STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002364	A. BUILDING: _____ B. WING _____	C 02/11/2017

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S 000	Initial Comments Complaint #1760663/IL91520 STATEMENT OF LICENSURE VIOLATIONS:	S 000		
S9999	Final Observations 300.610a) 300.1035a) 300.1035d) 300.1035e) 300.1210a) 300.1210b) 300.1210d)2) 300.1810b) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents'	S9999	Attachment A Statement of Licensure Violations	

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right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights.

d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record.

e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70]

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

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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.

Section 300.1810 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or

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S9999	Continued From page 3 neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on record review and interview, the facility failed to honor Advance Directives regarding Cardiopulmonary Resuscitation (CPR) as documented on the Physician Order for Life Sustaining Treatment (POLST) by failing to ensure resident requests for Advance Directives regarding Cardiopulmonary Resuscitation (CPR) were accurately incorporated into residents' medical record and physicians' orders for one of 27 residents (R1) reviewed for Advance Directives in the sample of 39. This failure resulted in R1 not receiving CPR when found unresponsive and subsequently expiring. Findings include: The facility's policy Advanced Directive Policy and End of Life Decision Making dated 12/20/12 documents, "Purpose: To establish guidelines to ensure that resident's rights are provided opportunity and education on determining advance directives and the right to accept or decline treatment and other related interventions. ...The resident's choices will be documented in the medical record and orders related to treatment, care, and services. ...The facility will identify, clarify, and periodically review as part of the care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. ... The facility will also on an ongoing basis review the resident's condition and existing choices and	S9999		

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modify approaches as appropriate. This would include a review for a resident condition change, significant decline or improvement in the resident's status."

The facility's policy Do Not Resuscitate (DNR) Order dated 1/7/01 documents "... Emergency Medical Services will ONLY recognize the standard form. A photocopy in the chart will not suffice..."

R1's Electronic Profile Sheet documents R1 was admitted to the facility 1/12/16, subsequently discharged to the hospital 12/28/16, and re-admitted to the facility 12/29/16.

R1's Physician Order for Life-Sustaining Treatment (POLST) dated 1/15/16, signed by R1, Z3 (R1's former Nurse Practitioner), and witnessed, documents "Attempt Resuscitation/CPR", and "Full treatment: Primary goal of sustaining life by medically indicated means including the use of intubation, mechanical ventilation and cardioversion, ... medically administered nutrition including feeding tubes."

R1's Social Service History and Assessment date 1/19/16 documents an option for DNR (do not resuscitate) which was not selected by R1.

R1's Care Plan dated as initiated 1/15/16 documents a focus area "pursuant to resident rights resident has elected full code status." The goal outlined in R1's Care Plan documents, "the resident's wishes for full code status as specified in (R1's) advanced directive document will be honored and clearly delineated in the medical record in compliance with state law." The interventions for R1's Care Plan were

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S9999	Continued From page 5 documented as "...document the code status on the POS (physician order sheet) ...." R1's Electronic Physician Order History documents physician orders dated 1/13/16 as "Full Code", dated 2/11/16 as "Full Code", and dated 12/29/16 as "DNR". The electronic Physician Order dated 12/29/16 does not match R1's POLST form. R1's Hospital Discharge Orders for R1 dated 12/29/16 documents "yes" and "no" selection boxes for the option "DNR" and this discharge order documents R1 as "DNR, NO". R1's Electronic Progress Notes dated 1/13/17 at 9:30 am, entered by E5, Nurse Practitioner, document R1 was "sitting up in the wheelchair, was continuing to work with therapy services, had no health complaints, was eating meals, had recently completed a course of antibiotic treatment due to a urinary tract infection, (R1's) recent blood laboratory values had no significant findings, no distress, and no pain." There were no subsequent progress notes in R1's medical record until 1/16/17 at 9:39 am. R1's Progress Note dated 1/16/17 at 9:39 am, entered by E6, Licensed Practical Nurse (LPN), documents, "upon entering (R1's) room, (R1) was cold, clammy, pale color to skin and labored breathing. VS (vital signs) 100.4 (temperature), 82 (pulse), 26 (respirations), 101/85 (blood pressure). 82 percent oxygen saturation on room air. PERRLA (pupils equal, round, reactive to light and accomodation), pulse was weak and hard to palpitate in wrist and pedal pulse. Apical pulse was attempted but wasn't able to be heard. Equal weak grips. 2 L (liters) of O2 (oxygen) was applied and oxygen (sat) (saturation) is now	S9999		

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stable at 90 percent. Resident has a slow response to verbal communication. (R1's) lower extremities are cold to touch and mottled up to hip. (E5) NP (Nurse Practitioner) completed an assessment on resident. She ordered the family be notified, continue on oxygen and keep resident comfortable. Resident's POA (Power of Attorney) (Z2) was notified of the change in condition and was advised to call the family. Resident is a DNR status."

R1's progress note dated 1/16/17 at 9:56 am, entered by E6, LPN, documents "Spoke with POA via phone in regards to resident's change in condition. The resident had a major decline in health. He (POA) was advised to call the family to visit (R1). POA stated he was the only family resident has but will come sometime today."

