STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145173	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEATHER HEALTH CARE CENTER	**15600 SOUTH HONORE STREET HARVEY, IL 60426**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow their policy and develop an individualized plan of care for management of shortness of breath for (R1) one of three residents reviewed for care plans. Findings Include: R1 clinical records shows R1 has [DIAGNOSES REDACTED]. R1's Physician order [REDACTED]. [MEDICATION NAME] solution 0.5-2.5(3) milligrams /3 milliliters ([MEDICATION NAME]- [MEDICATION NAME]), 1 inhale orally every 6 hours as needed for respiratory symptoms (inhale 1 via orally nebulizer). On 7/14/2020 at 12:28p.m V10 (Resident Care Coordinator) said R1 had a [DIAGNOSES REDACTED]. V10 said she didn't complete a care plan for management of shortness of breath, she guess it was an oversite. V10 said resident plan of care should be individualized based on the resident care needs. The care plan should be updated within 14 days. V10 said she would expect the nurse to manage the resident with difficulty breathing based on their nursing experience. V10 said she would expect the nurse to complete and assessment and the resident breathing, assess the vitals and oxygen levels. A review of R1's plan of care does not show a plan of care of management of shortness of breath. On 7/16/2020 at 2:15p.m V2 (Director of Nursing) said care plan should be updated when there's a new [DIAGNOSES REDACTED]. The facility policy titled Comprehensive Care Plan dated 11/2017 shows an individualized, person centered comprehensive care plan , including measureable objectives with timetables to meet resident physical , psychosocial and functional needs, is developed and implemented for each resident. In coordination with the resident and resident representative, as applicable, the interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plan are comprised of focused statements, goals and interventions. The comprehensive person centered care plan will reflect treatment goals, timetables and objectives in measurable outcomes. Describe the services that are to be provided to attain or maintain the highest practical physical, mental and psychosocial well-being, describe services that would be provided to the above, but the resident refuses, describe specialized services to be provided based on passrr recommendations, include the resident goals for progress, reflect the residents expressed wishes regarding care and treatment goals, including discharge planning, identify the professional services that are responsible for interventions, the comprehensive, person centered plan of care is developed with 7 days of the completion of the required comprehensive MDS. Assessment of the resident ongoing and care plans are revised based on the resident condition, preference, treatment and goals change. After the initial comprehensive, person centered plan of care is developed, formal care plan reviews will be held in conjunction with the MDS schedule and shall be no longer than 92 days apart.
F 0678 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure a resident receives CPR immediately after being found unresponsive and failed to have a professional staff (V3) certified\trained in cardio [MEDICAL CONDITION] resuscitation. This failure had the potential to affect one of three residents (R1) reviewed for difficulty breathing. Findings include: 1. MDS(Minimum Data Sheet) dated April, 2020, shows R1 has [DIAGNOSES REDACTED]. POS(Physician order [REDACTED]. V3 Nurses progress note dated [DATE] at 4:43a.m, documents, At 1:30am R1 asked for a breathing treatment. Treatment given for fifteen minutes, lungs auscultated and clear. Resident conversed with writer and aide. Resident (R1) allowed to rest. Upon doing 4:00 a.m. rounds resident observed in bed with no signs of life. No palpable pulse. No respirations. 911 called code blue initiated by all staff. Emergency services arrived and noted resident was unable to be coded. 4:25a.m. emergency services exited the facility. On [DATE] at 4:07p.m V7(CNA/Certified Nursing Aide) said on [DATE] at approximately 1:30 a.m., R1 complained of difficulty breathing. However, at this time, V7 changed his story and said it was 2:00a.m when R1 was complaining of difficulty breathing. V7 said he informed the nurse (V3) right away and V3 came and gave R1 a nebulizer breathing treatment and once the treatment finished the nurse came back to the resident room and removed the mask. On [DATE] at 4:50p.m, V5(Nurse) said, At approximately 1:00 a.m.,V7 came to the first floor nurses station and stated that R1 complained of difficulty breathing. V5 said she stood up, asked V3 if R1 had anything for difficulty breathing. She went to the medicine cart and retrieved the medication ([MEDICATION NAME]), took the medication to the room, asked R1 if he needed a treatment, put the medication in the in apparatus and placed the mask on R1's face. V5(Nurse) said she administered the breathing treatment for [REDACTED]. When asked about R1's condition prior to V5 giving R1 the breathing treatment V5 continued to say she did not complete the respiratory assessment she thinks that V3 completed the assessment. Nurse's progress notes dated [DATE]th, 2020 did not show documented assessment of R1's vitals(blood pressure, temperature, respiration, pulse), oxygen levels or lung sounds completed prior to R1 receiving the breathing treatment. There