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
	IL6008866	A. BUILDING: _____ B. WING _____	C 01/27/2024

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ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Complaint Investigation: 23210577/IL167980	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1035a)3)4)5) 300.1035e) 300.1210b) 300.1210c) 300.1210d)2)3) 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:	S9999		

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3) procedures for providing life-sustaining treatments available to residents at the facility;

4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;

5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

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

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.

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S9999	Continued From page 2 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: This failure resulted in two deficient practice statements. A. Based on interview and record review, the facility failed to have adequate qualified staff to conduct basic life support/cardiopulmonary resuscitation (BLS/CPR) per their job descriptions, failed to provide BLS/CPR for 1 resident (R6) of 9 residents reviewed for CPR in the sample of 22. B. Based on document review and interview, it was determined the facility failed to ensure emergency equipment was available for resident care. This failure has the potential to affect all residents with a current census of 87 residents. Findings include:	S9999		

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The facility Assessment dated 12/23 documents, "The facility must have sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

The Physician Services policy dated 10/20/21 documents "H. Any significant change in resident's condition will be reported to the attending physician immediately. At the time of accident or injury, personnel trained in first aid procedures shall provide immediate treatment."

On 9/20/23, the physician's admitting orders noted R6 was a full resuscitation, and the record lacked a Practitioner Order for Life-Sustaining Treatment (POLST/an advanced directive for resuscitation orders) form.

On 1/11/24 at 10:15 AM, V5 (Licensed Practical Nurse/LPN/day shift nurse) stated "R6 couldn't talk and didn't understand English. I repositioned R6 to R6's left side toward the window and R6's (family member) played music and was moving around like she/he was dancing and singing and R6 smiled like R6 enjoyed the activity. When I came in the next morning V12 (LPN) stated R6 had expired during the night. R6's (family member) was here (9/22/23) and stated "I don't understand. What happened? R6 was so bright yesterday."R6 was a full code (resuscitation), and CPR was not initiated."

On 1/11/24 at 3:15 PM, V13 (LPN/second shift nurse) stated "R6 was ok. I did trach (tracheostomy) care and R6 was on an antibiotic. R6 didn't really respond but R6 couldn't speak or

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understand English. R6 was stable on my shift."

On 1/11/24 at 4:14 PM, V12 (LPN/third shift nurse) stated "I don't recall the trach (R6) or what I was doing in the room, but I questioned R6's condition and what was R6's baseline. I went back (to nurse's station) to review R6's admission papers to determine if R6 needed to be transferred out (to hospital). I couldn't really tell if R6 was a code or not. I called 911 but when I went back into the room, R6 had expired. I canceled the transport." V12 stated V12 did not have a current BLS/CPR certification.

On 1/10/24 at 3:25 PM, V21 (Medical Director and Attending Physician) stated "If R6 had a full code order, CPR should have been initiated."

On 9/21/23 the "Third Shift" (9/22/23 10:00 PM to 6:00 AM shift) daily assignment sheet noted V12, V19 and V20 were the three (3) LPNs assigned to staff the three (3) floors with residents in the facility.

The facility was unable to provide current BLS/CPR certifications for 3 of 3 (V12, V19, V20) LPN's working in the facility when R6 expired on 9/22/23 as of 1/17/24.

B. The "Crash Cart Checklist (Third Shift Nurse Check Every Wednesday) noted "Top of Cart 1. Suction Machine 2. 02 (oxygen) Tan (Full in Proper Container) 3. CPR (cardiopulmonary resuscitation) Backboard 4. Supply List; Drawer 1 1. Stethoscope 2. Blood Pressure Cuff 3. Trash Bags 4. Note Pad/Ink Pens 5. Box of Non-Sterile Gloves 6. Face Shield; Drawer 2. 1. 1000 CC (cubic centimeters) of Normal Saline 2. IV (Intravenous) Start Kit 3. Sterile Water 4. J Loop IV accessory) 5. 3 cc Syringes for IV Flush 6. 22

