notes dated 4/4/2025 at 10:15 AM, 95 yo (year old) female readmitted to (Facility) on 4/3/25 from (Hospital) for pulm (pulmonary) edema. Res (Resident) returned with on O2 (oxygen) 2L/NC (2 liters nasal cannula). Per facility nurses' notes, resident vitals were stable with O2 sats (saturations) at 91%, no cough, pain or discomfort, A&O X2-3 (alert and orientated x 3) with intermittent confusion."

On 5/7/2025 at 11:00 AM, V5, Family of R2 stated, "I got a call from the facility around 7:00 PM, I was in my pajamas. They told me my mom was having a panic attack. When I got there at the facility my mom was not having a panic attack, she was gasping for air, and she was in distress. It was unimaginable seeing her like that. I got to the facility about 8:00 PM and seeing my mom gasping for air I tried to find a nurse, and

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could not find anyone, so I called 911 because something was not right. My mom is still at the hospital, but she is on a ventilator now and we have to decide if we want to keep her on it. I don't know why (Facility) did not send my mom out when she started having problems, I am at loss."

R2's Progress Notes dated 5/2/2025 at 8:45 PM, "This writer was doing med (medication) pass and CNA's (certified nursing assistants) on the hall attempted numerous times to reposition resident to get resident comfortable, and with no success. CNA took O2 (oxygen) and was stating at 76% on 2L (liters). This nurse tried 4L of Oxygen with no success of bringing O2 stats above 76%. Call was placed to daughter to see if she could come out and help. Daughter could not calm resident down and finally called 911 for her mother. At approximately 8:50 PM EMS (Emergency Medical Services) arrived to transport resident to (Hospital)." R2's Progress Notes does not document the Physician was notified.

On 5/6/2025 at 8;44 AM, V4, Emergency Medical Service Staff stated, "(V5, Family of R2) called EMS yesterday on 5/2/25 around 9 PM. She reported (R2) had been complaining of shortness of breath since the afternoon and the nurse (V6) did nothing for her and just told her to 'calm down'. No information was provided him upon arrival, and we did not get a handoff report. When EMS arrived, (R2) was in respiratory distress, not arrest, and did not go into arrest because they gave her a lot of ketamine. We did attempted intubation x 2 unsuccessful, and then had to use an I-gel for airway. R2 was transferred to (Hospital)."

R2's EMS (Emergency Medical Services) report

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dated 5/2/2025 at 9:07 PM, documents, "Dispatch reason: breathing problems, primary symptoms: Shortness of breath, Providers primary impression: Respiratory failure, unspecified. Narrative documents was dispatched to (Facility) for a 95 year old F (female) with shortness of breath. EMS responded emergent and arrived on scene without incident. EMS went inside the building and was directed to the PT (Patient's) room by the PT's daughter. PT's daughter reports that she called 911 after she found her mother lying in bed struggling to breathe. Pt's daughter reports the PT received dialysis earlier in the day. EMS found the PT sitting semi-fowlers (lying in bed with the head and upper body elevated to an angle of 30 to 45 degrees) in her bed. PT was a & o (alert and orientated) x 2 with a weak radial pulse, shallow and rapid respirations, and an open airway. PT's skin was flush and blue in extremities. PT was wearing a nasal cannula set at 6 lpm O2 (oxygen). EMS obtained a pulse Ox reading of 50. (Normal 92 or higher). EMT went to find the PT's nurse to obtain a report for the PT. Nurse came by to tell EMS that she is printing the PT's demographics and states that PT has been struggling to breathe for several hours. Nurse reports she came into the PT's room several times to tell her to calm down and slow her breathing for several hours. Nurse left the room, and EMS placed the PT on the stretcher and NRB at 15 lpm. EMS never received a throughout PT care report from the nurse nor was given the PT demographics. PT demographics were obtained from the hospital. EMS brought the PT to the ambulance and obtained vitals, attempted IV (intravenous) access 3x with 1 success, obtained 4-lead DKG, and placed the PT on CPAP with albuterol in line, EMS left the scene en route to (Hospital) emergent. PT began to become more lethargic and slowed her

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respirations while on CPAP. EMS determined the PT would inevitably go into respiratory arrest and began prepping for intubation. EMS estimated the PT weighed roughly 80 kg (kilograms). EMS began ventilating the PT via BVM and administrated 150 mg (milligrams) Ketamine. EMS attempted intubation 2x without success and placed a size 4 I-gel with success. EMS contacted (hospital) with their inbound report and received no questions or orders. EMS shortly arrived after without incident. (all times are approximate)."