was no documented assessment completed of R1 vital signs (blood pressure, respiration, pulse, temperature) or oxygen levels for R1 post the breathing treatment. On [DATE] at 9:27a.m, V2 (Director of Nursing) said the nurse should assess the blood pressure, temp, pulse, respirations, oxygen levels and complete an assessment of lung sounds prior to administering breathing treatment. V2 said the nurse should stay with the resident during a breathing treatment. V2 said CPR should be initiated by the first person to observe the resident with no pulse, and no respiration. V2 said the aide(V7) should not have left R1 whom was unresponsive. He should have called out for help, continue to stay with the resident and initiate CPR. On [DATE] at 4:07p.m during an interview with V7(CNA), he stated rounds are done every 2 hours or as needed. He said at about 3:30a.m he was doing rounds. R1 was laying in the bed. V7 called R1's name and shook R1 but he did not respond. V7 said he checked for a pulse on R1's neck and R1 did not have a pulse. V7 said he did not initiate CPR, he left the room to go get the nurse. V7 said he felt that the nurse could take care of R1 better than he could. V7 has active CPR certification dated [DATE]. On [DATE] at 4:50p.m during an interview, V5(Nurse) stated that at approximately 4:00a.m she announced Code Blue for R1 because R1 was not breathing. V5 said she was doing chest compressions for R1. V5 said she called 911. When asked who assisted her with the code, V5 didn't give an initial response. However, a few minutes later, V5 said, We all (V5 and V3) were doing CPR. V5 said when the paramedics arrived, they did not administer CPR because R1 had expired. Cardiopulmonary Resuscitation Policy dated ,[DATE] shows in-part: The American Heart Association guidelines will be followed. Cardiopulmonary resuscitation (CPR) will be initiated on all residents, employees or visitors whom this intervention is indicated. CPR will be initiated by any staff member certified in CPR. See guidelines from American heart association. BLS (basic life support) consist of these main parts: chest compressions airway, breathing, defibrillation. Step 4 shows begin cycles of 30 chest compressions and 2 breaths cycles. Figure 12 shows two rescuer CPR. The first rescuer performs chest compressions the second rescuers performs bag mask ventilation using a mask with supplemental oxygen (when

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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F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) available). The second rescuer ensures that the chest rises with each breath. Rescuers should switch roles after cycles of CPR (about every 2 minutes). 2. V3 employee record show V3 was hired in [DATE]. Review of V3 employee records does not show a record of CPR- Cardiopulmonary resuscitation certification. On [DATE] at 1:52p.m V9 (Business office Manager and HR office personnel) said whatever is in the employee files, is the available information. On [DATE] at 12:00p.m V2 (Director of Nursing) said they are trying to locate V3 CPR card. On [DATE] at 2:15 p.m.V11(Assistant Administrator) said License professional staff needs a CPR certification to work. We verified this information upon hiring but we do not have the record on file. V11 said CPR certification should be in the employee file. A this time, V2 agreed that License profesional staff need a CPR certification to work. The facility's job description for staff nurse (Registered Nurse/ License Practical Nurse) dated ,[DATE] shows qualifications must possess current CPR certification or become certified within two weeks of employment.
F 0695 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to follow their policy and protocol for respiratory assessment. This failure affects (R1) one of 3 residents reviewed for difficulty breathing. R1 was observed unresponsive by staff after receiving a breathing treatment and later died . Findings include: MDS(Minimum Data Sheet) dated April, 2020, shows R1 has [DIAGNOSES REDACTED]. POS (Physician order [REDACTED]. V3 Nurses progress note dated [DATE] at 4:43a.m, documents, At 1:30am R1 asked for a breathing treatment. Treatment given for fifteen minutes, lungs auscultated and clear. Resident conversed with writer and aide. Resident (R1) allowed to rest. Upon doing 4:00 a.m. rounds resident observed in bed with no signs of life. No palpable pulse. No respirations. 911 called code blue initiated by all staff. Emergency services arrived and noted resident was unable to be coded. 4:25a.m. emergency services exited the facility. On [DATE] at 4:07p.m V7(CNA/Certified Nursing Aide) said on [DATE] at approximately 1:30 a.m., R1 complained of difficulty breathing. However, at this time, V7 changed his story and said it was 2:00a.m when R1 was complaining of difficulty breathing. V7 said he informed the nurse (V3) right away and V3 came and gave R1 a nebulizer breathing treatment and once the treatment finished the nurse came back to the resident room and removed the mask. On [DATE] at 4:50p.m, V5(Nurse) said, At approximately 1:00 a.m.,V7 came to the first floor nurses station and stated that R1 complained of difficulty breathing. V5 said she stood up, asked V3 if R1 had anything for difficulty breathing. She went to the medicine cart and retrieved the medication ([MEDICATION NAME]), took the medication to the room, asked R1 if he needed a treatment, put the medication in the in apparatus