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S9999	Continued From page 5 Gauge IV Catheter 7. 24 Gauge IV Catheter 8. Alcohol Prep Pads 9. Continue Flo IV Tubing 10. Suction Tubing 11. Yankar Suction; Drawer 3 1. Oxygen Masks 2. Oxygen Cannulas 3. Oxygen Extension Tubing 4. Oxygen Connector 5. Oxygen Wrench 6. Oxygen Regulator; Drawer 5. Ambu Bag with 02 Connection Apparatus 2. IV Pump On 1/8/24 at 11:10 AM, the 3rd floor emergency/crash cart was observed in the nurse's station. The first drawer contained two (2) 3/16 by 1 1/2-inch sterile suction tubing's which were observed to have brown and red stains on the packages and were expired 7/31/23. The second drawer also contained the same suction tubing and was expired on 7/1/22. The cart lacked a suction machine, a backboard, stethoscope, blood pressure cuff, face shields, normal saline, 22- or 24-gauge catheters, oxygen wrench, oxygen regulator and IV pump. The crash cart checklist/supply list located on top of the emergency cart was noted as last being checked on 4/23. On 1/10/24 at 10:40, V11 (LPN, 3rd floor) stated "What is an airway box? Do you mean like a crash cart?" V11 demonstrated the crash cart. V11 stated "I haven't received trach care education since the previous patient. Maybe 6 months to a year." At 12:10 PM, V11 stated "R3 hasn't had oxygen since being on this floor. (If oxygen was needed) I'd call the head of housekeeping and they would bring it (oxygen concentrator) up and I'd take it in there (residents' room). The suction machine (for the crash cart) is in R3's room." On 1/10/24 at 12:00 PM, V9 (LPN Admissions Coordinator) stated "If there is an admission,	S9999		

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especially one with special needs, I send a message to everyone on our dashboard (electronic medical record). I will get the key from the DON or floor nurse and check storage. The ADON or DON are supposed to check to ensure supplies are available and now I'm the Assisting Director of Nursing. "C

The American Red Cross CPR/AED (Automated External Defibrillator) for Professional Rescuers and Health Care Providers handbook documents "If unconscious but breathing, place in a recovery position; If unconscious and no breathing but there is a pulse, give ventilations; If unconscious and no breathing or pulse, begin CPR."

(A)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210c)
300.1210d)2)3)

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

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S9999	Continued From page 7 and dated minutes of the meeting. h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 3) Objective observations of changes in a	S9999		

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resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure tracheostomy supplies were available for tracheostomy care and emergency treatment, failed to obtain physician orders for tracheostomy care, failed to have a tracheostomy policy and procedure, failed to ensure staff were qualified and/or competent to perform tracheostomy care and order appropriate tracheostomy supplies, for 3 of 3 residents (R3, R6, R7) admitted with tracheostomies in the sample of 22. The facility also failed to ensure physician orders were clarified upon admission to provide cares for 2 of 7 (R3, R6) residents reviewed for orders in the sample of 18.

Findings include:

R3 was admitted to the facility on 12/11/23 with diagnoses of cerebral vascular accident (stroke), had an inability to speak, was cognitively impaired, had acute respiratory failure that required an insertion of a tracheostomy (an opening in the neck into the windpipe to help air and oxygen reach the lungs).

On 12/11/23 a Physician's Order noted to "Provide tracheostomy cleaning daily and PRN/as needed every night shift for Trach (Tracheostomy) care. Suction tracheostomy as needed for increased sputum production" and "Sodium Chloride Inhalation Nebulization Solution

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3% 4 ml (milliliter) inhale orally via nebulizer two times a day for SOB/shortness of breath and wheezing Start Date:12/11/2023 D/C/discontinue Date: 12/18/2023."

On 12/11/23, R3's Order Summary Report noted to provide tracheostomy cleaning every evening and on an as needed basis. The record lacked orders about the tracheostomy size, how often to change the tracheostomy tube and if the inner cannula was reusable or disposable and how often to change the tracheostomy inner cannula.

The Medication Administration Record noted R3's lung sounds were clear before and after nebulizer treatments 12/11/23 through 12/18/23.

On 12/12/23 at 3:45 AM, the Progress Note noted the trach was nasopharyngeal (suction catheter inserted into the nose down to the back of the throat to remove upper airway secretions) suctioned for a small amount of thin green secretions.

On 12/16/23 at 5:27 AM, the Progress Note noted V3 (Licensed Practical Nurse/LPN) "Attempted to suction resident at beginning of shift due to increased secretions, inner cannula not in place."

On 12/17/23 at 8:35 PM, the Progress Note noted V23 (LPN/Agency) "Suctioned trach as needed with return of thin clear secretions."

On 12/18/23 at 2:37 PM, the Progress Note documented "V21 (Attending Physician/Medical Director) made aware of residents situation due to trach not having inner canula. Verbal phone order to send resident to ER (emergency room)."

On 12/18/23 the ED/Emergency Department

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Provider's Note stated R3 presented to the ED by ambulance for a tracheostomy tube problem; the ED physician consulted with RT/Respiratory Therapist regarding tracheostomy tube replacement which was ultimately replaced successfully; then, R3 was discharged back to facility.

On 12/18/23 at 7:30 PM, the Progress Note noted "R3 returned to facility per AMT/Advanced Medical Transport, no new orders received. Resident remains alert and w/o/without s/s/signs and symptoms of distress. Tracheostomy tube size 4 DCT (disposable cuffed tracheostomy) in place with inner cannula noted."

