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| CHILDREN'S HABILITATION CENTER | 121 WEST 154TH STREET HARVEY, IL 60426 |

| (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) COMPLETION DATE |
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| W 000 | INITIAL COMMENTS<br><br>COMPLAINT INVESTIGATION<br>1493784/IL71685 | W 000 | | |
| W9999 | FINAL OBSERVATIONS<br><br>STATEMENT OF LICENSURE VIOLATIONS:<br><br>390.620a)<br>390.1040b)<br>390.1040k)2)<br>390.1040k)3)<br>390.3240a)<br><br>Section 390.620 Resident Care Policies<br>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.<br><br>Section 390.1040 Nursing Services<br>b) There shall be a sufficient number of nursing and auxiliary personnel on duty 24 hours each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents.<br>k) Nursing care shall include at a minimum the following:<br>2) All treatment such as: enemas, irrigations, catherizations, applications of dressing or bandages, supervision of special diets, | W9999 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W9999 | Continued From page 1<br>restorative and habilitative measures in Section 390.1620(a)(11) and other treatments involving a like level of skill, shall be properly administered.<br>3) All 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, nursing or psychosocial evaluation and treatment shall be provided.<br>Section 390.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements are not met as evidenced by:<br><br>Based on record review and interview, it was determined that E6 (Respiratory Therapist) failed to follow established facility policies, and provide adequate health care monitoring for 1 of 1 resident (R3), who unexpectedly died after his tracheostomy(breathing) tube became dislodged. E6 failed to immediately;<br>1) Address R3's respiratory alarm.<br>2) Call a Code Blue to address a cardiopulmonary emergency.<br><br>Findings include:<br><br>Facility policies titled;<br>"Room Coverage" dated 1/7/13 requires, "TAs [Certified Nurse Aids] are never to leave the room for any reason without having coverage from another TA, RT(Respiratory Therapist), LPN or RN."<br>"Code Blue", dated 1/2006 requires, "All cardiac and / or respiratory emergencies are designated | W9999 | | |

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| W9999 | Continued From page 2<br>as Code Blue. The staff member who notices a patient in distress will alert staff of a Code Blue situation by loudly saying the words into the corridor. The Respiratory Therapist will assist in suctioning, use of [ventilation] bag, etc as needed.<br>"Accidental Decannulation" dated 6/2010,requires, "If attempts to reinsert the tube are unsuccessful, an appropriately sized face mask should be used with the manual resuscitator..."<br><br>According to the record, R3 was a 6 year old with guardianship under the Department of Child and Family Services (DCFS), however the parents had visiting privileges. R3 had diagnoses which included Premature Birth, Profound Intellectual Disability, Intrauterine Drug Exposure, Microcephaly, Dysmorphic Cranial Features, Hydrocephalus with a Ventricular-Peritoneal Shunt, Hypertonia, Respiratory Failure, Seizures, Autonomic Instability, and Adrenal Insufficiency. R3 was dependent on a ventilator for breathing and a feeding tube for nutrition. R3 responded to touch and sound inconsistently, and had spontaneous movement. R3 shared a room with other residents, across from the nurses' station.<br><br>Z1's (Medical Director) annual history and physical, dated 11/30/13, states R3's "condition stable, yet guarded. No restoration potential. Requires total assistance." According to the physician order sheet, dated 8/20/14, R3 had a size 5 Shiley tracheostomy tube. This was reflected in staff documentation throughout the record<br><br>According to the nurse's progress notes:<br>A Code Blue was called on 8/26/14, at | W9999 | | |

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approximately 8:00 PM, by E6 (RT/ Respiratory Therapist), who reported that R3's tracheostomy tube had come out. Response time and the initiation of Cardiopulmonary Resuscitation (CPR) was immediate after the Code was called. R3 was found by the responding staff, unresponsive, cyanotic (pale/bluish), and without a pulse or blood pressure, however he was warm to touch. Ambulance transport arrived and continued CPR to the hospital where R3 was pronounced dead shortly after arriving. R3's Cook County Death Certificate, dated 9/3/14, states the Cause of Death is "Pending Investigation".

