STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146013	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Nursing & Rehab Center	6909 West North Avenue Oak Park, IL 60302

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and records review, the facility failed to notify the physician of a resident's decrease in blood pressure and decrease in oxygen saturation causing a further decline in condition. This affected one of three residents (R1) reviewed for notification of an acute change in condition. This failure resulted in R1 being sent to the hospital thirteen hours later emergently in respiratory distress, going in to cardiac arrest while in the emergency department, and expiring. Findings Include: R1 is a [AGE] year old with the following diagnosis: quadriplegia, encounter for gastrostomy, and acute respiratory failure. A Nursing note dated [DATE] at 11:32AM documents in the morning, R1 was noted resting in bed and left eye opened to name being called. At 11:20AM, V3 (Former Nurse) found R1 diaphoretic with cool/clammy skin, respiratory rate of 60 breaths per minute, and a heart rate of 96 beats per minute. A blood pressure was unable to be detected and the oxygen level was 85%. Lung sounds were coarse to the upper airway. 911 was called and on scene at 11:25AM. R1 was transferred to the hospital. A Nursing note that is struck out, dated [DATE] at 5:17PM, documents R1 was awake and looks around but is not verbal. R1's vital signs were 97.8 temperature, ,d+[DATE] blood pressure, 90 heart rate, respiratory rate 18, and oxygen level 90%. Monitor R1 for change of condition. This note was written by V7 (Nurse) and was the nurse that took care of R1 during the change of condition on [DATE]. The Fire Department Sheet dated [DATE] documents the fire department was called at 11:17AM, and they were on scene at 11:25 AM. The facility called 911 for R1 having breathing problems. Upon entering the room, R1 was unresponsive lying in the fetal position and was tachypneic at approximately 40 breaths per minute. Staff on scene stated they came to check on R1 and found R1 with an oxygen level of 84% on 5L of oxygen via nasal cannula. The crew noted R1 had shallow, rapid respirations. Staff did not provide any information regarding R1 feeling unwell or having any abnormal complaints or vital signs until just prior to contacting 911. The first set of vital signs were taken at 11:25 AM. The pulse was 164 bpm, the respirations were 60 breaths per minute, and the oxygen level was 94% after R1 was put on a nonrebreather mask at 15L. A blood pressure was unable to be obtained. During transport to the hospital, a manual blood pressure was able to be measured at 80/P. The diastolic number was unable to be obtained. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The Hospital Records dated [DATE] document R1 presented to the emergency room for respiratory distress. Per the paramedics, the facility noted that R1 was unresponsive and tachypneic that morning. R1 was in acute distress, ill-appearing, and diaphoretic upon arrival. R1's carotid pulse was thready and the radial/dorsalis pedis pulses were not able to be felt. R1 is in respiratory distress, exhibits retractions with agonal breathing, and has diminished breath sounds throughout the lungs. The one set of vital signs upon R1's arrival were a pulse of 109 bpm, respirations of 45 breaths per minute, blood pressure at ,d+[DATE], and temperature of 109 F. All of the vital signs are abnormal. R1 arrived to the emergency room at 11:50AM and a code blue was called at 11:54AM. R1 became apneic and pulseless. R1 underwent multiple rounds of CPR in addition to an attempt to rapidly reduce R1's temperature with ice. R1 did not have return of spontaneous circulation and was pronounced dead at 12:42 PM. R1 did have laboratory bloodwork drawn during the code blue. The complete blood count showed that the white blood count was elevated to 13.73 K/uL (Kilo per microliter) (normal is 4XXX,d+[DATE].0 K/uL). This indicates R1 had an infection somewhere in the body. The Death certificate was requested, but a cause of death was still pending at the time of the investigation. A Nursing note dated [DATE] documents R1 expired while hospitalized . There are no progress notes documenting the change in R1's vital signs on [DATE] or any physician notification of the change in condition. On [DATE] at 1:47PM, V3 (Former Nurse) stated if something was abnormal then V3 would have talked to the doctor because R1 is nonverbal. V3 reported it is the nurse's responsibility to pick up little clues from residents' change in condition when they are unable to verbalize. V3 denied getting any report that R1 was having any issues overnight. V3 stated no one told V3 that R1 had a low blood pressure overnight. V3 reported if R1's blood pressure was normally in the 100's and hadn't had any medication to decrease it, then , d+[DATE] points lower would be considered a change. V3 stated V3 would have contacted the physician for the blood pressure of ,d+[DATE] because it is considered a change and the physician need to give