On 12/18/23 at 8:26 PM, the Progress Note noted the Advanced Practical Nurse was contacted for tracheostomy orders, new orders were received, and an extra trach tube (provided by the hospital) was affixed to the wall above head of bed for emergency interventions.

On 12/18/23 the Order Summary Report noted orders to "Change tracheostomy tube (size 4 DCT) every month and prn/as needed; Change tracheostomy inner cannula daily and prn; Tracheal suctioning every shift and prn; Tracheostomy care every shift et (and) prn."

On 1/8/24 at 2:42 PM, V3 (LPN) stated R3 did have an inner cannula upon admission and identified the inner cannula was missing on 12/16/23. V3 stated the lack of inner cannula was known by the former Director of Nursing/DON (V4) on 12/15/23. V3 stated "V4 was observed to suction R3 without the inner cannula in place and that's when we (V3 and V23/LPN) knew R3 had to go to the hospital and get this remedied (new trach tube insertion). Oxygen levels never

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dropped and R3 was never in distress." On 1/9/24 at 3:31 PM, V3 stated "No, you can definitely not suction a resident without an inner cannula in place or you could damage their airway."

On 1/8/24 at 3:00 PM, V1 (Administrator) stated "I know V4 DON took the inner cannula (from R3's room). We didn't have any (tracheostomy tubes) that size. I sent V4 to (a medical supply store) but they didn't have that size. We called the hospital, but they said they didn't have any either. I don't know that the admissions office would call to ensure we had the right size of trach prior to admission and I'm sure it's not in any policy." V1 stated that V4 had been suctioning R3 without the inner canula in place. V1 stated there was a module for tracheostomy care and maintenance on the facilities e-learning software although the module had not been assigned or completed by any employee as of 1/11/24.

On 1/10/24 at 1:00 PM, V21 (Medical Director/R3's Attending Physician) stated "I asked them (facility) to get a Respiratory Therapist to come down and assess or evaluate R3. I told them they needed to have the RT review the trach protocol with them (facility staff). I specifically told them to consult RT during rounds with V4. I was surprised they had a trach patient here. Staff never stated they felt uncomfortable, but I don't think they get any training on it (trach care). I actually sent them a faxed protocol from (local hospital) for trach care. Yes, they should have emergency equipment available and tach tubes, inner cannulas and ambu bags should be at the patient's bedside. At this point I haven't heard that anything has been put into place to keep this from happening again. We need a Respiratory Therapist, and one should be on call. I didn't even know the facility would accept a

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trach patient. Really surprised me."

On 1/10/24 at 1:30 PM, V21 (Medical Director and R3's attending physician) stated the facility should have called V21 to clarify tracheostomy care orders.

2. R6 a non-English speaking cognitively impaired resident, was admitted to the facility on 9/20/23 with diagnoses of stroke and acute respiratory failure with a tracheostomy tube.

The record lacked documentation and admission orders were faxed to the admitting physician for signature or obtained verbally.

The record noted the Hospital's Physician Progress Notes last dated 9/18/23, the most recent medication list was dated 9/13/23 and the record lacked a hospital discharge summary.

On 1/11/24 at 11:25 AM, V24's (V21's office staff member for Medical Records specific to Nursing homes) stated "I will look for R6's referral and orders." On 1/11/24 at 4:00 PM, V24 stated no admission records or faxes for orders were received by the office for R6.

On 1/18/24 at 10:00 AM, V9 (Admission Nurse) stated "We don't send orders to the physician, and we don't call to clarify orders. The doctors have signed off on them at the previous hospital. We use the discharge orders."

On 1/17/24 at 12:30 PM, V21 stated "Normally, admission orders are sent via fax to my office for review and signature. I would expect the facility to notify me of an admission."

The Physician Services policy dated 10/20/21 noted "C. Upon resident admission, the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008866	A. BUILDING: _____ B. WING _____	C 01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

(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
S9999	Continued From page 13 is responsible for informing this facility in writing of the following: a. Medications b. Treatments. e. Special procedures for continuing health and safety of patient i. Code Status." As of 1/16/24 at 1:30 PM, the facility lacked a policy and procedure for tracheostomy care based on nationally recognized guidelines. On 1/25/24 at 10:00 AM, V1 (Administrator) stated V21 (Medical Director) had not reviewed policies, the survey plan of care or staff training material. V1 stated the Quality meeting will be next week and the material will be presented to V21 at that time. V1 stated the Tracheostomy Care policy updated 1/17/24 and the Tracheostomy Care Education presented to the staff on 1/16/24 and 1/18/24 lacked a reference it was based on a Nationally Recognized Guidelines. V1 verbally agreed the policy and the staff education presented lacked procedural instruction for tracheostomy suctioning and required emergency equipment. (A)	S9999		