STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000806	A. BUILDING: _____ B. WING _____	C 06/10/2021

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BEECHER MANOR NRSG & REHAB CTR	1201 DIXIE HIGHWAY BEECHER, IL 60401

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S 000	Initial Comments Complaint Investigation: 2173677 /IL00134342	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1035a)1) 300.1035a)2) 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' 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. Included within this policy shall be: 1) implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45]; 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. (Section 2-104.2 of the Act); These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident's Do Not Resuscitate (DNR) order was honored when she was found without a pulse. This failure resulted in the resident having Cardiopulmonary Resuscitation (CPR) initiated, followed by intubation, then ventilator placement in an Intensive Care Unit (ICU). This applies to all residents residing in the facility. The June 2, 2021 Resident Roster showed 84 residents reside in the facility. The findings include: R1's Face Sheet showed she was admitted to the facility on April 7, 2021. R1's Face Sheet showed her diagnoses included atrial fibrillation, heart failure, diabetes, and chronic kidney disease. On June 2, 2021 at 11:05, V6 LPN (Licensed Practical Nurse) stated she remembered R1. V6 stated she remembered R1 being "alert and oriented and not really very motivated for care."	S9999		

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S9999	Continued From page 2 R1's Practitioner Order for Life-Saving Treatment (POLST) Form showed R1's wishes were that she did not want resuscitation to be attempted if she had no pulse and was not breathing. Signatures on R1's POLST Form were dated April 8, 2021. R1's EMR (Electronic Medical Record) showed the Form was uploaded on April 9, 2021, under the "Resident Forms" tab at 11:16 AM. R1's POLST Form specified that R1 had chosen "Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally, avoid the intensive care unit." On June 3, 2021 at 3:17 PM, V10 LPN (Licensed Practical Nurse) said she was checking R1's vital signs on April 17th, 2021 at 4:15AM and found R1's oxygen saturation to be 66%. V10 said she turned R1's oxygen up and there was no improvement. V10 said R1 started to decline and V10 called for V9 RN (Registered Nurse) to assist her. V10 said she checked both the Advanced Directives binder and R1's EMR for presence of a POLST Form and was unable to find one. V10 said when she returned to R1's room, R1's fingers were blue, and no pulse could be found. V10 said CPR was started. V10 stated 911 was called and R1's POLST was found after Emergency Medical Service (EMS) had arrived. V10 said the Physicians Orders for Life-Sustaining Treatment (POLST) form should be in the Advanced Directives tab in the EMR.	S9999		

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S9999	Continued From page 3 On June 3, 2021 at 1:40 PM, V9 (RN) said she was asked by V10 (LPN) to assist her with R1 during the early morning of April 17, 2021. V9 said V10 went to look for R1's POLST and was unable to find it in the Advanced Directives binder or in the EMR. V9 said R1 went unresponsive and had no palpable pulse and no respirations. V9 said CPR was started and 911 was called. V9 said after the EMS arrived the POLST was found. V9 said EMS had intubated R1 before the POLST was found. V9 stated "as a nurse, we should know each resident's code status as soon as possible when coming on the shift." V21's (Admission Coordinator) April 17, 2021 typed and unsigned statement from the investigation of R1's incident showed V21 " ...noticed the crash cart on the outside of [R1's room]. I also know since I just did admission paperwork that [R1] was a DNR-since the paperwork was something I had seen with admission paperwork contact. I entered the room-informed the nurses [R1] was a DNR-went to the binder to find and retrieve the POLST form. The POLST form was located in the advanced directive book under the [first initial of R1's last name] tab. Copies were made and given to paramedics." On June 3, 2021 at 12:15PM, V7 (RN) said she was the Director of Nursing (DON) on the day R1 was given CPR. V7 said CPR consisted of chest compressions and artificial ventilation. V7 stated that V10 had told her R1's POLST DNR Form was not in the Advanced Directives binder, and it was not under the "Advanced Directive" tab in the EMR. The facility's undated Do-Not-Resuscitate	S9999		

