

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/4/04  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145734</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>8/13/04</b>
NAME OF PROVIDER OR SUPPLIER  <b>EVERGREEN HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805</b>		
(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	
F9999	<p><b>FINAL OBSERVATIONS</b></p> <p>Surveyor: 08705</p> <p>Complaint 0493252 F281 &amp; 300.690 Complaint 0493265 F224, F309 &amp; 300.690 Complaint 0493325 No deficiencies/findings Complaint 0493516 No deficiencies/findings</p> <p>Licensure findings:</p> <p>300.1010h) 300.1210a) 300.1210b)3) 300.3240a)</p> <p>The facility shall notify the resident's physician of any accident, injury or significant change in a resident's condition that threatens the health safety or welfare of a resident. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p>	F9999			

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F9999	<p>Continued From page 15</p> <p>The facility must provide the necessary care and services to attain or maintain the highest practicable physical mental, and emotional 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.</p> <p>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.</p> <p>AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT NEGLECT A RESIDENT.</p> <p>.</p> <p>These regulations are not met, as evidenced by the following:</p> <p>Based on record review and staff interviews, the facility failed to ensure that 1 resident (R2) received the necessary care and services to maintain the highest practicable physical well-being as evidenced by the failure to assess, monitor and record vital signs when the resident was in an acute condition on 7/6/04 which ended in death. The lack of assessment in an acute situation, monitoring of an acute situation and recording of vital signs during an acute situation placed R2 and other residents in the facility at risk.</p>	F9999		

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F9999	<p>Continued From page 16</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. R2 was a 30 year old resident with diagnoses that included Brain Injury Secondary to a Motor Vehicle Accident, Quadriplegia, Seizure Disorder and Persistent Vegetative State. He resided at the facility for the last 4 years. According to E1 (administrator), R2 had a history of elevated temperatures related to his brain injury and episodes of constipation. Review of the clinical record for R2 from 12/28/03 until 7/6/04 did not indicate that the resident had any elevated temperatures during that time. Prior to 7/6/04, the last recorded temperature was 5/21/04.</li> <li>2. On 7/6/04, it was documented in the progress notes, by E8 (Night Nurse) that the resident had an axillary temperature of 104.7 degrees and a pulse rate of 152 at 2:00am. E8 administered acetaminophen at 2:00am according to the medication administration record (MAR). There was no documentation of any assessment being done (i.e. lung auscultation, checking for fecal impaction or checking his urine for signs of infection). The next reference made by E8 was at 6:00am when she documented that his axillary temperature was 99 degrees. The increased pulse rate was not mentioned and there was no indication that his pulse or blood pressure had been rechecked. Z3 (R2's physician) was not notified - there was no documentation of it in the chart and it was confirmed by Z3 during interview on 8/11/04.</li> <li>3. On 7/6/04, it was documented in the progress notes, by E9 (Day Nurse) that the resident had an axillary temperature of 101.4 at 10:30am. E9 administered acetaminophen at that time</li> </ol>	F9999		

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F9999	<p>Continued From page 17</p> <p>according to the progress notes. There was no documentation of any further assessment or vital signs on the day shift. There was no recorded pulse rate. Z3 was not notified - there was no documentation of it in the chart and it was confirmed by Z3 during interview on 8/11/04.</p> <p>4. On 7/6/04, E8 documented the R2's elevated temperature and pulse rate on the 24 hour report. There was no intervention by nursing administration to ensure that this resident was being monitored.</p> <p>5. On 7/6/04, at 2:05pm (12 hours after the initial elevated temperature), R2 was found unresponsive with no vital signs. His axillary temperature at this time, as stated by E4 (ADON) on interview on 8/11/04, was 107 degrees. Cardiopulmonary Resuscitation (CPR) was initiated and 911 was called.</p> <p>6. On 7/6/04, at 2:10pm, the paramedics arrived and took over CPR. R2 was transported to the emergency room where he was pronounced dead at 2:33pm. The emergency room records document his axillary temperature as 106.8 degrees and his rectal temperature as 108 degrees. On interview on 8/11/04, Z4 (emergency room nurse) stated that she took care of R2 in the emergency room. When asked why she checked his temperature after he was pronounced dead, she stated that his skin was very hot to the touch. The emergency room record also documented that all extremities were rigid at the time he arrived in the emergency room.</p> <p>7. On 8/11/04, Z3 (R2's physician) stated on interview that he had not been notified by the night nurse or the day nurse. He further stated that if he</p>	F9999		

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F9999	Continued From page 18 had been notified he would have sent the resident to the hospital. When asked if he wanted to be notified, he stated "yes" and added that they notify him for all kinds of "simple things".	F9999		