On 5/7/2025 at 2:12 PM, V7, Certified nursing assistant (CNA) stated she works full time in the facility. She only takes vitals if a nurse would ask her, as usually they like to do it themselves. Vitals would be blood pressure, temperature, pulse, and oxygen. Anything like that. If she would chart vitals then they would be in the electronic medical records under vitals.

On 5/8/2025 at 2:17 PM, V9, CNA stated she has been working here in the facility for two years. CNA's can take vitals, but don't normally take vitals. She will take vitals if a nurse asks her to, but the nurses usually do not ask her. Vitals would include temperature, blood pressure, pulse and oxygen. All vitals are documented in the resident's electronic records under the vitals tabs.

On 5/8/2025 at 2:19 PM, V10, CNA stated, she had been working in the facility for over a year now. "If a nurse asks me I will take vitals, but the nurses usually take their own vitals. If I would ever take a vital, I would put it in the computer under vitals. I am not aware of (R2) ever having panic attacks."

On 5/7/2025 at 10:33 AM, V11, Licensed Practical

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Nurse (LPN) stated she likes to take her own vitals, blood pressure, temperature, pulse oxygen. If a resident is experiencing a change of condition, she will always take their vitals. Vital are then charted in the computer under the vital section. "(R2) would yell at a lot and scream if she wanted something. She was cognitively intact and was redirectable. I am not aware of her refusing care or needing her family to get her in order for her to do something. She was on dialysis on Mondays, Wednesdays, and Fridays, and she was on oxygen. I am not aware of her ever having panic attacks."

On 5/7/2025 at 4:04 PM, V12, CNA stated, "(R2) was able to tell you what she wanted. She would yell and scream if she wanted something. She likes to try and stay up until 7:30 PM most nights and then she would fall asleep in her wheelchair and not want to lay down. She was on oxygen and dialysis. I never saw her have any panic attacks. I don't usually take vitals."

On 5/7/2025 at 4:14 PM, V13, CNA stated, "I will take a vital if the nurse asks me to. Otherwise, I normally do not take vitals. If I take vitals I record it in the computer under the vital spot. (R2) was on dialysis and normally did not get back until later. (R2) is in the hospital right now. Her old roommate passed away. I am not aware of (R2) having any behaviors and/or panic attacks."

R2's Oxygen Vitals for May 2025 do not document any vitals were taken for R2 and/or documented as being performed.

R2's Emergency Room Visit Hospital Records dated 5/2/2025 document, "On EMS arrival patient the patient was cyanotic with a SPO2 of 50% with labored breathing. She was placed on a

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non-re-breather mask and then CPAP with an increase of her SPO2 to the 70's. Eventually an LMA (laryngeal mask airway) was placed, and she was bagged on arrival. Due to high probability of clinically significant, life-threatening deterioration, the patient required my highest level of preparedness to intervene emergently, and I personally spent this critical care time directly and personally managing the patient. The patient was evaluated by myself in the emergency department. History obtained from EMS report along with patient's daughter who arrived shortly after EMS and physical exam was performed/ external medical records were reviewed at this time. IV (intravascular) was established and pertinent tests were ordered. EMS did attempt to intubate the patient prior to arrival to the emergency department and they were unsuccessful, an I-gel was placed at this time and patent is currently bagged. Shortly after arrival to the emergency department, patient was intubated due to hypoxic respiratory failure and severe respiratory distress. Shortly after intubation, patient's blood pressure dropped, and patient is currently mapping less than 65. Patient was administrated 1 L (liter) IV fluid bolus with normal saline without any improvement of her blood pressure and at this time she was started on pressors with norepinephrine due to concern for shock. Review of Systems was unable to be obtained as R2 was on mechanical ventilation."

