### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

A. Building: ___________________________
B. Wing: ___________________________

C. Date Survey Completed: 06/16/2009

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**Summary Statement of Deficiencies**

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<td>setting and suctioning. Always there is an assessment of emergency airway management and code blue procedures. He will also include airway management and how to assess for impending signs of distress. In addition, the in-service will be video competency assessed by the respiratory therapy director. Annually during their evaluation period, there will be another competency assessment performed to determine continue compliance. 8. All rooms where tracheostomy patients are located have in wall oxygen and suctioning capability at each bedside all suction and oxygen equipment is connected to the main generator in the event of a power failure there will be no disruption in service to the patient. 9. The director of respiratory or her designee will do rounds on a daily basis to ensure compliance. Any variance in compliance will be immediately corrected and reported to the clinical administrator to take appropriate disciplinary action.</td>
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**F9999 Final Observations**

**Licensure Violations**

- 300.1210a)
- 300.1210b)(3)
- 300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

- a) The facility must provide the necessary care and services to attain or maintain the highest...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**DES PLAINES, IL 60016**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**BALLARD NURSING CENTER**

**NAME OF PROVIDER OR SUPPLIER**

**practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.**

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) 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 evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

**Section 300.3240 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 requirements are not met as evidenced by:

Based on record review, interview, and review of the facility policy, the facility failed to ensure a tracheostomy tube was properly placed for a resident (R7). The facility failed to reassess the placement of the tracheostomy or notify the MD of the problem placement, this failure resulted in the resident not receiving adequate oxygenation during a respiratory arrest. This failure resulted in the resident (R7) being hospitalized and expiring with respiratory failure.
The facility also failed to provide a physician order for the size of the tracheostomy size and type for 1 of 8 residents (R5) in the sampled with tracheostomy.

Finding Includes:

The face sheet denoted R7 was admitted on 10/17/08 with diagnoses including Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Diabetes Mellitus, Calcium Channel Blocker, Depression and Pneumonia. R7 was alert and oriented X 3.

The Aerosol Flow Sheet dated 10/18/08 at 0840 denoted: "patient found with trach out. Reinserted. Suction for small amount of bloody suction." 1140 Oxygen saturation 96%. 1600 Oxygen saturation 94%. 2100 Oxygen saturation 90%. 2200: "patient stated that he wanted to go to bed. Certified Nurse Aide (CNA) placed resident in bed at this time. Oxygen saturation was checked and residents fingers were cold." 2300: "Reattempted to get oxygen saturation; read 79 - 80% at this time time. patient is unresponsive. Tried to suction trach and met resistance. 2nd therapist was called and I informed Respiratory Therapist (E5) and I started another Nebulizer treatment as respiratory therapist began to bag resident, resident's right cheek began to puff up. Respiratory therapist tried to suction trach and only got a lot of blood. Respiratory continue to try and bag resident and resident finally awaked. Residents cheeks began to swell up while he was being bagged. Resident passed out and code blue was called. Respiratory therapist stopped trach bagging as we both concluded that the resident had Subcutaneous Emphysema and Respiratory
Therapist began to mask bag the resident. Resident was coded. Noted paramedic on the scene and took residents to the hospital."

The hospital emergency Notes dated 10/18/08 stated, "Patient arrived to Emergency room in Full Arrest with Cardiac Pulmonary Resuscitate in progresses per Paramedics. The patient is a 61 year old male who presents with a complaint of major medical problem, per paramedics at the nursing home this evening patient become short of breath and had an arrest where he stopped breathing. Cardia Pulmonary Resuscitated was started. Down time for approximately 30 minutes prior to arrival to the emergency room. Paramedics state that the nursing home staff was bagging him through his tracheostomy but his cheeks was ballooning up so they ventilation him with an Ambu bag. Upon arrival the patient was unresponsive, pulseless and pupil dilated and asystolic arrest. 'Initial priority was evaluating his airway.' He had a tracheostomy in place and I immediately removed. Exam was due to marked saphenous crepitus to the neck and face. Digital exam with finger revealed multiple subcutaneous tracks in the neck through his tracheostomy site one which I was eventually able to locate as his trachea. Within two minutes of arrival placed and 6.0 Et tube into the trachea and was able to ventilate him at that time but he had gone at least 30 minutes without ventilation. Impression: fatal respiratory arrest. Critical Care X 30 minutes."

