| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6014872 | A. BUILDING: _____ B. WING _____ | 06/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BETHANY REHAB & HCC | 3298 RESOURCE PARKWAY DEKALB, IL 60115 |

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| S 000 | Initial Comments<br><br>Licensure Findings | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610<br>300.1030a)<br>300.1210b)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1030 Medical Emergencies<br><br>a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:<br><br>1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>acute respiratory distress, failure, or arrest).<br><br>2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).<br><br>3) Traumatic injuries (for example, fractures, burns, and lacerations).<br><br>4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).<br><br>5) Other medical emergencies (for example, convulsions and shock).<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident<br><br>These Regulations are not met as evidenced by:<br>Based on interview and record review the facility failed to seek emergency medical treatment for a resident with a rapid change in condition. This failure resulted in R15 being found unresponsive | S9999 | | |

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| S9999 | Continued From page 2<br>and requiring CPR (cardiopulmonary resuscitation).<br><br>This applies to 1 of 15 residents (R15) reviewed for change of condition in the sample of 15.<br><br>The findings include:<br><br>The nurses note written by E16 Registered Nurse (RN) dated December 27, 2016 for R15 shows, "Upon arrival at 0700 (7:00AM) I got report from the night shift nurse who stated that R15 was not feeling well, her blood sugars had been lower than usual throughout the night but had stabilized at 93. I held her morning insulin and encouraged her to eat some breakfast which she ate some fruit and drank some orange juice and I would check her sugar before lunch. I checked on her again and she said she wasn't feeling well and she was tired. Her lungs sounded coarse and I could hear some secretions in her throat that she was attempting to cough up. At 1103 (11:03 AM) I checked her blood sugar and it was 83. I got her to sip some orange juice and I checked her oxygen saturations which were 87%, and I also asked her to state her name, the year, and where she was. She stated her name, that she was in rehab, but thought it was 2006 I bumped her oxygen up to 5L (5 liters). I called the doctor at this time and talked to the nurse who I reported all of her symptoms too. She stated she would have the doctor call back as soon as possible. At 1135 (11:35 AM) I went back in to check her again and her oxygen saturations had dropped to 73. I placed her on her CPAP (continuous positive airway pressure). She continued to drop to 65. I placed her on a 15L (15 liter) non-rebreather. Her sats (oxygen saturations) came up to 93%. I attempted to give her a nebulizer treatment at this time which lasted 5 | S9999 | | |

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minutes before her oxygen saturations dropped again. And I put her back on the non-rebreather. I placed another call to the doctor at 1210 (12:10 PM). I reported further changes in condition including the fact that she was still confused, and her drop in oxygen requiring a non-rebreather. The nurse stated that the on call doc and the nurse practitioner were both in rooms and that as soon as she could get one of them I would receive a call back. At 1230 (12:30 PM) I went in to check on R15, she was still on her non-rebreather at 15L sating 92%. At 1255 (12:55 PM) I went back in to check on her and noticed her oxygen tank was getting low but she was looking at me and shaking her head "yes", so I ran to grab a new oxygen tank, upon arriving back to her room at 1256 (12:56 PM) R15 was unresponsive. I checked for a pulse but could not find one. I ran and grabbed the closest nurse I could find and she checked for a pulse as well and could not find one. I ran to grab the crash cart and asked for someone to call 911 and for more help in the room. CPR (cardiopulmonary resuscitation) initiated at 1300 (1:00 PM) and continued until paramedics arrived at 1308 (1:08 PM). The doctor called back at 1310 (1:10 PM)."

On June 7, 2017 at 8:30 AM, E16 RN stated, she came in at 7:00 AM and got report from the night shift nurse. She was told that R15 hadn't been doing well. She was seen the day before by the doctor. Her blood sugar was low. She checked on her and she was ok and responsive. She was doing morning medication pass and checked her blood sugar. It was in the 80's. She gave her some juice. The Certified Nursing Assistants (CNAs) came in to clean her up and turn her. She became short of breath. Her oxygen saturation was low. She went to talk to the Assistant Director of Nursing (ADON) and

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Director of Nursing (DON). They said to wait until the doctor called back. She continued the non-rebreather and called the doctor again to send her out to the hospital. She never got a call back. She went to check on her again, asked her a question, she nodded yes. She left to get a new oxygen tank and when she came back she didn't have a pulse. She started the code. She felt R15 needed to go to the hospital. "I was told by the DON and ADON not to send her out because the doctor had seen her prior and to wait for them to call back. I finally did get a call back but the paramedics had already taken over. The nurse said to send her to the hospital. When I found her unresponsive, I left to get a nurse. I grabbed the first person I could, which was E15 Medicare Nurse Manager. It was not longer than 30 seconds when I left and grabbed E15. When we went back into the room, she confirmed R15 didn't have a pulse and started compressions while I left to get the crash cart and get more help. I saw a CNA and told her to call 911 and get more help. I knew she was a full code because I had checked earlier in the day. I felt like I couldn't properly do my job. My judgment was to send her out to the hospital. I thought I could get into trouble or lose my job if I sent her out."

On June 7, 2017 at 9:22 AM, E15 Medicare Nurse Manager stated, "I was down by the nursing station when E15 came and grabbed me. She said, "I don't think R15 has a pulse." I confirmed she wasn't breathing and had no pulse. I asked E15 what R15's code status was and she said she was a full code. I immediately started compressions."

On June 7, 2017 at 9:36 AM, E2 Director of Nursing stated, "R15 had severe chronic obstructive pulmonary disease (COPD) and was

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morbidly obese. She was in and out of the hospital because of COPD and chronic respiratory issues. She started with shortness of breath. She was still responding and put on a non-rebreather. The nurse called the doctor and made several attempts with no response back from the doctor. The nurse went to get another oxygen tank and when she came back she found her unresponsive. She initiated CPR. E15 had updated me about what was going on, told her to update the doctor. I also went and talked with R15, she stated, "I just don't feel good." I told E15 to keep an eye on her. I actually spoke with E15 after the incident and told her that if a patient is declining rapidly she can send by 911. I wanted the nurses to be aware even off hours if interventions are not helping and the doctor is not responding, they can send the patient out without an order from the doctor. A lot of the nurses didn't know that."

On June 8, 2017 at 1:16 PM, Z1 R15's physician stated, "if she thought she was in imminent danger, I would expect them to send her (to the hospital)."

R15's electronic medical record lists her diagnoses to include: unspecified systolic congestive heart failure, essential primary hypertension, morbid obesity with alveolar hypoventilation, chronic obstructive pulmonary disease, other abnormalities of breathing, and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia.

The EMR shows R15's oxygen saturation on December 27, 2016 at 11:28 AM was 63% with oxygen via nasal cannula.

The facility's significant condition change and

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| S9999 | Continued From page 6<br>notification policy (no date) shows, "A significant change in the resident's physical, mental or psychosocial states. (See below for examples). Sudden onset of shortness of breath; Significant change in/or unstable vital signs. When any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner ...The medical practitioner will be contacted immediately for any emergencies regardless of the time of day ...If the medical practitioner cannot be reached, the director of nursing or the charge nurse can make arrangements for transportation to the emergency department."<br><br>( A ) | S9999 | | |