On 5/7/2025 at 9:25 PM, V14, Wound Nurse Licensed Practical Nurse (LPN) stated, "I remember that night because I got called in because another nurse did not show up. When I walked in the door, they handed me the keys to the med cart and then the phone rang, and I was on the phone for over 30 minutes. (R2) was hollering and yelling all night. 'I can't breathe, I

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can't breathe' we were telling her to calm herself down and I am in the middle of a medication pass. Her oxygen level was 76% but I think she was in a panic attack, and we were trying to get her to calm down. I did not take her oxygen, but I watched (V15, CNA) take it and it was at 76 %. I am not sure if I contacted the doctor. We normally send residents out to the hospital when the oxygen is 84% or less. I did not send (R2) out because it was a crazy night, and I thought (R2) was having a panic attack and just wanted someone to sit with her. We contacted her daughter and she came and she was the one that called 911."

On 5/7/2025 at 9:55 PM, V15, Certified Nursing Assistant (CNA) stated, "(R2) started yelling out for help, she was yelling I can't breathe, I can't breathe. I went into her room to check on her. It seemed like (R2) was having a panic attack. I had to answer a few more call lights, and (R2) continued to yell out. I called her daughter, and she came out because I thought she was having a panic attack. We got two admits back-to-back that night, so we were busy. Then, I think her daughter called 911. We did not call 911. I did take vitals on (R2) but I can't remember what they were. I wrote them down a piece of paper and gave them to (V14). I did not put them in the computer."

On 5/8/2025 at 7:46 AM, V16, Medical Director stated, "I would expect all oxygen levels to be at 92% or higher. If a resident was stating they could not breathe and their oxygen levels were 76 % I would expect staff to ensure the resident was not in distress, maybe change the tank, make sure everything was working, if the levels did not improve then I would have them send them out immediately. If they were in distress, I would want

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them sent out immediately. I was not aware of (R2) I get so many calls I cannot say if I was or was not contacted. Nothing is coming to my mind, but if she was distressed and the levels were not improving, I would of wanted her sent out immediately."

On 5/8/2025 at 12:24 PM, V2, Director of Nursing stated, "I expect all vitals to be charted and, in the resident's, medical records. I was not aware (R2) was in distress with her oxygen levels."

The Facility undated Change of Condition Policy documents, "To ensure that medical care problems are communicated to the attending physician or authorized designee and family/ responsible party in a timely, efficient, and effective manner. A significant change in the residents' physical, mental, or psychosocial status (i.e.) deterioration in health, mental, or psychosocial status in either life- threatening conditions or clinical complications); A decision to transfer or discharge the resident from the facility."

IJ Abatement:
1. R2 is no longer in facility. 5-8-25
2. Admin/DON were inserviced by VP of Clinical
3. Admin inserviced IDT team
4. Current staff inserviced on change of condition and notifying nurse. Change of condition, notifying MD, document vitals, SBAR, head to toe assessment, full set of vitals, and continued vitals. Completed by 5-8-25
2.Completed by VP of Clinical Services.
3.Completed by Administrator.
4. Completed by IDT team, DON, & administrator.
5. Last 30 days of change of conditions in residents have been reviewed to ensure that no

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other issues have been identified.
6. All residents with change of condition reviewing medical records.
7. Review of policy and procedures have been completed with MD. Reviewed & updated.
8. Initial change of conditions in residents nurse will notify MD and follow MD orders at the time of change of condition.
9. Noted change of condition where oxygen levels are below 92%, titrate it up 1L, recheck q 30 mins until O2 can reach 92%, if distress is noted notify MD. If no, change in condition MD is to be notified again. Standing order provided by MD. Being completed by VP of clinical, Director of Nursing, MD, and administrator by 5/9/25.
10. All working staff have been in -serviced on change of condition policy and procedure. Currently all staff on shift have been in-serviced. Total facility staff in-serviced at 75%. 100% completion will be done by 5/9/25. Being Completed by IDT team, DON, administrator, and/or designee by start of next worked shift.

11. No staff will work before being in serviced on change of condition.

Ongoing - Beding completed by IDT team, DON, administrator, and/or designee by start of next working shift.

12. A Quality assurance tool was implemented; daily audit of the 24 hour report and dc notices for change of conditions, vitals, dc notes, and MD notification if there is a noted change of condition. Audits to continue daily x4 weeks to ensure that change of condition is documented. 5/9/25

Audits complete by: DON/Designee
13. Root Cause Analysis completed for Change

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S9999	Continued From page 11 of Condition Deficiency: Failed to assess change of condition. Root Cause: Attached Initiated: 5/8/2025 (A)	S9999		