The facility Investigative Conclusion, dated 8/27/14, and written by E2 (Director of Nurses) states, "It appears that R3 may have dislodged his trach[eostomy tube] with movement or coughing minutes before the Code Blue was called. His trach is uncuffed, which could make it easier to slide out... [R3] has a known history of seizure activity, and that creates another possibility of trach dislodgement... It is also known that [R3] is unable to survive without his artificial airway and ventilator for extremely short periods of time. He becomes cyanotic quickly, but has been stabilized in the past with quick intervention."

According to staff documentation on 8/26/14, 3-11 shift (incident occurred at 8pm),:
The incoming TA/CNA (E7) assigned to R3, checked off the following shift change acceptance log "Is trach and vent tubing appropriately placed? Yes" "Are all monitors on and working properly? Yes".
The RT documented on the Ventilator Flow Sheet, dated 8/26/14 at 3:20 PM, R3's ventilator settings, which were according to physician

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| W9999 | Continued From page 4<br>orders. R3 had a pulse oxygen level of 97%, at 7:45 AM that day.<br>Nursing documented on the Pulmonary Assessment sheet, for 3-11pm shift, that R3's color, and respiratory effort, was "normal" , and his breath sounds were "coarse".<br>The nursing progress note checklist, for 3-11pm shift, reads R3's trach ties had been changed at 4 PM, the trach tube was in place and the apnea monitor was on.<br><br>Nursing documented on the Code Blue form, dated 8/26/14 at 8pm that;<br>E6 (assigned RT) "reported going to resident's bedside and trach out." R3's apnea and ventilator machines were alarming at the time the Code Blue was called. The ventilation bag, for manual respirations, was at the bedside. R3 was found "cyanotic", trach tube "out", and heart rate, blood pressure, and respirations "U" (unobtainable). By 8:01, CPR, including mechanical ventilation, was in progress, and the trach tube had been reinserted. The paramedics arrived at 8:10pm and transported R3 to the hospital, continuing CPR.<br><br>According to the facility Investigative Report and written interviews:<br>E8 (LPN) flushed R3's feeding tube at 5:10 pm, and he was stable.<br>E9 (TA/CNA) relieved for lunch from 5:30 to 6:15 pm, and R3 was asleep.<br>E10 (Night Charge Nurse) made rounds in R3's room at approximately 7:10pm, the residents were stable, and the apnea alarms were operational.<br>E11 (Day Charge Nurse) made rounds at 6:06 pm and R3 was stable, awake, and laying supine in his crib. E11 pulled down the side rail, visualized | W9999 | | |

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| W9999 | Continued From page 5<br>R3's "trach in place midline and intact to the ventilator" E11 observed R3 "properly attached to the apnea monitor", which was working. No alarms were sounding at that time.<br>E7 (assigned CNA) noted R3 was stable during her assigned 3-11pm shift. She wrote that he was "squirming" toward the end of the bed which was not unusual, and she put a blanket under his feet to keep him up in bed. E7 wrote that E6 (RT) was in the room and she asked E6 to watch the residents while she brought a paper to the DON. E7 said all the residents were fine, without any sounding alarms, when she left, however upon her return, E6 told her (E7) to call a Code Blue.<br>On 8/27/14, E6 (assigned RT) described in her written statement, to the question of what happened before the incident, that she was in R3's room making her assigned ventilator checks and noticed R3's alarm was sounding, but did not "think twice because he has a tendency to alarm for a minute and then be quiet. I proceeded to do a quick vent check on [another resident in the room]. R3 was still alarming so I went immediately to assess him. The total time I spent with [the other resident] was no longer than 5 minutes. As I was with [other resident] the TA [CNA/E7] asked how long I was going to be in room, I said a while and she left room. While doing vent check on [other resident], the TA was with [resident next to R3] and talking to R3, trying to quiet R3."<br>Then to the question - what were you doing with the resident at the time of the occurrence? E6 wrote, "Patient was alarming. I moved tubing which usually silences alarm. At the same time I noticed the patient's color was not normal and proceeded to check trach. Trach was not in. I then called Code Blue. As I was calling Code Blue, I reinserted trach. Everyone arrived to | W9999 | | |