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S9999	Continued From page 4 Directives Policy showed "Screening for DNR Directives upon Admission ...A copy of this form will be placed in the resident's medical record under 'Advanced Directives' tab. Advanced Directives are not effective until a copy is provided to the facility and made a part of the resident's medical record." Under the "Checking the Medical Records" portion of the Policy, it showed "In the event of an emergency, staff should also check in Resident's Medical Record under 'Advanced Directives' tab." On June 3, 2021 at 12:41 PM, V8 (LPN) said Advanced Directives can be found under the "Advanced Directives" tab in the Electronic Medical Record or in the Advanced Directives binder kept at the nurse's station. On June 3, 2021 at 12:53PM, V6 (LPN) also said a resident's POLST DNR would be kept in the EMR under the "Advanced Directive" tab. V6 stated "if I was in a bad situation I would not have time to open every tab under documents (in the EMR)." On June 8, 2021 at 1:10 PM, V17 (R1's Primary Care Physician and Facility Medical Director) said he would not expect CPR to be performed on any resident with a completed POLST DNR. V17 said if a resident has Pulseless Electrical Activity (PEA), the outcome after resuscitation is usually brain injury or brain death. V17 said any resident with a completed POLST DNR (with resident, medical provider, and witness signature) is to be considered a DNR when the facility receives the form. R1's April 17, 2021 progress note from 4:14 AM (authored by V10) showed "Upon entering residents room resident stated that she is having a hard time breathing, this nurse took her [oxygen level], it was 66, turned [oxygen] to 5L, gave a	S9999		

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S9999	Continued From page 5 breathing [treatment], [oxygen level] was then 52. Another nurse called in for assistance, resident became unresponsive- 911 called. CPR initiated. On call for ... NP (Nurse Practitioner) was notified of 911 and resident going to the hospital ..." R1's April 17th, 2021 Ambulance Run Report showed " ...upon arrival crew found nursing home staff doing CPR [Cardiopulmonary Resuscitation]. CPR stopped for pulse check, no pulse or breathing period crew asked if patient was a full code or DNR [Do- Not- Resuscitate]. Nursing home told crew "not sure if there is a DNR." CPR started with the nursing home staff assisting, along with monitor, IO [Interosseus], ET [Endotracheal Tube], BVM [Bag Valve Mask], and meds ... the Lucas CPR machine with started. Again, asked nursing home staff if any DNR, reply was the same. Crew was getting ready to move patient over to the cot when another nursing home staff member found a valid DNR ..." R1's April 17th, 2021 hospital note from 6:10 AM showed "...arrives by ambulance status post return of spontaneous circulation after cardiopulmonary arrest. Patient is intubated and unresponsive.... Nursing home staff doing chest compressions to resuscitate the patient.... The medics successfully resuscitated the patient while at the nursing home... Medics state that after the patient was resuscitated, they did locate a DNR form." R1's 9:25AM showed " ... 100% oxygen per ventilator, patient noted with decerebrate posturing (body posture indicating significant brain stem damage) and startle reflex, focal seizures to face noted ..." R1's April 19th, 2021 hospital note from 10:16AM (two days later) showed " ... is in the ICU and on	S9999		

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S9999	Continued From page 6 ventilator support. She opens her eyes to the calling of her name and tracks my movements ... She does not squeeze either hand upon command, nor does she move her feet. She does retract each hand upon nail bed pressure, and she does move her feet upon plantar stimulation. A copy of her Illinois POLST form is in her hard chart indicating DNR/ DNI ..." R1's April 21st, 2021 at 11:04AM hospital record showed " ... Continues to be maintained on ventilator support, day five. Not following any commands to open her eyes or move any of her extremities. She does retract in nail bed pressure all extremities ..." R1's 1:49PM hospital note showed " ...Patient remains intubated on mechanical ventilation. She is responsive to noxious stimulus .... She is not following commands. EEG show signs of anoxic encephalopathy. MRI shows diffuse white matter injury." R1's hospital note from 2:33PM then showed " ... explained the likelihood anoxic brain injury from going for a prolonged period of time without breathing and the likelihood of her returning to her previous state. They [R1's family] are in agreement that they will not be pursuing tracheostomy or feeding tube. We discussed compassionate extubation/ withdrawal of life sustaining measures and they [R1's family] are in agreement for discontinuation of life support ..." On June 3, 2021 at 8:48 AM, V12 (R1's Daughter) said R1's family was notified by the facility around 5:30AM on April 17, 2021 that R1 "had went unresponsive with no heartbeat." V12 said R1's family was later notified by the hospital that R1 had been intubated and "they got a heartbeat back." V12 said R1 was cognitively intact and had told her "I don't want to be on any machines (meaning a ventilator)." V12 said R1	S9999		