orders or tell staff what to do. On [DATE] at 2:55PM, V5 (Nurse) stated any abnormal vital signs for R1 then V5 would call the provider to see the next steps. V5 reported nurses can't decide what to do if a resident is having a change in condition and physicians have to tell staff what to do so that is why they have to notify the physician of the change. V5 reported nurses also have to document a phone call with a physician and say what the orders are. V5 stated if anything with R1 is off, even everything else is ok staff still needs to call the physician. V5 reported if vitals are slightly off for R1, the physician needs to be notified because R1 is nonverbal. V5 stated typically R1's baseline blood pressure was 100's or 110's but if R1 is in the 90's or 130's then V5 would definitely call to make the physician aware. On [DATE] at 1:36PM, V7 (Nurse) stated V7 was the one taking care of R1 on the overnight shift. V7 reported that the last blood pressure was lower than usual. V7 stated R1's blood pressure normally was over 100. V7 denied notifying a physician for that blood pressure. V7 reported a normal oxygen level is above 92%. V7 stated V7 didn't think 90% was abnormal for R1. V7 denied calling the doctor for the low oxygen level either. V7 reported V7 might have rechecked the vital signs and they were normal. V7 denied documenting the second set of vital signs because they were normal. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:59PM, V8 (Director of Nursing/DON) stated when there is any change in temperature or blood pressure, if they aren't responding the way they used to, or if they are sweating are things we watch for because R1 is nonverbal. V8 reported anything different from what a resident normally does is considered a change in condition. V8 stated a change in condition is specific for each resident and each resident has their own way of showing a change in condition. V8 stated any change in condition needs to be reported to the physician. V8 reported if the vitals aren't normal or a resident isn't responding how they normally respond then the physician should be called immediately. V8 stated the reason to call the physician is to get and orders or see what has to be done to help the resident. V8 reported staff should have called the doctor immediately when a change in R1's vital sings was noted. On [DATE] at 2:29PM, V9 (Nurse Practitioner) stated since R1 frequently had infections based on the chronic conditions R1 had, if anything was going on with R1 then R1 was sent to the hospital. V9 reported R1 had a communication barrier so with that and the chronic urinary catheter and G tube there was no hesitation to send R1 out. V9 stated when V3 did call V9 about R1's condition that V9 just said to send R1 out via 911 and not wait. V9 reported staff needs to be aware of resident's baseline so they know when something is different. V9 stated staff need to be rounding on residents and if anything is noted to be different then staff need to do a set of recent vitals and call the physician or nurse practitioner immediately. V9 reported R1's normal blood pressures were ,d+[DATE]. V9 stated if R1's blood pressure was around 90 then V9 would have wanted to be notified. V9 reported if the oxygen was at 90% then the physician/nurse practitioner should have been called. V9 stated if a resident is normally at 95% but drops down to 90%, it means there is a change and orders need to be put in to help the resident. The Minimum Data Set, dated dated dated [DATE] documents a Brief Interview for Mental Status score cannot be performed due to R1 being nonverbal. Section J of the MDS documents R1 currently does not have a condition or chronic disease that may result in a life expectancy of less than six months. The Medication Administration Record dated ,d+[DATE] documents the last set of vital signs on [DATE] on the evening shift were as blood pressure ,d+[DATE] (R1's normal blood pressure ranged 100s/,d+[DATE]'s), temperature 98.5 degrees Fahrenheit, pulse 91(R1's normal pulse is documents in the 70's), respirations 18 breaths per minute, and oxygen level 90% on room air (R1's normal oxygen level is 95% or above). R1's vital signs for ,d+[DATE] were reviewed and does not document a blood pressure less than ,d+[DATE], a pulse greater than 78 beats per minute, or an oxygen level less than 95% on room air. The Care Plan dated [DATE] documents R1 is on enhanced barrier precautions for feeding tubes. An intervention documented is to assess for signs and symptoms of active infection and notify the physician. The policy titled, Change in Resident's Condition or Status, that is not dated documents, Purpose: To ensure that the resident's attending physician and representative is notified of changes in the resident's condition and/or status. Policy: 1. The Nurse will notify the resident's attending physician when: .there is a significant change in the resident's physical, mental, and psychosocial status .deemed necessary or appropriate by the resident .3. A significant change of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status.