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room and CPR was started."
E12 (RN) arrived in R3's room after the Code was called and observed the trach dislodged, but it was immediately replaced without difficulty and R3 was bagged [manually ventilated].
E13 (LPN) responded to the Code, and saw E6 looking at R3 and saying the trach was out. E13 put the trach back in, noted R3 was cyanotic, and that the Nurse Manager could not obtain a pulse. CPR was started.

E6 was contacted by phone on 9/16/14, at 9:55 AM, but stated she did not feel comfortable answering verbal questions.

E2 (DON/ Director of Nursing ) documented in the Incident Report Summary that 3 RNs, 1 LPN and a RT responded immediately to the Code. She said E13 (LPN) reinserted R3's trach tube and bagged him at 100% oxygen, with chest compressions started by E12 (RN). She said R3 remained cyanotic and without a pulse while at the facility, and that CPR was still being done upon transport to the hospital.

A hallway camera, without sound, was focused on the nurses' station and R3's bedroom doorway. R3's crib is near the doorway and visible on camera. The facility reviewed the timed camera recording, along with this surveyor, identifying staff. Figures can be seen in the video, but the video is not clear enough to see specific details. Multiple staff are seen at the nurses' station, and outside R3's bedroom doorway, throughout the recording. At approximately 7:53, E7 leaves the room after walking over to E6, who is seen at another resident's bedside. At 7:59.12, E6 is seen going to the bedside of a resident next to R3, and then directly to the ventilator side of R3's

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bed. At 8:00.33, E13 walks by the doorway, followed by E2 (DON) at 8:01. At 801.05, E6 is still at R3's bedside, and E7 is seen entering the room, facing E6. E7 turns back toward the hallway [calling the Code] and immediately staff are seen running into the room.

On 9/16/14, at 12:15 pm, E5 (RT Supervisor), E4 (Trach Nurse/LPN) and E3 (RN) confirmed that R3's trach tube was a #5 uncuffed Shiley, which is correct, following the physician orders.

Z2 (Advanced Practice Nurse), confirmed that her signed 8/2014 physician order sheet, with a Shiley #5 trach tube listed, is how an order is written for an uncuffed trach tube. Z2 said if a trach tube is cuffed, the order includes the word 'cuffed' and specifies how much air is needed to inflate the cuff. This was confirmed when physician order sheets were compared between residents who have cuffed trach tubes versus uncuffed.

Z1 (Medical Director) stated on 9/2/14, at 4 pm, that she was immediately informed of the incident. Z1 stated that R3 had severe neurological deficits, and was labile and fragile. Z1 said that due to his fragile baseline, R3 had very little reserve for any physical stressor, such as being off the ventilator for even a short time, and it could be a factor in his death. However, Z1 said she is unsure what the cause of death is. Z1 said that most of the pediatric patients have uncuffed trach tubes, and R3 was very small for his age. Z1 said an outside ENT Specialist follows these residents as needed for their respiratory issues, such as ventilation and tracheostomies.
The facility provided an appointment calendar,

