STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145665	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at the Lake,the	2534 Elim Avenue Zion, IL 60099

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35178 Based on interview and record review the facility failed to follow the physician's order to send R1, who was hypoxic, and having difficulty breathing to the hospital. This failure resulted in R1's deterioration towards the end of the evening shift, on [DATE] to needing cardiopulmonary resuscitation (CPR) on [DATE] at 2:25AM, to R1's death at the facility in her room at 3:10AM, for 1 of 5 residents reviewed for quality of nursing care in the sample of 5. The Immediate Jeopardy began on [DATE], towards the end of the 3:00PM to 11:00PM shift, when V6 (RN-Registered Nurse) provided R1 with a 100% non-rebreather due to R1 having difficulty breathing and becoming hypoxic with blood oxygen levels dropping below 90%. V6 (RN) failed to follow R1's Physician Order provided on [DATE] at 1:13PM, showing to send R1 to hospital with difficulty breathing/SOB (shortness of breath). The findings include: V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 5:28PM. The Immediate Jeopardy was removed on [DATE] at 2:30PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. On [DATE] at 10:13AM, V4 (RT-Respiratory Therapist) said, when using an oxygen NRB (Non-rebreather Mask) with an oxygen tank, the flow should be 15 liters (L) or higher to ensure the patient receives 100% oxygen. The NRB has a bag attached. The bag must be filled with oxygen to ensure the exhaled carbon dioxide is released and does not collect inside the mask. If less than 15L oxygen flow rate is maintained the resident will get less oxygen intake and their blood carbon dioxide levels will increase. A concentrator has a maximum output of 50% oxygen; a NRB cannot be used with an oxygen concentrator. Respiratory Therapists manage residents on ventilators. We do not manage oxygen administrator for non-ventilator patients. On [DATE] at 11:55AM, V3 (Licensed Practical Nurse/LPN) (11:00PM to 7:00AM, shift) said, R1 was on a non-rebreather. The respiratory therapist (V5 RT) was the one that switched her over. We had her on a nasal cannula, RT (Respiratory Therapy) changed her over to the non-rebreather, I did not perform intervention, I documented. We thought the concentrator may not be working so we switched her over to the tank. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:32PM, V5 (RT) said, I did not place the NRB on R1. I arrived for the Code Blue (cardiopulmonary resuscitation) and began using a bag valve mask. R1's Progress Notes by V5 (RT) dated [DATE] at 2:35AM, shows Respiratory Note, Note Text: Code blue called to resident's room. RT arrived immediately to room and began to bag resident on flush oxygen. EMT (Emergency Medical Technician) arrived and took over bagging (providing oxygen (O2) via Bag Valve mask). On [DATE] at 1:03PM, V6 (Registered Nurse/RN) said, I put the NRB mask on R1 towards the end of my shift [sic] (3:00PM to 11:00PM). Her oxygen level was going down below 90%. I put her on the NRB and it increased her blood oxygen level to ,d+[DATE]%. R1 is not normally on oxygen. I did not obtain an order for the use of a NRB mask. On [DATE] at 11:51AM, V2 (Director of Nursing/DON) said, NRB are for emergency use. There is no standing order for NRB mask use. When a non-rebreather is used, it is an emergency. The nurse would not stop to get an order. On [DATE] at 2:06PM, V7 (Physician Extender) said, when I was called ([DATE] at 1:13PM), R1 had SOB (shortness of breath) and a blood oxygen level of 90%. I think the patient had just come back from dialysis. R1 had a plural effusion prior and episodes of SOB with activity and change in position. If there are changes in R1's condition the staff did not mention any other indicator to send resident to hospital. I was not informed about the results of the stat (immediate) chest x-ray. If I had received the results of the chest x-ray, I would have provided orders; a finding of atelectasis and pneumonia are not normal. If notified, I could compare x-rays, if a worse problem is identified, we could have sent the patient out to the hospital. I cannot tell you what I would have done, I am not certain. I did not have a chance to make a comparison. The information was not relayed to me. I was not informed about the non-rebreather mask. Everything depends on the condition of the patient. If the resident's breathing is abnormal and blood oxygen levels are going down, they need to send the patient to the hospital. The nurse should follow my instructions as well. When the indications are present to send the resident to the hospital .the nurse is aware of the protocol. After using up all the measures, and the condition of the patient is declining with hypoxia (low oxygen level) and SOB we need to send the resident to hospital right away. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Notes dated [DATE] at 12:30AM, shows, V3 (LPN) Note Text: Approx 12:30am resident was assessed by 2 nurses. SPO2 (blood oxygen level) ,d+[DATE]% via O2L (liters) non-rebreather mask. 12:47am po (by mouth) med (medication) was administered. Resident monitored and checked periodically. Approx (approximately) 1:30am VS (vital signs) obtained. T (temperature) 97.1 P (pulse) 65 R (reparations)16 SPO2 (peripheral oxygen saturation) 97% via non-rebreather mask with O2@ 2L . 1:55am Resident has order to send her out to ER, but if condition worsens, send out 911. Call placed to transport ambulance for ETA (estimated time of arrival) update. Approx 2:10 Resident reassessed by 2 nurses. Approx 2:15am resident reassessed and noted resident with faint pulse and respiration, minimal response to verbal and physical stimuli. O2 increased to 10L per non-rebreather mask due to hypoxia. Approx 2:20am Resident reassessed again and unable to obtain pulse/respiration. Code blue and 911 called. CPR-Cardio Pulmonary Resuscitation initiated. Crash cart obtained and AED (Automatic External Defibrillator) applied. No shock advised. Ambu bag (bag valve mask) applied. IV NS (intravenous-normal saline) fluids administered to PICC (peripherally inserted central catheter) line in L (left) upper arm. CPR continued. Approx 2:25am RT arrived to room and took over ambu bag. CPR continued. No pulse. Staff continued CPR until paramedics arrived at approx 2:34. EMT took over code upon arrival to room. Paramedics started 2 more IV lines with fluids, to both legs. CPR continued. Approx 3:10am resident pronounced dead. MD (physician) notified of resident status. Administrator and DON (director of nursing) notified of resident status. Family notified and updated of resident status. Approx 4am coroner was notified of death and he released the body for funeral home pick up. R1's Physician Order [DATE] at 1:13PM, shows, send to hospital with difficulty breathing/SOB. R1's Physician Order [DATE] at 1:13PM, shows, stat chest x-ray. R1's Chest X-Ray, reported date [DATE] at 8:16PM, shows, suboptimal pulmonary expansion. Near complete opacification right hemithorax. Patchy perihilar and lower lobe opacities left lung. The findings may reflect atelectasis and pneumonia. Follow-up as clinically indicated. R1's Abdomen, 2 View X-ray reported date [DATE] at 11:38AM, shows, Lung Bases are clear. Review of R1's Physician's Orders dated [DATE] to [DATE] shows, R1 did not have an oxygen order for the use of a 100% non-rebreather mask. R1's oxygen order dated [DATE] shows, oxygen continuous 2 liters per minute via nasal cannula. The facility's Physician Orders policy dated [DATE] shows, it is the policy of this facility to ensure that all resident .plan of care must be in accordance to the licensed physician's order. The facility shall ensure to follow physician orders as it is written Physician orders will be carried out at a reasonable time. Provision of care, treatment and services administered must be approved by the attending physician The facility's Oxygen Therapy and Administration policy dated [DATE] defines, Hypoxia as oxygen saturation levels of less than 92%. R1's Physician Order dated [DATE] at 3:56PM, shows, FULL CODE. R1's Death Certification dated, [DATE] shows, Cause of death: Cardiopulmonary Arrest, End Stage Renal Failure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. On [DATE] [Name of Director of Nursing] DON, initiated in-services for Nurses, CNAS, and Respiratory Therapists on change of condition policy, including recognizing change of conditions, and ensure resident's experiencing a change in condition requiring emergency lifesaving interventions are sent to the hospital in a timely manner. The facility will ensure that new hires, staff on leave, and agency staff will be in-serviced prior to their first shift regarding this topic. 2. On [DATE] [Name of Director of Nursing] DON, initiated in-services for Nurses, CNAS, and Respiratory Therapists on reviewing the resident's stat diagnostic tests and report abnormal findings to the physician for all residents in the facility, and to ensure physician orders are carried out for resident's experiencing a change in condition. The facility will ensure that new hires, staff on leave, and agency staff will be in-serviced prior to their first shift regarding this topic. 3. QA tool titled F684 QA Tool was initiated on [DATE]. This audit tool will be utilized to monitor education regarding change of condition, ensuring emergency life-saving interventions in timely manner, reviewing residents stat diagnostic tests and reporting abnormal findings to the physician for all residents in the facility, ensure physician orders are carried out for all resident's experiencing a change in condition. This will be carried out by [Name of Administrator] administrator, for 5 residents, twice a week for 8 weeks.