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
	IL6002711	A. BUILDING: ______ B. WING ______	C 02/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NSG & REHAB CENTER	1095 UNIVERSITY DRIVE EDWARDSVILLE, IL 62025

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S 000	Initial Comments Complaint 2140679/IL130622 F 563 G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to allow a resident to have end-of-life compassion care visits from family for one resident (R2) reviewed for visitation. This failure resulted in psychosocial harm in that R2 died in the facility without R2's daughter being allowed at R2's bedside. A reasonable person would have been upset without being able to see their child prior to death.

Finding includes:

R2's Care plan dated 11/21/2019, documents the following as a problem area under category of psychosocial well-being: "I am at risk for alteration in mood and psychosocial well-being due to the changes and restrictions on visitation imposed by the CDC guidelines because of the COVID 19 virus and risk for exposure. I am not able to see and interact with persons who are important to me."

R2 Progress Note dated 02/01/2021 at 10:57 AM documents "(R2's family) called angry about visitation policy. Per IDPH one person is allowed into facility per day for 30 minutes to visit resident. It has to be the same person which was told to family. Daughter had come into visit yesterday and told the other daughter tried to come in to building to visit and she was not allowed. Since it was not the same daughter coming in such as policy states, we did not allow her in. Her husband called and upset about policy."

R2's Progress Note documents on 02/02/2021 at 05:21 AM "CNA (Certified Nurse's Aide)

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S9999	Continued From page 2 summoned this nurse to resident's room. Upon entering resident's room this nurse noted resident to not be breathing. This nurse summoned second nurse to residents' room. Both nurses assessed for signs of life. None noted. No breath sounds, apical or radial pulses noted. Resident pronounced deceased at 5:19 AM by this nurse and DON. (Hospice) contacted. Awaiting their call back at this time." On 2/2/2021 at 9:03 AM, V1, Administrator, stated "Our policy for visitors is if a patient is actively dying one person can come in daily and that has to be the same person to visit daily. We tell the family they have to decide on the one person that will visit the patient. Since we are still in tier 3, CMS guidelines are very vague, but they say to be very restrictive." On 2/2/2021 at 10:55 AM, V6, Licensed Practical Nurse, stated that R2 died this morning at approximately 5 A.M. V6 stated that R2 did not have COVID and death was due to medical condition. V6 stated R2 was on quarantine area due to recent re-admit back from the hospital. V6 stated that R2 did not have a good prognosis and came back on hospice. V6 stated there was no family with R2 when R2 died. V6 stated family is allowed with a resident if resident is actively dying. V6 stated the family member has to pass through screening to visit and wear the PPE gear. V6 stated "There can only be one family member, but I think it can be different family each time, but I am not sure, I will have to ask, but I think they are allowed to swap, but again, I would ask to make sure first." On 2/2/2021 at 11:16 AM, V3, R2's son-in-law, stated R2 was sent to hospital Friday for altered mental status, R2 had a history of CVAs (cerebral	S9999		

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S9999	Continued From page 3 vascular accident) and ended up having another stroke. V3 stated "They decided (R2) would return to the nursing home on hospice. (V5, R2's daughter) called the facility and was told only one family member a day for 30 minutes and nothing more than that, no other specifics. (V5) let (V5's sister) go first on Saturday to see (R2). Then on Sunday, (V5) called to say (V5) was coming to visit, and the facility told (V5) they couldn't come inside. The facility told (V5) that only one family member could come a day and it had to be the same family member each day. V3 stated "I called and tried to talk to them because we knew it wouldn't be long. (R2) had a swallow test and had no reflux and family had decided no feeding tube. When I called, they said they were going by the state mandated rules of only 1 visitor for hospice patients." V3 stated he went to IDPH's website and the rules were vague, but it did say to work with family to allow for in visit presentation. V3 stated "I called back (V2, Director of Nurse/DON) and talked to both (V2) and (V1). I told them what I read online and asked why (V5) wasn't being allowed to visit. They told me that allowing more in would be putting other residents at risk because (V5) would be going up and down the hall around other residents. I then asked if we got (V5) COVID tested and proved negative would that work. They said that would take two weeks to get the results back. I asked them how they got to come in and aren't they getting tested weekly getting results faster than 2 weeks. I asked how they do it and get results back sooner to be able to be around residents. They then told me staff take precautions outside of work. I told them (V5) is a stay at home mom and took same precautions. They still wouldn't let (V5) go in to see (R2.) I asked for somebody higher up with the agency name and number and they gave me (V4's/	S9999		