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| W9999 | Continued From page 8<br>showing R3 had a scheduled ENT appointment in 11/2014.<br><br>However, Z3 (Pulmonologist), wrote in his exam note, dated 7/8/14, that R3 had an inflated cuffed #5 Shiley trach tube. E5 (RT Supervisor) confirmed this note, and said he made rounds with Z3 when he examined R3, and R3 never had a cuffed trach tube. An attempt was made to interview Z3, but the call was not returned.<br><br>E2 (DON) stated on 9/2/14 at 4pm, that she was present during the incident. According to E2, E6 said R3's trach tube became dislodged and she had put it back in, however the responding Code Team found the trach tube dislodged, and R3 cyanotic. E2 said E6 should have immediately called for help once she realized R3's trach was out, and / or he was in respiratory distress. According to E6 and the video, multiple staff were near the room and at the nurse's station, within hearing range. E2 said R3's trach was always the uncuffed type, which tend to dislodge easier and trigger the low volume ventilator alarm more often than cuffed trach tubes. E2 confirmed that many pediatric trach tubes are uncuffed and need close monitoring.<br>According to E2, all staff have been retrained regarding answering alarms, and immediately calling a Code Blue for cardiopulmonary distress. She said the Assistant DON will be doing Quality Assurance reviews by monitoring, rounding and interviewing staff regarding these issues. This was confirmed by documentation of meetings and training.<br><br>On 9/15/14 at 12:25 pm, E2 confirmed that R3 had 3 incidents in the past 3 months when his uncuffed trach tube came out, but was | W9999 | | |

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immediately put back in by monitoring staff. E2 provided documentation and said these incidents were triggered by specific causes, such as dressing with a T- shirt over his head, and transferring from the wheelchair to the bed. During these incidents staff was near, reinserted the tube, and R3 remained stable.

E1 (Administrator/CEO) stated on 9/2/14, at 3 pm, that a full investigation was immediately started after the incident, and involved staff did not have resident contact until a determination was made. E1 said the video confirmed the interviews and observations. She stated that E6 said the low volume ventilator alarm was going off, but that she did not respond immediately because she thought it was just his machine, and it had done this in the past. E2 said E6 was hired with good credentials and oriented properly. E6 was terminated on 8/28/14.

According to the Notice of Disciplinary Action form, dated 8/28/14, E6's termination was because "Employee failed to follow CHC's Code Blue Policy. Employee also failed to follow CHC's Accidental Decannulation Policy."

According to documentation, E6 is currently a Licensed Respiratory Care Practitioner and is certified in the specialty of Neonatal/Pediatric Respiratory Care. E6 started working at this facility in 4/2014, and was oriented to policies and procedures, including the Code Blue and Accidental Decannulation policy.

Rooms 112, 115 and 120, were observed on 9/2/14, at 6:15 pm. In these rooms are multiple residents with tracheostomies, on ventilators and on apnea alarms. The machinery appeared to be

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| W9999 | Continued From page 10<br>functioning well, alarms in place, and tracheostomy tubes secure.<br><br>(A) | W9999 | | |

imposed plan of correction

Plan of Correction
Children's Habilitation Center
121 West 154th Street
Harvey, Illinois 60426

Survey Date: September 16, 2014
Survey Type: Complaint Investigation (IL071685/1493784)

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider to the allegations or conclusions set for the in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by provisions of Federal and State Law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of the survey.

This is to serve as this facility's credible allegation of compliance with State and Federal Regulations.

**390.240a)**

Children's Habilitation Center has a comprehensive set of policies and procedures to ensure that residents are not subject to abuse or neglect.

R3 is no longer a resident of the facility.

All residents with trachs were identified as being potentially affected by the alleged deficiency.

E6 is no longer employed by Children's Habilitation Center.

All care staff were inserviced regarding promptly answering alarms and their responsibility for immediately calling code blues in situations involving cardiopulmonary distress. The policies and procedures for responding to alarms and for code blues were reviewed to assure that they provided appropriate direction to staff on responding to these situations.

Ongoing compliance will be assured through follow up inservices to be completed in the next two quarters for all care staff. Ongoing compliance will be further assured by the DON and her designee who will monitor compliance through regular rounding, observation of staff response to alarms and spot staff interviews to ensure understanding and compliance with facility policies. This rounding and observation will continue for the next 60 days. Staff who fail to follow the facility policies regarding responding to alarms and calling code blues will be subject to discipline including but not limited to termination, suspension, reprimand and reeducation.

**Correction Date:** September 18, 2014