and placed the mask on R1's face. V5(Nurse) said she administered the breathing treatment for [REDACTED]. When asked about R1's condition prior to V5 giving R1 the breathing treatment V5 continued to say she did not complete the respiratory assessment she thinks that V3 completed the assessment. Nurse's progress notes dated [DATE]th, 2020 did not show documented assessment of R1's vitals(blood pressure, temperature, respiration, pulse), oxygen levels or lung sounds completed prior to R1 receiving the breathing treatment. There was no documented assessment completed of R1 vital signs (blood pressure, respiration, pulse, temperature) or oxygen levels for R1 post the breathing treatment. MAR(Medication Administration Record) dated [DATE] indicates there was no documentation showing [MEDICATION NAME] treatment for [REDACTED]. A review of R1's plan of care does not show a plan of care of management of shortness of breath. On [DATE] at 9:27a.m, V2 (Director of Nursing) said the nurse should assess the blood pressure, temp, pulse, respirations, oxygen levels and complete an assessment of lung sounds prior to administering breathing treatment. V2 said the nurse should stay with the resident during a breathing treatment. V2 said CPR should be initiated by the first person to observe the resident with no pulse, and no respiration. V2 said the aide(V7) should not have left R1 whom was unresponsive. He should have called out for help, continue to stay with the resident and initiate CPR. On [DATE] at 12:51p.m, V4(NP-Nurse Practitioner) said he visited R1 on [DATE] and R1 did not have any concerns related to shortness of breath or difficulty breathing. The cause of death cannot be determined without having an autopsy. R1's death was sudden. A [MEDICAL CONDITIONS] embolism and Covid 19 can cause sudden death without warning but he cannot make that determination. V4 said he was not notified of R1 having difficulty breathing on [DATE], he was not on call. He said the [MEDICATION NAME] treatment was appropriate for a resident experiencing shortness of breath. The breathing treatment did not cause R1's death. V4 said when a resident is having difficulty breathing the provider should be notified to try and determine the cause of the difficulty breathing especially since covid 19 is causing a pandemic right now. There could have been many reason any person experience difficulty breathing, and further testing may have been warranted. It's just a difficult circumstance because R1's death was sudden. V4 said he would expect the nurse to complete an assessment if the resident is complaining of difficulty breathing. On [DATE] at 11:08a.m., V6 (Nurse) observed administering breathing treatment to R2. V6 assessed R2 lungs sounds. She took R2's vitals prior to administrating the breathing treatment. V6 said the rational for assessing the lungs and vitals pre and post treatment is to determine if the medication was effective, also explained the rationale for staying with the resident while the treating is going, to encourage the resident to take deep breaths and also to ensure the resident gets all the medication. V6 observed documenting the vital signs and oxygen level post treatment. There were no concerns with V6. Administering Med Via Nebulizer Policy dated ,[DATE] shows in part: Administering medications via nebulizer for medications to be dispensed into the respiratory tract. Equipment stethoscope, medication, nebulizer tubing and chamber and air compressor or oxygen hook up. Procedure shows to gather equipment check order against MAR, perform hand hygiene, knock before entering the room and identify yourself, explain the procedure to the resident, complete necessary assessment before administering medication, open nebulizer cup and place premeasured unit dose inside and close cup, turn on air compressor or oxygen, instruct resident to inhale slowly and deeply through the mouth, continue inhalation until all mediation in the nebulizer cup has been aerosolized, stay with the resident while receiving medication. Reassess lung sounds and document medication administration. On [DATE] at 4:07p.m during an interview with V7(CNA), he stated rounds are done every 2 hours or as needed. He said at about 3:30a.m he was doing rounds. R1 was laying in the bed. V7 called R1's name and shook R1 but he did not respond. V7 said he checked for a pulse on R1's neck and R1 did not have a pulse. V7 said he did not initiate CPR, he left the room to go get the nurse. V7 said he felt that the nurse could take care of R1 better than he could. V7 has active CPR certification dated [DATE]. On [DATE] at 4:50p.m during an interview, V5(Nurse) stated that at approximately 4:00a.m she announced Code Blue for R1 because R1 was not breathing. V5 said she was doing chest compressions for R1. V5 said she called 911. When asked who assisted her with the code, V5 didn't give an initial response. However, a few minutes later, V5 said, We all(V5 and V3) were doing CPR. V5 said when the paramedics arrived, they did not administer CPR because R1 had expired. Cardiopulmonary Resuscitation Policy dated ,[DATE] shows in-part: The American Heart Association guidelines will be followed. Cardiopulmonary resuscitation (CPR) will be initiated on all residents, employees or visitors whom this intervention is indicated. CPR will be initiated by any staff member certified in CPR. See guidelines from American heart association. 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