E3, Respiratory Therapist Supervisor, on 05/27/09 at 2:00 pm stated, "We checked residents every four hour with tracheostomy and vent. According to documentation of E8 did not check resident (R7) every four hour."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
BALLARD NURSING CENTER

SUMMARY STATEMENT OF DEFICIENCIES

E4, Respiratory Therapist, on 05/27/09 at 2:20 pm in the conference room stated, "I found R7's tracheostomy (trach) was out. I reinserted the trach. The trach went in real easy and quick. There was some resistance on suctioning after inserting catheter. I called E6 and E7 (Respiratory Therapist) to check the trach. E6 and E7 said trach was O.K. Later I told E7 to assess the respirator and trach of R7 again." Surveyor asked did you tell E8 you had a problem with R7's trach? E4 stated, "Yes, I told her there was a problem with the trach. I told her everything that happened on the day shift."

E5, Respiratory Therapist, on 05/27/09 at 2:40 pm per telephone stated, "The Therapist (E8) approach me and said she was having a problem with R7's trach. She was having trouble bagging. I tried to bag R7. I tried to suction him. I could only insert the catheter approximately 3 to 4 inches and did not received any secretion return and oxygen saturation reading was approximately 75%. The inner cannula was not in place. The resistance was very high. So, I tried to bag through mouth and nose with little result."

E8, Respiratory Therapist, on 05/28/09 at 11:45 am per telephone stated, "The trach was already occluded when I got to work. The supervisor and all staff members knew it was occluded because they were on the floor. They were discussing it when I got off the elevator. It was about 7:00pm. I was left on the floor with a resident (R7) non functional trach in which you could not pass a suctioning tube down. E4 was therapist reported the trach was not function. She was getting a little resistance on suctioning. The resident trach was not functioning. The trach was fully occluded with dried up blood. They could not passed a suctioning..."
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- tubing because of the dried up blood in the trach tube. I told the nurse the resident's trach was occluded and I did not reassessed the trach. It was approximately 8:45pm. R7 was still sitting in the chair. He was nodding in the chair. I asked him if wanted to go back to bed. I checked R7's oxygen saturation. I don't remember saturation number. His fingers were cold. When fingers are cold cannot get accurate/correct oxygen saturation reading. I told him will be back to check his oxygen saturation. I got the certified nurse aide to put him back into the bed. Asked R7 can I suction him. He said "Yes." I suctioned a thin amount of blood. I could not put the trach tubing always down it was a full occlusion. At 10:00 pm I hear a loud snoring sound (Snoring sound - A lot of secretion or stroke). He was snoring lying flat in bed. I tried to suction. This time I felt the occlusion in the trach. I was unable to pass the trach tubing. It was a full occlusion in the trach tubing. I started pouring saline down the trach. To see if the saline would dissolved the clot. He was very restlessness. As I pushed more of the tubing down R7 became more restlessness and unresponsive. I was also getting some pieces of blood clot coming out of the tubing. The airway was obstructed and occluded. Saline was not dissolving the clot, so I tried to Ambu bag him. The Ambu bag could not be sneeze. The trach was occluded. He was not responsive. E5 came up. He started to Ambu R7. He said it was hard to bag him. He said it was occluded. The resident was unresponsive. He was awake for a few minute and started to fight. He said "Raise my head up and I cannot breath." I raised head of bed up. E5 continue to bag him with Ambu bag. His cheeks began to swell up. R7 said "I don't feel good." He passed out. I knew it was Subcutaneous Emphysema (Air was going
### Statement of Deficiencies and Plan of Correction

**Ballard Nursing Center**

9300 Ballard Road
Des Plaines, IL 60016

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The Respiratory Therapy Appropriate Documentation stated, "(2). All Ventilator and Trach patients, CPAP and Bi-PAP patients will be assessed and documented on every four."

The faculty did not present any documentation that resident was reassessed for patency of the tracheostomy tube.

2. R5 was observed on 05/27/09 at 9:40 am lying on a low bed with mattress on both sides of the bed. R5 was observed with tracheostomy.
## Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Ballard Nursing Center  
**Street Address, City, State, Zip Code:** 9300 Ballard Road, Des Plaines, IL 60016  
**Provider's Plan of Correction:** (Each corrective action should be cross-referenced to the appropriate deficiency)

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Collar in place. R5’s diagnosis included Respiratory Failure, Hypertension, Hypothyroid, C. Difficile in Stool, Chronic Colon Fistula, and Sigmoid Colon Resection.

The Physician order and care plan dated 02/17/09 through 05/27/09 denoted that R5 did not have a trach size or type on the physician order.

Upon prompting to check the physician order and care plan for the size and type of the tracheostomy, E3 stated, "There is no size or type on the physician order. I called physician to get the size and type on the trach. There should be physician order with the size and type on the trach."

The Respiratory Care Services and Trach Tube Change dated 05/15/09 stated, "1. * Confirm physician order for trach change with size and type identified."

### (A)