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S9999	Continued From page 7 did have a DNR on file in the facility. On June 3, 2021 at 3:51 PM, V5 HIMC (Health Information Management Coordinator) said R1's POLST was in the "Resident Documents" tab and not "Advanced Directives" tab in error. V5 said V1 (Administrator) had asked her to scan the POLST form in to the "Advanced Directives" tab on June 2, 2021 (during the investigation by the Illinois Department of Public Health). [On June 3, 2021 at 4:20 PM, V1 (Administrator) said he asked V5 to scan the POLST form into the "Advanced Directives" tab on June 2, 2021 because it was in the wrong place.] V5 said she was on medical leave at the time R1 was admitted. V5 said V13 (Medical Records Assistant) was the staff member to upload the POLST DNR form into the EMR. V5 said V13 "must not have known where to put it." V5 said she was on medical leave from March 31, 2021 through May 3, 2021. V5 said her tasks were delegated to V13 (Medical Records Assistant) during that time. On June 8, 2021 at 9:49AM V5 (HIMC) said the medical records personnel schedule is Monday through Friday 8:30AM to 5:30PM. V5 said Nursing staff are not able to scan records into the Electronic Medical Record (EMR). V5 said if a POLST DNR form is brought in after hours or on the weekend it will be placed in the "to be scanned box" and scanned into the EMR when medical records personnel arrive for their next shift. V5 said medical records were responsible for uploading the POLST DNR form when it was given to them by Social Services. V5 said Social Services were responsible for auditing the Advanced Directive Binder on the unit. V5 said Social Services performed an audit every Friday.	S9999		

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S9999	Continued From page 8 V5 said if a resident's POLST DNR Form was not placed in the correct place earlier in the week, it would not be found until Friday. V5 stated she did not know who is responsible for auditing the EMR. On June 4, 2021 at 2:03 PM, V13 (Medical Records Assistant) said she was hired by the facility because V5 (HIMC) was going to be on medical leave. V13 said she was trained by V5 (HIMC). V13 said she was not adequately trained. V13 said she was responsible for uploading POLST DNR forms into the EMR. V13 stated "if I would have been properly trained the DNR (R1's POLST DNR form) would be in the right place." V13 said she did not know if anyone was responsible to audit where she placed documents in the EMR. On June 8, 2021 at 10:20AM, V3 (Social Services Director) said that the Social Services personnel schedule was Monday through Friday from 8:00AM to 5:00PM. V3 said if a resident's family brought in a POLST DNR form after hours or on the weekend, it was the responsibility of the nurse to place the form in the Advanced Directives binder. V3 said if the nurse was to place the POLST DNR form in the "to scan" box it would not be found until Social Service staff were to return. V3 said she was also off on medical leave from March 5, 2021 through June 1, 2021. V3 said during her absence, V15 (Social Services Assistant) was responsible to audit the POLST DNR forms in the binder. V3 said the Social Service department was not responsible for auditing the EMR. V3 said Social Services was responsible for auditing the Advanced Directives binder. V3 stated she did not have an audit tool. V3 said a roster is used to check the Advanced Directives binder on Fridays and an email is sent	S9999		

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S9999	Continued From page 9 to the Administrator, Director of Nursing, and Medical Records Personnel. V3 said she was unsure how the audits were verified that are completed weekly. V3 stated she did not know who was responsible for auditing the EMR for POLST Forms, nor was she aware of any special audits completed on new resident admissions. On June 8th, 2021 at 10:45AM V15 (Social Services Assistant) said she was acting as the Social Services Director from March 5, 2021 through June 1, 2021 during V3's absence. V15 said Social Services are not responsible for auditing the EMR. V15 said when a POLST DNR form is brought into or completed in the facility, it is placed in the Advanced Directives binder and then given to Medical Records. V15 stated she did not know who was responsible for auditing the EMR. On June 8, 2021 at 11:38AM V11 (LPN, Minimum Data Set [MDS] Coordinator) said she was responsible for auditing the EMR. V11 said she audits EMRs when doing resident assessments. V11 said MDS assessments are completed on admission, with any significant change, and quarterly. V11 said when auditing the scanned documents, she goes through everything and does not look at the specific tabs the documents are under. V11 said if a resident who wished to be a full code (to have CPR initiated if found without a pulse) changed their wishes to DNR, she would not specifically audit the chart until the next scheduled MDS assessment. V11 said she is not made aware of any changes to residents' code status. V11 said R1's chart was reviewed on April 13, 2021 (five days after her DNR POLST was signed and four days before she was given CPR).	S9999		

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S9999	Continued From page 10 The Facility Advanced Directives policy dated November 2016 showed " ... 6. Copies of the written advance directive documents will be filed/ uploaded in the resident's clinical record ...10. For staff not having access rights to the resident's clinical record, the resident's advanced directive is maintained on the nursing unit and available to staff members for reference to and consideration of in rendering care and services to residents to whom they are assigned for duty." (A)	S9999		