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(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 - Actual harm 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** 40102 Based on interview and record review, the facility failed to conduct a comprehensive assessment of a resident after experiencing a decrease in blood pressure and oxygen level and failed to reassess vital signs later in the shift. This affected one of three residents (R1) reviewed for comprehensive nursing assessments. This failure resulted in R1 being sent to the hospital in respiratory distress, going into cardiac arrest in the emergency room , and expiring. Findings Include: R1 is a [AGE] year old with the following diagnosis: quadriplegia, encounter for gastrostomy, and acute respiratory failure. A Nursing note dated [DATE] at 11:32AM documents in the morning, R1 was noted resting in bed and left eye opened to name being called. At 11:20AM, V3 (Former Nurse) found R1 diaphoretic with cool/clammy skin, respiratory rate of 60 breaths per minute, and a heart rate of 96 beats per minute. A blood pressure was unable to be detected and the oxygen level was 85%. Lung sounds were coarse to the upper airway. 911 was called and on scene at 11:25AM. R1 was transferred to the hospital. A Nursing note that is struck out, dated [DATE] at 5:17PM, documents R1 was awake and looks around but is not verbal. R1's vital signs were 97.8 temperature, ,d+[DATE] blood pressure, 90 heart rate, respiratory rate 18, and oxygen level 90%. Monitor R1 for change of condition. This note was documented by V7 (Nurse) who was the nurse taking care of R1 on [DATE] when R1 first had a change in vital signs. This note is dated [DATE], but R1 was no longer at the facility on [DATE] at this time. The Fire Department Sheet dated [DATE] documents the fire department was called at 11:17AM, and they were on scene at 11:25 AM. The facility called 911 for R1 having breathing problems. Upon entering the room, R1 was unresponsive lying in the fetal position and was tachypneic at approximately 40 breaths per minute. Staff on scene stated they came to check on R1 and found R1 with an oxygen level of 84% on 5L of oxygen via nasal cannula. The crew noted R1 had shallow, rapid respirations. Staff did not provide any information regarding R1 feeling unwell or having any abnormal complaints or vital signs until just prior to contacting 911. The first set of vital signs were taken at 11:25 AM. The pulse was 164 bpm, the respirations were 60 breaths per minute, and the oxygen level was 94% after R1 was put on a nonrebreather mask at 15L. A blood pressure was unable to be obtained. During transport to the hospital, a manual blood pressure was able to be measured at 80/P. The diastolic number was unable to be obtained. (continued on next page)

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(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 - Actual harm Residents Affected - Few	The Hospital Records dated [DATE] document R1 presented to the emergency room for respiratory distress. Per the paramedics, the facility noted that R1 was unresponsive and tachypneic that morning. R1 was in acute distress, ill-appearing, and diaphoretic upon arrival. R1's carotid pulse was thready and the radial/dorsalis pedis pulses were not able to be felt. R1 is in respiratory distress, exhibits retractions with agonal breathing, and has diminished breath sounds throughout the lungs. The one set of vital signs upon R1's arrival were a pulse of 109 bpm, respirations of 45 breaths per minute, blood pressure at ,d+[DATE], and temperature of 109 F. All of the vital signs are abnormal. R1 arrived to the emergency room at 11:50AM and a code blue was called at 11:54AM. R1 became apneic and pulseless. R1 underwent multiple rounds of CPR in addition to an attempt to rapidly reduce R1's temperature with ice. R1 did not have return of spontaneous circulation and was pronounced dead at 12:42 PM. R1 did have laboratory bloodwork drawn during the code blue. The complete blood count showed that the white blood count was elevated to 13.73 K/uL (Kilo per microliter) (normal is 4XXX,d+[DATE].0 K/uL). This indicates R1 had an infection somewhere in the body. The Death certificate was requested, but a cause of death was still pending at the time of the investigation. A Nursing note dated [DATE] documents R1 expired while hospitalized . There are no progress notes documenting the change in R1's vital signs on [DATE] or any follow up assessments/ vital signs that were performed to make sure there was no further decline in R1's condition. On [DATE] at 1:33PM, V2 (CNA) stated R1 was sleeping when V2 rounded on R1 around 7AM and 9AM. V2 reported R1 is usually awake at 9AM but V2 went and changed R1 at 9AM but R1 went back to sleep. V2 stated the only change noted with R1 the morning R1 went to the hospital was that R1 was more sleepy than usual. V2 reported R1 is nonverbal and unable to communicate R1's needs. On [DATE] at 1:47PM, V3 (Former Nurse) stated when V3 first rounded on R1 after getting report around 7:30AM R1 was sleeping. V3 reported rounding in R1 again around 9AM to check R1's Gtube (Gastrostomy tube) feed and R1 looked at V3 and smiled. V3 confirmed this was R1's only way to communicate with staff. V3 stated around 11AM R1 was diaphoretic and in respiratory distress breathing short and fast breaths. V3 denied being notified in report that R1 had a lower blood pressure and oxygen level the night before. V3 reported staff needs to monitor vital signs closely of residents that are not