R1's progress note dated 1/16/17 at 12:26 pm, entered by E6, LPN, documents "resident has passed away at 10:30 am, discharged to (funeral home)."

On 2/2/17 at 9:22 am, E1, Administrator, stated, "(E10, LPN) was the nurse who entered the orders from the hospital upon (R1's) readmission from the hospital. The discharge orders from the hospital documented DNR = NO. (E10, LPN) was adamant about she thought the hospital orders documented DNR. (R1) was supposed to be resuscitated, (R1) was a full code. The orders were put into the computer as DNR. (R1) was a full code from a prior admission here at our facility. When (R1) died, the nurse on duty (E6, LPN) looked at the computer which said DNR, and then looked at our book which didn't match the computer. By the time we verified (R1's) code status, it was too late, we didn't call 911, we called the coroner to investigate. Our nurse

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practitioner (E5) was involved with the death (of R1), she was the one who found the computer and book didn't match. We did check with the hospital to make sure (R1) didn't have any new advanced directive while (R1) was there, but there wasn't. It was our mistake. (R1) is his own person, his brother (Z2) is not the legal power of attorney."

On 2/2/17 at 12:06 pm, E3, Social Services director, stated, "With all new admissions either the resident or the POA will decide the code status, I write it on the POLST, I usually sign as a witness, then take the POLST to (E5, NP) and she signs it. Right across the desk (from E5) is (E11, Quality Assurance Nurse) who puts the code status in the Physician Orders on the computer. (R1) was a full code. For re-admissions, the nurse puts the orders into the computer."

On 2/2/17 at 1:25 pm, E4, Acting Director of Nursing (Assistant Director of Nursing), stated, "When a resident stops breathing or having a heartbeat, I expect the nurses to look in the computer to verify a resident's code status, the second place to look is the code status books for the POLST which are on each medication cart for every resident in the building, and the third option would be to look in the social services office. I worked as an emergency room nurse, so I know seconds mean lives, so I would start CPR on everybody unless I have the POLST right there in front of me that says not to. If there is any doubt as to a resident's code status, I would start CPR."

On 2/2/17 at 1:44 pm, E5, Nurse Practitioner, stated, "The nurse called me to come assess (R1) and I looked at (R1's) code status in the computer. Unfortunately, the status was not

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correct. Typically, it is the nurse who puts the orders into the computer when a resident is readmitted from the hospital."

On 2/2/17 at 2:00 pm, E8, Registered Nurse, stated, "We have code status books on our medication carts, also in the computer. My preference is to look at the hard copy in the book because that is where the DNR form (POLST) is signed by the resident. We used to have marks on the resident's charts, but we don't use the charts anymore, just the computer."

On 2/2/17 at 2:03 pm, E7, Registered Nurse, stated, "I look on the monitor (computer) for code status, also there is a book in the bottom drawer of the medication cart, and the POLST has a copy scanned into the computer."

On 2/2/17 at 2:13 pm, E9, LPN, stated, "Each resident's code status is in a book in the bottom drawer of our medication carts and in the computer system."

On 2/2/17 at 2:35 pm, E2, Director of Nursing, stated, "We found in the computer (R1) was supposed to be DNR, but we found in the books and clinical documents (R1) was a full code. I expect the nurses to look on the computer, or the book on the med cart with the copy of the POLST."

On 2/2/17 at 3:17 pm, Z1, Primary Care Physician for R1, stated, "If a resident has chosen to initiate CPR and is to have full medical treatment to sustain life, then yes I would expect the staff to initiate CPR if the resident has no pulse and no respirations, they needed to make an attempt. If (R1) was in declining health, they could have sent (R1) to the hospital for acute

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S9999	Continued From page 9 treatment." On 2/3/17 at 1:54 pm, E6, LPN, stated, "Around breakfast time on (1/16/17) (R1) wasn't feeling too good, and wasn't looking too good. (R1) was cold and clammy, I had difficulty checking for a pulse, and (R1) was mottled. I asked the NP (E5) to come and check on (R1) and do an assessment, and I put oxygen on (R1). The NP (E5) checked the code status in the computer and (R1) was listed as DNR. The NP said we would not send (R1) to the hospital since (R1) was DNR, just keep (R1) comfortable. We decided to move (R1) to another room for privacy in case his family wanted to come visit. As soon as (R1) was taken to the other room, they came and told me (R1) wasn't breathing. I went to the room and there was no pulse and no respirations. It was less than an hour between our assessments and the time (R1) passed away. When the coroner came to the facility, he asked for a copy of (R1's) DNR sheet, and that's when I noticed the sheet said he was supposed a full code. By that time, it was too late to begin any CPR." The Certificate of Death Worksheet certified dated 1/19/17 documents (R1's) date of death as 1/16/17 and the cause of (R1's) death as Acute Myocardial Infarction and Acute Congestive Heart Failure. This cause of death was determined by Z1, R1's Primary Care Physician. AA	S9999		