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W 331	Continued From page 19 not to leave the room without informing the charge or team nurse, along with the relief CNA. Cross covered rooms are no longer side to side, with a bathroom between, but are across the hall from one another to allow better monitoring. All staff were trained on respiratory monitoring, signs of respiratory distress, tracheal care, resident positioning, and apnea monitor care and functioning. This rounding will be documented on new room rounding forms. All above will be monitored by the Director of Nursing. 2) The investigation regarding R1's death has been reopened for thorough completion. Staff have been disciplined due to the investigative findings and / or obstruction of the investigation. The CNAs responsible for R1 at the time of this incident have been terminated. Facility Directors have been re-trained regarding completion of thorough investigations. The facility Administrator will monitor for compliance. While the Immediate Jeopardy was removed on 1/17/13 at 3:30 PM, the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 390.620a) 390.620b)6) 390.700a) 390.3240a) Section 390.620 Resident Care Policies	W9999		

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W9999	Continued From page 20 a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. b) These policies shall include: 6) A written statement for resident care services including administrative services, physician services, emergency services, personal care and nursing services, dental services, (re)habilitative services, physical therapy, occupational therapy, psychology, social services, speech pathology and audiology, organized recreational activity services, work activity and prevocational, dietary services, resident medical records, pharmaceutical services, diagnostic services (including laboratory and x-ray) and educational services. Section 390.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	W9999		

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W9999	Continued From page 21 Section 390.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by the following: Based on record review and interview, it was determined the facility failed to ensure that staff provided adequate health care monitoring for 1 of 1 resident (R1), out of a sample of 3. R1 died unexpectedly after her tracheostomy (breathing) tube was dislodged when the facility failed to: 1) Ensure supervision was conducted per policy, and according to the resident's (R1) needs. 2) Conduct a thorough investigation of R1's unexpected death. 3) Restrict involved staff from resident care while the investigation was being conducted. 4) Develop and implement a policy for staff monitoring of assigned residents, including during relief coverage, which identifies the rounding time frames and monitoring procedures, during such rounds. R1's Cause of Death is Asphyxia due to displacement of the tracheostomy tube. Findings include: On 12/25/12 the facility failed to monitor R1 adequately. R1's tracheostomy tube became dislodged. R1 was discovered in full	W9999		

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cardiopulmonary arrest, and was pronounced dead in the hospital emergency department. The official Cause of Death is Asphyxia from tracheostomy dislodgement.

Facility's policy titled, "Room Coverage Rounds, dated 11/2012, requires, "All RNs are to complete rounds every 2 hours. RN's are to complete the following while doing rounds: 2. Check that apnea monitor is operating properly and not obstructed. 4. Check to ensure that every residents trach is positioned properly..." "LPNs are to complete rounds every 2 hours on their assigned shift. LPNs are to complete the following tasks while doing rounds: 2. Check that every apnea monitor is operating properly and not obstructed for all residents. 4. Check to ensure every residents', on assigned teams, trach[eostomy] is positioned properly." "TA [Team Assistants] / CNAs are to complete rounds every 10 minutes on their assigned shift within their assigned rooms. CNAs are to complete the following while doing their rounds: 2. Check that every apnea monitor is operating properly. 3. Check that every resident in assigned room is positioned properly in his/her bed or chair. 6. Monitor the trach[eostomy] tubing of each resident in the assigned room every 10 minutes. * TAs are never to leave the room for any reason without having coverage from another TA, LPN or RN. Must speak to the person covering room in person. Must let the Charge Nurse know when you have left the room for any reason and who is covering."

The face sheet, dated 8/21/12, documents that R1 was a 10 year old with diagnoses including Static Encephalopathy, Spastic Quadriplegia,

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Subglottic Stenosis with partially paralyzed vocal cords, Diffuse Interstitial And Alveolar Lung Disease, and Tracheostomy tube placement. R1's annual Individual Program Plan (IPP), dated 12/2/12, states that R1 was dependent for all activities of daily living (ADL), mobility and transfers. She was non-verbal, used a manual wheelchair for dependent mobilization and slept in a crib. The Respiratory Therapy (RT) assessment, dated 11/27/12, states R1 had a tracheostomy with a collar delivering room air [oxygen percentage]. The Physical Therapy (PT) assessment, dated 11/19/12, states R1 functioned at a 4 month old motor skill level, but could roll side to side when in bed. The Physical Therapist also wrote, "Functional Limitations - ...activities limited by spasticity, lack of postural control and poor head control. [R1] is dependent on others for transfer, ADLs and requires maximum support in all positions." The Speech Therapy evaluation dated 11/19/12 documents that R1 smiled and emitted some vocalizations, but did not communicate. She tracked with her eyes inconsistently and slowly.