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S9999	Continued From page 4 Corporate Nurse) name and number. I tried to call (V4), but (V4) was in a meeting and I had to go out on a flight. What really got my goat, when (R2) died, they said (V5) could now come into the facility to be with (R2). They wouldn't let (V5) come in because (V5) was putting others at risk when (R2) was alive, but when (R2) is dead, it is ok. That doesn't make sense." On 2/2/2021 at 12:20 PM an interview was conducted with V1 and V2. V2 stated the following "Unfortunately, yes, we only allow 1 person per family to do compassion care. The family has to pick the one person who gets to come in. It is usually the POA (Power of Attorney). They go through all the checks for COVID and then wear a gown, mask and gloves when visiting." V2 stated "If we were to have an outbreak, we wouldn't be able to track everyone who was allowed into the building, if we let more in with a resident. We wouldn't be able to keep track of all visitors, there are days we don't have enough staff for that, depending on how staffing is at the time, and it is too hard to figure out who would need notified." V2 stated "There was one time a couple months ago that the old administrator let a patient's wife and daughter both come in, but that is the only time we have done more than one." V1 stated "I let both daughters come in this morning when (R2) passed away." V2 stated, "(V1) did that because the family got a waiver." V1 stated "Somebody above me made the decision to give the family a waiver on visitation. The POA's spouse, called (V4, Corporate Nurse), and (V4) called me and said (V4) gave the family a waiver to let both daughters come into the facility." V2 stated that V5 did not come to visit R2, even though they got a waiver. V1 stated "(V4) was the one that told the family both daughters could do a bedside	S9999		

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visit."

On 2/2/2021 at 12:26 PM V3 was called to verify that V4 had given the family a waiver to allow both daughters to visit R2 for compassionate care visit prior to her death. V3 stated "I didn't talk to (V4). (V4) wasn't in the office, I think they said (V4) was in a meeting, and then I had to go out on a flight. When I got back from the flight it was too late to call (V4) back. No, nobody called us to say they were giving us a waiver and (V5, R2's daughter) could go into the facility for a bedside visit."

On 2/2/2021, at 12:34 PM, an interview was conducted with V4 via telephone. V4 stated "I didn't give the family a waiver, I didn't talk to (V3). I talked to (V1) about the patient. I do know with COVID we are trying to be very cautious. We try to do virtual visits or window visits. I didn't talk to the family. I told (V1) to go ahead and let both daughters come in and see (R2)." When asked would was responsible for calling the daughters to let them know they could come for compassionate care visit with R2, V4 stated "(V1) or (V2) was supposed to call and let them know." At that time, while on the phone V4 asked if surveyor could put her on speaker to confer with V1 and V2. While V1, V2 and V4 were all on speaker phone, V1 stated "We thought (V4) was telling (V3), because (V3) said (V3) was calling (V4). When we talked to (V4), we thought (V4) had (V3) on the phone and was going to tell (V3). We didn't call (V3)." V1 confirmed that no one contacted V3 to ensure V5, R2's daughter, could make a bedside compassionate care visit prior to his death.

On 2/2/2021 at 6:34 PM, V3 stated "(R2) would have been upset that family wasn't allowed in.

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S9999	Continued From page 6 (R2) did better when family was around. What made it worse for (V5) is that (V5) was pregnant last of 2019 and didn't get to see (R2), then COVID hit 2020 and wasn't allowed inside visits anymore, so (V5) hadn't got to be with (R2) since end of 2019. (R2) had an extensive medical history with several strokes that left (R2) very impaired. Before (R2's) continued strokes, (R2) was a very smart man, (R2) developed instruction manuals. (V5) was very protective of (R2), was (R2's) guardian and loved (R2). I think (R2) would be upset in knowing (V5) wasn't allowed to visit. (R2) loved family and loved seeing (V5). (R2) just did better when family was with him." Centers for Medicare & Medicaid Services (C.M.S.) issued QSO-20-39-NH dated 9/17/2020, for visitation guidance in nursing homes during the COVID-19 epidemic. The guidance provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents. The section titled "Compassionate Care Visits," stated in part "Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits." (B)	S9999		