Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006555	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOKOMIS REHAB & HEALTH CARE CENTER	505 STEVENS STREET NOKOMIS, IL 62075

(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
S 000	Initial Comments Complaint #1646098 /IL89406 Statement of Licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 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 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:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:
Based on interview and record review, the facility failed to implement effective interventions to prevent pulling out a tracheostomy tube for 1 of 1 resident (R2) reviewed for tracheostomy care in the sample of 12. This resulted in asphyxiation and death of R2 on 9/25/16 at the facility.

Findings include:

R2's Physician Order Sheet (POS) for 9/2016 documents, in part, "Diagnoses: Intracranial Hemorrhage, Hemiplegia, Respiratory Failure, Tracheostomy, Gastrostomy. 9/2/16 Order Clarification: O2 (Oxygen) at 5 liters per tracheostomy mask at 35% humidity." R2's Physician Order (PO) dated 9/7/16 documents, "May place mitt on left hand."

R2's Minimum Data Set (MDS) dated 9/15/16 documents R2 has severely impaired cognitive skills for daily decision making, and totally dependent on staff for all activities of daily living (ADLs).

The Incident Report Form - IDPH (Illinois Department of Public Health) Notification dated 10/3/16 documents, "On 9/25/16 at 2330 (11:30 PM), staff entered (R2's) room and noted tracheostomy tube out. (R2) was a full code so CPR (Cardiopulmonary resuscitation) was initiated as per protocol. EMS (Emergency Medical Services) was dispatched. EMS arrived

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S9999	Continued From page 2	S9999		

approximately 2335 (11:35 PM) and they continued with CPR without success. Attempts were made to reinsert the tracheostomy tube without success due to swelling from the tube being pulled out with the cuff inflated. The Deputy Coroner was onsite with the EMS and pronounced (R2).

Upon investigation, it was noted that (R2) had a history of pulling at her tracheostomy tube, (indwelling urinary) catheter and gastrostomy tube. (R2) had a mitt to her left hand to keep her from pulling at the tubes. She was also on 15 minute checks. Interviews with staff show that CNAs (Certified Nursing Aides) were in the room at approximately 2315 (11:15 PM) to check on the resident and she was resting quietly with her tracheostomy intact and mitt in place. At 2330 (11:30 PM) the nurse on duty entered her room and noted her tracheostomy tube was out and CPR was initiated. EMS was also dispatched and continued CPR until their arrival. Attempts were made to reinsert the tracheostomy tube without success due to swelling at the site. (R2) was utilizing a #6 shiley cuffed tracheostomy tube. Upon review of her record, (R2) had a history of difficult intubation approximately 20 years ago which caused tracheal adhesions and stenosis. Approximately 3 years ago she had balloon dilation due to episodes of choking at home and it was discovered that she had the adhesions and stenosis." The Final Incident Investigation dated 10/3/16 documents E3, Licensed Practical Nurse (LPN), E6, CNA, and E11, CNA, were interviewed during the investigation.

R2's Care Plan, undated, documents, "Resident newly admitted with tracheostomy size #6 shiley. Routine tracheostomy care every shift and prn (as needed). Suction prn. 9/7/16 Wear mitt on left

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S9999	Continued From page 3	S9999		

hand due to pulling at tracheostomy tube, feeding tube and (indwelling urinary) catheter."

R2's Nursing Admission Assessment, dated 9/2/16, documents, "ADL (Activities of Daily Living) Functional Abilities: Right arm and right leg with no movement since Intracranial Hemorrhage on 8/21/16."

R2's Nurse's Note, dated 9/5/16 at 2000 (8:00 PM) documents, "Resident noted pulling at trach (tracheostomy) mask."

R2's Nurse's Note, dated 9/6/16, at 0100 (1:00 AM) documents, "Resident restless in bed pulling at Oxygen mask and removing it."

R2's Nurse's Note, dated 9/7/16 at 1315 (1:15 PM) documents, "Resident has pulled on tracheostomy times 2 - has removed inner cannula. Family reports hospital had left hand restricted as to not pull on trach. Phoned MD for mitt for left hand."

R2's Nurse's Note, dated 9/18/16, at 0020 documents, "Resident continue to pull at G-tube (Gastrostomy tube) and tracheostomy this shift."

R2's Nurse's Note, dated 9/25/16, at 2300 (11:00 PM) documents, "Resident resting quietly. Respirations even, unlabored."

R2's Nurse's Note, dated 9/25/16, at 2330 (11:30 PM) documents, "Went to resident room to give medication. Went to get flush kit. Noted resident trach out and resident not breathing. 911 called. CPR started. EMTs arrived took over CPR." The Nurse's Note documented "At 2335 "(Z3, Coroner) here, CPR stopped. No sign of life."

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S9999	Continued From page 4	S9999		

R2's Resident 15 Minute Check Monitoring Sheets for 9/2016 document R2 was monitored from 9/3/16 through 9/25/16 for being at risk due to tracheostomy. The Resident 15 Minute Check Monitoring Sheet dated 9/25/16 documents last time R2 was checked at 11:15 PM R2 was asleep and calm.