able to communicate their needs so changes can be picked up quickly and addressed. V3 stated V3 called 911 and R1 was sent to the hospital where R1 expired. On [DATE] at 2:55PM, V5 (Nurse) stated R1 did have a couple UTIs so staff would watch out for high temperature, foul smelling urine, and any other unstable vital signs that would indicate an infection. V5 reported if any vitals are abnormal, a physician should be notified to determine the next steps for the resident. V5 stated due to R1 being nonverbal a physician should be notified at even a slight difference in blood pressure such as a ,d+[DATE] number difference in blood pressure because the resident cannot tell staff any other ways they are feeling. V5 reported if the physician is not notified then a recheck of the vitals need to be performed to monitor the resident's condition. V5 said, As a nurse you need to either be rechecking the vitals or calling the physician for a resident like this. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:37PM, V6 (Certified Nursing Assistant/CNA) stated V6 took care of R1 the night before R1 went to the hospital. V6 denied anyone telling V6 R1 was having a low blood pressure or lower oxygen level. On [DATE] at 1:36PM, V7 (Nurse) stated R1 appeared healthy on the [DATE] overnight shift (11PM-7AM). V7 reported doing vital signs once on R1 and R1's blood pressure was lower than normal. V7 stated R1's blood pressure was normally over 100 and the oxygen level was also in the low 90s. V7 reported a normal oxygen level is 92% and above. V7 stated V7 did not document a recheck of any vital signs. V7 denied knowing why documenting a reassessment was important. V7 denied doing another assessment on R1 in the night and only would round on R1. V7 stated R1 was sleeping during the shift and V7 did not want to wake up R1 because R1 seemed ok. On [DATE] at 1:59PM, V8 (Director of Nursing/DON) stated staff called V8 right before R1 was sent out and notified V8 that R1 had a change in condition. V8 reported if a resident has an abnormal vital sign, then it must be reassessed by staff to make sure the resident is not getting worse. V8 stated the reassessment should be documented to show the vital sign has improved or stayed the same. V8 reported the physician should have been notified about R1's blood pressure to get orders on what to do next. On [DATE] at 2:29PM, V9 (Nurse Practitioner) stated R1 had a lot of chronic, challenging issues due to being a quadriplegic. V9 reported R1 had a lot of urinary tract infections with the chronic urinary catheter and R1 kept getting infections. V9 stated anything was going on with R1 then staff just sent R1 to the hospital. V9 reported due to R1's communication barrier and having chronic infections staff wouldn't hesitate to send R1 out. V9 reported R1 is at high risk for infection so staff just sends R1 to the hospital to not take any chances. V9 stated staff need to be aware of R1's baseline so they know when something is different. V9 reported if anything changes with a resident then the physician/nurse practitioner need to be notified immediately. V9 stated R1's normal blood pressures were ,d+[DATE] and if R1 had a blood pressure around 90, then the physician/ nurse practitioner would want to be notified. V9 reported the oxygen was at 90% then they also should have been called. V9 stated a resident normally has an oxygen level at 95% it means there is a change in condition and interventions need to be put in place. V9 was asked if a resident has a change to vital signs, what should staff do? V9 reported V9 would expect staff to be monitoring the resident to make sure there is no further change in condition or decline. V9 stated staff could monitoring the resident by more frequent rounding or additional vital signs to see what condition a resident is in. The Minimum Data Set, dated dated dated [DATE] documents a Brief Interview for Mental Status score cannot be performed due to R1 being nonverbal. Section J of the MDS documents R1 currently does not have a condition or chronic disease that may result in a life expectancy of less than six months. The Medication Administration Record dated ,d+[DATE] documents the last set of vital signs on [DATE] as blood pressure ,d+[DATE] (R1's normal blood pressure ranged 100s/,d+[DATE]s), temperature 98.5 degrees Fahrenheit, pulse 91(R1's normal pulse is documents in the 70s), respirations 18 breaths per minute, and oxygen level 90% on room air (R1's normal oxygen level is 95% or above). R1's vital signs for ,d+[DATE] were reviewed and does not document a blood pressure less than ,d+[DATE], a pulse greater than 78 beats per minute, or an oxygen level less than 95% on room air. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The policy titled, Standard Patient Monitoring Policy, dated [DATE] documents, Policy: To provide proactive interventions promoting enhanced physical, mental, and psychosocial well-being of residents. We will be proactive in anticipating needs of resident and aide in identifying issues or concerns. Procedure: .Any unusual occurrence or change in status of a resident will be reported to the charge nurse. The policy titled, Vital Signs, that is not dated documents, Frequency of Monitoring: Vital signs (temperature, pulse, respirations, and blood pressure) are usually checked at regular intervals, such as daily or weekly, depending on the resident's condition and physician's orders. These procedure help ensure that any changes in a resident's health are detected early, allowing for timely medical intervention.