R1's record includes a "Physician's Certification" letter requesting a waiver from the state, granting more than 4 residents per room. The waiver, dated 11/10/12 and signed by Z2 (Medical Director) states "The above named resident [R1] is in need of consistent supervision during all hours..." An accompanying letter, addressed to the Illinois Department of Public Health (IDPH), states "...The residents residing at [Facility] are severely, medically impaired and require a complex, intensive and skilled array of services delivered by staff on a continuous bases as documented in their medical care plan. ...These

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residents require direct and continuous monitoring. In addition, a Certified Nurses Aid (CNA) is assigned to each room on every shift." This was confirmed by E1 (CEO) on 1/14/13, at 9:30 AM, who said that the entire facility has been granted a waiver by IDPH to allow additional staff for close monitoring of the residents, including R1. E1 said that each room is assigned a Certified Nurses Aid (CNA), but these CNAs cross cover their room, and a second room, while the other CNA goes on break, or leaves the room for any reason. E1 said it is the expectation that the covering CNA walks the two rooms, visually observing each resident from the bedside at approximately 3 minute intervals, ensuring they are in stable condition, however the policy does not specify the interval time.

According to an Incident report, dated 12/25/12 at 5:10 AM, R1 was found, "cyanotic [skin= pale / bluish in color] with trach[eostomy] out by Team Assistant [E9 / CNA]. Code Blue [respiratory emergency] called..." Cardiopulmonary Resuscitation (CPR) was started, R1 was transported to, and pronounced dead, in the hospital Emergency Room soon after arrival.

The facility's Investigation / Conclusion was signed by E6 (Director of Nursing / DON) on 12/27/12, and by E2 (Administrator) on 12/31/12. E6's Conclusion includes, "[R1] was very active, it is a possibility that the trach was dislodged with this movement. The apnea monitor parameters were checked and found to be functioning properly. The staff responded to the code blue and performed according to policy. CPR was started immediately and all notifications were made expediently and documented per policy.

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There was no abuse or neglect noted."
E2's Conclusion is, "I find no evidence that abuse or neglect was the cause of death. This conclusion was made after reading all witness statements from those involved during the code, reading notes within the chart and having read the investigative report that was submitted by the DON [E6]."

The facility's Investigation including the witness statements, and R1's record, was reviewed. E9 (CNA) was assigned to R1's room (RM) 104, which included 3 other residents. According to the written witness statements: E9 went to the bathroom and came back to find R1 on her stomach. When E9 turned R1 over, the tracheostomy tube was out and E9 called a Code Blue (Respiratory Emergency). E11 (CNA assigned to cover E9's room during lunch and breaks) heard E9 calling a Code Blue, went into the room and saw R1's tracheostomy tube out. The first responding LPN (E7) found R1 on her back, cyanotic, with the trach tube out. E7 attempted to put the trach tube back in R1's stoma, had trouble at first, but then successfully changed the tube. R1 was not breathing and had no heart beat, so CPR was initiated immediately. Paramedics arrived, took over CPR, and transported R1 to the hospital where she was pronounced dead, in the Emergency Room, soon after arrival. The Ambulance Transport Record documented their contact time with R1 was from 5:17 to 5:20 AM, and R1 was in asystole (no heartbeat) the entire time.

The Code Blue Progress Note / Record, completed by E10 (LPN), was reviewed. It documented that at 5:10 AM (the first time

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documented), R1 was "cyanotic" with an "unobtainable" pulse, but from 5:11 AM to 5:14 AM, E10 documented that R1's "heart rate" ranged from 127 to 143. However at this time, documentation shows cardiac compressions were being done. E10 also documented "No" under the question "Did the monitor alarm?"

On 1/14/13 at 9:15 AM, E1 (CEO) said that she asked E10 about the Code Blue Record documentation, that the apnea monitor did not alarm. E1 said the apnea monitor had been checked and was functioning properly. However, E10 was interviewed by this surveyor on 1/14/13, at 1 PM, and said the alarm was attached to R1, the red alarm light blinking, but there was not a sound. E10 said the alarm should have been sounding and she wrote "No" because to the best of her knowledge, it had not sounded.

During an interview on 1/14/13, at 9:15 AM, E1 stated that E9 (CNA assigned to R1) said the apnea alarm sounded and alerted E9 that something was wrong with R1.
However this was not in E9's written statement. E9's written Investigative statement includes, "R1 playing in bed. Told TA [E11 / CNA] going to bathroom. Came back to do AM care. [R1] was on stomach. I turned [R1] over, trach was out. Called Code Blue."

E9 told this surveyor on 1/14/13, at 9:15 AM, that E11 was the relief CNA and covered R1's Rm 104, while E9 was at lunch from 3:10 AM to 4 AM. E11 was assigned to Room (Rm) 102, which is connected to Rm 104 by a bathroom. E9 said when she returned at 4 AM, R1 was sleeping on

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her side and all monitors were on. She said R1 looked "OK". E9 said she then took a bathroom break around 4:50 AM and again told E11 to cover the room. When E9 returned to the room, E11 was not present and E9 started to prepare for morning care. Minutes after arriving back in the room, E9 said she walked over to R1's bed, touched R1 who felt cool and limp, turned R1 over finding her blue and not breathing. E9 said that R1's alarm never sounded.