On 10/26/16 at 10:40 AM, E2, Director of Nursing (DON), stated the facility had only one resident with a tracheostomy and that was R2 and the facility did not have any resident with tracheostomy after R2 expired. E2 stated she worked on the floor and took care of R2 on 9/18/16 and caught R2 with her mitt off several times and pulling at her trach. E2 stated she did not actually observe R2 take her mitt off.

On 10/26/16 at 11:20 AM, E3, LPN, stated she had seen R2 without her mitt on but she had never seen R2 take her mitt off. E3 stated that on the night of 9/25/16 she saw R2 without her mitt on but R2 was not trying to pull her trach when she did rounds at 11:00 PM. E3 stated when she returned to give R2 her medication at 11:30 PM, R2's mitt was off, and her trach was out. E3 stated R2 was not breathing and she called 911 and initiated CPR. E3 stated EMS arrived and continued CPR and attempted to reinsert the tracheostomy tube without success, E3 stated R2 was pronounced at 11:35 PM.

On 10/26/16 at 12:15 PM, E6, CNA, stated she did the 15 minute check on 9/25/16 at 11:15 PM and R2 had her mitt on and she was calm, comfortable and her trach was in place. E6 stated that in the past she had caught R2 with the inner cannula of her trach out and reported it. E6 stated she had seen R2 with her hand on her trach, but had not actually seen her take it out because she

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S9999	Continued From page 5	S9999		

would stop R2 from pulling it out.

On 10/26/16 at 1:40 PM, E4, LPN, stated she had never seen R2 remove her mitt, but she had seen her without it and immediately put it back on.

On 10/26/16 at 4:10 PM, E5, LPN, stated she had not seen R2 take her mitt off. E5 stated she had seen R2 without it and put the mitt back on R2's left hand.

On 10/26/16 at 4:12 PM, E7, CNA, stated she had not witnessed R2 took off her mitt or pull out her tracheostomy, but she has seen R2 without her mitt and reported it to the nurse on duty.

On 10/27/16 at 10:32 AM, E8, LPN, stated she had seen R2 rubbing her mittened left hand against her side to take the mitt off. E8 stated she noticed R2 doing this shortly after R2 was ordered the mitt. E8 stated she would put the mitt back on R2 right away.

On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 without the mitt on while doing the 15 minute checks and E10 would put the mitt back on R2 right away. E10 stated she had not seen R2 with her trach tube out.

On 10/27/16 at 10:42 AM, E9, CNA, stated she had seen R2 try to take off her mitt by putting it under her right arm and wiggle her left hand out of it. E9 stated she would always put it back on R2's left hand and report it to the nurse. E9 stated she had noticed R2 trying to take off her mitt as soon as R2 was made to wear it.

On 10/27/16 at 3:10 PM, when asked if she reviewed or reassessed the current interventions in place to prevent R2 from pulling her

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S9999	Continued From page 6	S9999		

tracheostomy tube, E2 stated, "It took (R2) awhile to take off the hand mitt and staff were there to check on (R2) every 15 minutes. " E2 stated she was not aware before 9/18/16 when she took care of R2 as floor nurse that R2 was pulling at her trach. E2 stated nobody reported to her about it.

On 10/31/16 at 8:15 AM, when asked, "Would you say that the trach being pulled out at that time led to (R2's) expiration? " Z4, Deputy Coroner stated, "Yes. The trach was her only means of breathing. I was there and I tried to reinsert the trach myself without success. When we got there (R2) was gone."

On 10/31/16 at 8:48 AM, when asked, "Would you say that the trach being pulled out on 9/25/16 when R2 was found not breathing led to her expiration? ", Z3, R2's Physician, stated, "(R2) was pretty sick. But the trach being pulled out at that time could have a lot to do with her expiration."

The Facility Policy on Tracheostomy Care, undated, documents, "Residents who have tracheostomy will have trach care done daily, or when needed to keep the airway clean and unobstructed. "The Facility Policy related to tracheostomy care did not address appropriate interventions to keep a resident with tracheostomy safe when they show signs of attempting to pull out their tracheostomy tube.

(A)

Imposed Plan of Correction
Nokomis Rehab and HCC
November 3, 2016 complaint# 1646098/IL89406
Violation: A

300.610a)

300.1210b)

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
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:

Section 300.3240 Abuse and Neglect
a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions. The assessments for all residents identified as risk for harm as a result of facility failure to implement the facility's Tracheostomy Care policy will be reviewed and the facility's policy will be revised as necessary based on the outcome of the review.

II. Nursing staff will be in-serviced on the facility's Tracheostomy Care policy. The nursing staff will be in-serviced on thorough nursing assessments and safety interventions for residents requiring respiratory care. The in-services will cover, at a minimum, knowledge and implementation of accurate assessment and monitoring of residents with artificial airways including but not limited to tracheostomy care, ensuring tracheostomy stays intact and adequate respiratory care is provided, accurate report of incidents and follow-up of incidents identifying causative factors, resident changes or indicators that may require reassessment or other interventions to prevent harm and or adverse effects.

III. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

IV. The Administrator and Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Corrections.

Attachment B
Imposed Plan of Correction