Final Observations

Statement of Licensure Violation:
Complaint #2047840/IL127411
1 of 1 Violation

300.610a)
300.1210b)
300.1210(d)(3)
300.1220b(2)
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 300.1210 General Requirements for Nursing and Personal Care
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETE DATE</th>
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<td>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. Restorative measures shall include, at a minimum, the following procedures:</td>
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<td>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:</td>
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<td>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.</td>
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<td>Section 300.1220 Supervision of Nursing Services</td>
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<td>b) The DON shall supervise and oversee the nursing services of the facility, including:</td>
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<td>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements,</td>
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<td>S9999</td>
<td>Continued From page 2 psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the Facility failed to complete timely assessments, to notify the physician of a change of condition, to monitor vital signs and to provide medical treatment in a timely manner for 1 of 3 residents (R48) reviewed for care and services in the sample of 8. This failure resulted in R48 being hospitalized on a ventilator and dying on 8/28/2020. This past noncompliance occurred from 8/2/2020 to 8/20/2020. Findings include: R48's Physician Order Sheet (POS), August 2020 documents a diagnosis of Alzheimer disease, anxiety, diabetes, cerebral vascular accident, (CVA) and chronic pulmonary disease. R48's Face Sheet documents a diagnosis of COVID-19 (undated).</td>
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R48's Nurses Notes dated 8/1/2020 documents, at 2 PM, "Spoke with (nurse) at local hospital where (R48) was admitted with diagnosis of pneumonia." The Nurses Notes do not document why R48 was being sent out to the hospital, or what symptoms R48 was displaying before being sent out to the hospital, or what her vital signs were.

R48's Nurses Notes do not have any other documentation for 8/1/2020. There was no documentation in R48's medical records of vitals being performed on R48 for 7/30/2020 or 7/31/2020. The last vitals documented for R48 was on 7/29/2020 at 11:15 PM, and there were no other vitals documented as being taken for R48 on 8/1/2020.

On 10/6/2020 at 10:32 AM, V13, Infection Control Preventionist stated, "we expect all residents especially those who are positive with COVID-19 to have vitals taken every 4 hours and documented. We had some issues with staff not taking vitals, but I think we are now on top of things."

R48's POS dated August 2020 does not document R48 went out to the hospital on 8/1/2020.

R48's Hospital Records "arrival date of 8/1/2020 at 12:32 PM, documents, "79-year-old sent in from the nursing home because of altered mental status. Patient apparently was seen this morning at the nursing home and found to be less responsive, short of breath, and Emergency Medical System (EMS) was called. Patient does admit to some diarrhea this morning."
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R48's Laboratory Results taken at the local hospital document R48 had a positive COVID-19 test on 8/1/2020 at 12:50 PM, and it was verified on 8/2/2020 at 7:00 PM.  
R48's Hospital Records dated 8/2/2020 documents a final diagnosis of COVID-19 and pneumonia. The records document, "(R48) looked considerable better on the day of the discharge than on the 3rd (August) so at this point in time, we feel comfortable in discharging her back to the nursing home."  
R48's Nurses Notes dated 8/5/2020 at 4:24 AM, "resident readmitted from (local hospital) New Orders sent to pharmacy, assessment complete. No signs or symptoms of distress noted, will continue to assess and monitor residents.  
R48's medical chart does not contain any more notes in charts until 8/14/2020 including daily vital signs being performed and documented by the facility.  
On 10/7/2020 at 8:25 AM, V53, Family of R48 stated, "Initially my mom went out to the hospital because her Oxygen was dropping, and they sent her out to the hospital she was tested at the hospital and was positive for COVID-19. That was on 8/1/2020. (R48) while she was in the hospital, she got better so they sent her back to the facility on 8/5/2020. Then 15 days later (August 20) her oxygen dropped again and they had to send her out again to the hospital but this time she never recovered. I am not sure they were monitoring her and keeping a close eye on her condition. They knew she had COVID I just don't understand.”  
Nurses Notes dated 8/20/2020 (no time | S9999 | |
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documented) R48's oxygen levels were documented at 72. "Resident has visible distress of breathing upon this nurse entering room this nurse and certified Nursing Assistant pulled resident up in bed and elevated, Head of Bed (HOB) non-rebreather applied, Oxygen levels increased to 81. This nurse notified on call Physician and orders received to send resident out. 911 dialed and resident transferred to hospital. Family notified and Doctor notified of resident transfer. Report called to (local hospital). R48's medical records do not document any other vitals were taken that day.

R48's POS dated 8/20/2020, "Send to Emergency Room for evaluation and treatment."

R48's Hospital Records dated 8/21/2020 documents, (R48) is a 79 year old Caucasian female with history of dementia, hypertension, cerebral vascular accident, (CVA), who was reportedly nonverbal and sent to the emergency room from (nursing home) due to shortness of breath. All history is obtained from the chart as she is unable to provide related to chronic encephalopathy. She was found to be hypoxic in the emergency room and was placed on 10 liters of oxygen. She was recently found to be COVID-19 positive on admission from August 1 to August 5th. She was admitted to the Intensive Care Unit (ICU) for further management. Reason for consultation, Acute hypoxemic respiratory failure."

R48's Hospital Records dated 8/28/2020 "79-year-old female with COVID-19, hypoxemic respiratory failure who initially improved and was weaned to nasal cannula but later developed aspiration, rapid Atrial Fibrillation (Afib) and required incubation and mechanical ventilation.
Continued From page 6

She had multiple comorbidities and was frail. This morning she developed cardiac arrest and protocol was implemented but she passed away at 9:26 AM."

On 10/6/2020 vital sign sheets were requested for R48 and no vital sign sheets were produced for R48 other than her vitals taken on the selective nurse’s notes.

On 10/8/2020 at 2:11 PM, V60, Nurse Practitioner stated, "For any resident who test positive we expect the facility to monitor vitals, listen to lung sounds, do temperatures, heart rate, Blood pressure, pulse, oxygen levels, to look at the residents for any signs or symptoms of shortness of breath, any respiratory issues going on, look at their level of conscientiousness, (R48) had dementia and when she came back from the hospital I know she was placed on the COVID unit. I was not there every day, but I would expect them to monitor her condition and document their results."


The CDC website page, "Responding to Coronavirus (COVID-19) in Nursing Homes, Updated 4/30/2020, document the facility should implement the following for residents who have tested positive for COVID-19 or who are experiencing the symptoms of COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vitals signs, oxygen saturations via pulse oximetry and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections; and Consider..."
Continued From page 7

increasing monitoring of symptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms."

The Policy provided by the facility for "COVID Monitoring" dated 7/7/2020 documents, "It shall be the policy to utilize accepted Infection Control Methods to prevent and Control the Spread of a respiratory illness, caused by Novel Coronavirus (COVID-19). Older adults and patients with comorbid conditions are at an increased risk for more severe illness. Actively monitoring for Coronavirus is an important aspect of the ongoing infection control program. Temperatures are taken daily of all residents and staff." This policy was outdated and does not follow the Center for Disease guidelines for increased monitoring for at least 3 times daily.

(A)