E11(CNA who relieved in R1's room before the incident) was interviewed by phone, on 1/14/13, at 11:15 AM. E11 said, when she relieves another CNA and is covering a second room, she checks on the second room every 10 to 15 minutes. E11 stated that on 12/25/12, she relieved E9 in R1's room, during E9's lunch break [approximately 3:15 to 4:00 AM]. When asked how often she monitored the room during E9's shorter bathroom break at approximately 4:50 AM, E11 responded that she monitors for bathroom breaks, if told. E11's phone then cut off. E11 did not return further calls from this surveyor.

E4 (LPN assigned to R1) said on 1/10/13, at 3 PM, that E9 did not inform her that E9 was going on break and leaving R1's room for the bathroom break at approximately 4:50 AM. E4 stated that she was on break, out of the building for less that 15 minutes, when R1's Code Blue was called. E7 said she was not sure who covered R1's room while E9 (assigned CNA) went on bathroom break around 4:50 AM, but assumed it was the covering CNA (E11).

E7 (first responding LPN) said on 1/14/13, at

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12:15 PM, that she could not be sure if she heard the alarm sounding when she walked into the room. E7 said she was the first to respond to the Code Blue. She said when she entered the room, R1 was on her back, cyanotic, cool to touch, with no respirations or heart beat. The tracheostomy was out. E7 could not remember if the trach tube was still attached to R1's anchor ties, or on the bed.

E12 (Charge RN) said on 1/14/13, at 10 AM, that she did not hear R1's apnea monitor alarming at the time of the incident. She said that E9 did not inform her that E9 was going on a bathroom break and leaving R1's room at approximately 4:50 AM.

Z1 (Facility Pulmonologist) stated on 1/10/13 at approximately 2 PM, that he knows of R1. He reviewed the recent ENT consultation notes in R1's record. He stated that R1 had decreased motor functioning and therefore may not have been able to protect her airway if she was lying on stomach. He said normally R1 should not have been on her stomach, and if she did move onto her stomach, should be moved back to her side, to prevent an airway obstruction. He said R1 could not move much air above or around her tracheostomy site. Therefore, if R1's tracheostomy tube came out or was obstructed, there could easily be respiratory distress, followed by full arrest.

Z2 (Medical Director) said on 1/14/13 at 1:50 PM, that she is aware of R1's death, but does not know the official Cause of Death. She said R1 could not have taken the tracheostomy tube out, but it may have come out from her thrashing

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about. Z2 stated R1 should have been only on her back or sides, not the stomach. She said the expectation is that staff monitor the rooms during break times. The monitoring should include staff walking over to the residents' side, visualizing and ensuring their stability. This should occur approximately every 3 minutes.

The facility's Investigation, along with R1's records, lacked documentation of the following; 1) A detailed timeline of events which preceded R1's cardio-pulmonary arrest. 2) R1's condition, and the frequency of monitoring by E11 (relief CNA), while E9 was at dinner and on bathroom break. 3) Whether the assigned LPN, RN and Respiratory Therapist (RT) conducted their 2 hour rounds properly. 4) Whether E9 informed E11, and the assigned nurse and / or charge nurse, that she was leaving R1's room for a break? 5) Was the apnea monitor hooked up to R1 correctly, to ensure proper monitoring? 6) Was R1 properly positioned in bed? 7) Why did E10 document on the Code Record that the apnea alarm did not sound, and was it heard by other staff? 8) Did R1 have a heartbeat as recorded and if so why were cardiac compressions still being done? 9) Was the correct size tracheostomy tube, correct O2 percentage, and correct tracheostomy anchor ties in place?

E6 (DON) said on 1/10/13, at approximately 1 PM, that she had conducted the investigation, however had concentrated on the Code Blue process, not the time period preceding R1's arrest. She confirmed that R1 was found cyanotic, in full cardio-pulmonary arrest, and never regained a heartbeat. E6 said many of the subjects lacking in the Investigation had been

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reviewed, but there is no documentation. E6 said she had not asked if the trach tube size was correct, or if it was properly anchored at the time of dislodgement. She was unsure why there was a "heart rate" recorded while cardiac compression were being done. She confirmed there is not a detailed timeline investigation that staff monitored R1 as required.

E1 stated on 1/14/13 at 9:30 AM, that conflicting staff interviews made the investigation difficult. On 1/14/13 at 3:30 PM, E1 said that E9, the assigned CNA, was the only staff suspended because of this incident, and that E11 (covering CNA) has worked since 12/25/12.
The employee file of E11 was reviewed. The file included paperwork regarding an incident on 9/21/12 when staff relieving E11's room during change of shift, found the residents' monitor alarms sounding and not properly attached, along with other negative care issues. The paperwork documented that E11 refused to sign it.

The Medical Examiners Office (Z4) was contacted on 1/14/12, at 10:30 AM and stated R1's cause of death is; #1 = Asphyxia due to displacement of the tracheostomy tube, #2 = Multiple Congenital Defects, Manner = Accidental. The Office stated that the Death Certificate is not yet available.

A