

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

PRINTED: 12/16/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2004
NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6125 SOUTH KENWOOD CHICAGO, IL 60637		
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F9999	<p>FINAL OBSERVATIONS</p> <p>300.690(a) 300.1030(a) 300.1035(a) 300.1210(a) 300.1220(b)(6)</p> <p>The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.</p> <p>The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities.</p> <p>Every facility shall respect the residents' right to make decisions relating to their own medical</p>	F9999			

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F9999	<p>Continued From page 16</p> <p>treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights.</p> <p>The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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 rprovided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>The DON shall supervise and oversee the nursing services of the facility, including: Developing and maintaining nursing service objectives, standards of nursing practice, writtenn policies and procedures, and written job descriptions for each level of nursing personnel.</p> <p>These requirements are not met as evidenced by :</p> <p>Based on staff interview, record review, review of facility CPR (Cardio-Pulmonary Resuscitation) policy, the facility failed to perform CPR and failed to call emergency services (911) on 1 resident (R4) on 5/19/04 at approximately 8:30 pm after the resident was found in a chair unresponsive, without vital signs and bleeding from her nostrils. The lack of performing CPR and notifying emergency services by facility staff placed R4 and other residents in the facility at risk.</p> <p>Findings include:</p>	F9999			

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F9999	<p>Continued From page 17</p> <p>R4 was a 43 y.o. admitted 3/15/04 with multiple diagnoses including diabetes, cardiac arrhythmia, hypertension, and opioid abuse. R4 did not have a DNR (Do Not Resuscitate) status. Current physician orders show that R4 had pass privileges to leave the facility, and E4 (Social Service) told surveyors on 6/15/04 that R4 attended a outside day program daily. R4 resided on the 6th floor of the facility.</p> <p>Per nursing notes dated 5/19/04 written by E13 (Licensed Practical Nurse), the following is stated: 4pm - "Resident noted ambulating independent around unit and off unit and is alert and verbally responsive. In no apparent distress." 5pm - "Resident stated "I will take my meds later at 9pm" and left unit. 7pm - "Resident noted sitting up in room during rounds. Alert by nursing staff." 8:30pm - "Upon making rounds, CNA observed resident laying in bed with small amount of epistaxis around nose and mouth. No response, unable to obtain pulse or heart beat, no spontaneous respirations noted. Nursing supervisor called and responded to the floor. Presumed Death policy observed." This statement contradicts the verbal interview E 13 told to the surveyors on 6/16/04 (see following paragraphs) about resident being found in a chair and not found in the bed.</p> <p>Further nursing notes written by E14 (Licensed Practical Nurse (LPN) - PM Supervisor) state that Z1(physician) was paged at 8:30pm and returned the call at 10:45pm.. The family was called at 8:48pm and arrived at the facility at 10:30pm. The family gave E14 the name of the funeral home</p>	F9999			

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F9999	<p>Continued From page 18</p> <p>they wanted to use, E14 notified the funeral home, and R4's body was picked up from the facility at 11:30pm. No autopsy was done or ordered.</p> <p>Review of nursing notes from 12/28/03 thru 5/17/04 do not show a pattern of R4 complaining of any type of major physical ailment. Entries detail R4 as being alert, ambulatory, going out on pass, and staff dealing with R4's refusal of medications or her behavior problems.</p> <p>Interview with E13 (6th floor nurse on 5/19/04) on 6/16/04 at 3:50pm revealed that she had seen R4 around 4pm that day and asked her if she was going to take her 5pm medications. R4 replied that she would not because she was going out to dinner. E13 was not sure if R4 went out or not, but R4 did not come back for the 5pm medications. E13 also stated that R4 seemed "very happy that day."</p> <p>E13 said that the last person who made rounds was an activity aide (E20) who saw R4 sitting up in a chair by the window.</p> <p>At about 8pm, E12(Certified Nursing Assistant - CNA) called for her to come quickly to R4's room. E13 observed R4 by the window slumped forward in a chair, blood around her nose. There was no pulse or respirations noted. R4 felt warm to touch around the face and neck, but her feet were cold. E12 stayed in the room and E14 went to call the supervisor (E14). E14 came in and took over the situation, and E13 did not go into the room again until later when other staff came in to put R4 into bed.</p> <p>E13 did not begin CPR or call 911 emergency services because "they are instructed to call the supervisor when something unusual happens."</p>	F9999			

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F9999	<p>Continued From page 19</p> <p>E13 felt that because R4 had no pulse and respirations, she was already dead, and she would only start CPR if there were signs of life (warm body, etc.)</p> <p>E12 (CNA) was interviewed on 6/16/04 at 3:35pm . E12 stated that she returned from lunch break about 8pm on 5/19/04 and answered a call light and talked with another resident. E13 asked her to check on R4 since she had not been up to the nurse's station. About 8-8:15pm, E12 went and knocked on R4's door and when there was no answer, she went in. E12 observed R4 sitting in a chair. E12 touched her, did not get a response and called the nurse to come STAT (quickly). R4 did not feel cold to her when she touched her. E 13 came in and took R4's pulse and respirations and then went to call the supervisor.</p> <p>E12 was interviewed again on 6//21/04, by phone, and stated that she had stayed with the resident until other staff (could not remember how many or who) came to put R4 into the bed. E 12 went out to get linen when E14 came into the room so she did not see what E14 had actually done to assess R4.</p> <p>E20 (activity aide) was interviewed on 6/17/04 at 11:40am and stated that she had seen R4 on 5/ 19/04 sitting in a chair in her room at 4:45pm and told her to come down to the dining room for dinner. R4 did not complain of feeling sick to her, nor did she act differently that she normally did. E20 saw R4 again around 6:20pm in her room and talked with her about not coming down to eat, and also told her about a movie they were going to show in the dayroom. E20 did not see R 4 after that time.</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>E14 (PM Supervisor- LPN) was interviewed on 6/16/04 at 4:25pm. E14 stated that she saw R4 on 5/19/04 at about 3pm on the elevator. E14 talked with R4 and stated that she seemed "happy." E14 saw R4 again briefly at around 6pm in the 6th floor smoking room.</p> <p>E14 revealed that at around 8:30pm, she was paged to come to the 6th floor STAT. A CNA took her to R4's room where she observed R4 slumped over in a chair with a small pool of blood at her feet. R4 felt cool to touch, had no pulse or respiration. E14 then told E13 to make the necessary calls.</p> <p>E14 also told surveyors that, although she knew R4 was not A DNR, she did not do CPR because R4 "was already gone; and that 911 will not come to the facility if a resident is already dead." E14 followed the facility's "Presumed Death Policy" and did not file a incident report or call the police department.</p> <p>E30 (CNA) was interviewed on 6/22/04 and stated that she saw R4 on 5/19/04 in the lobby when she came on duty, and R4 told her she was waiting for a friend. E30 made rounds at 5:15pm to let the residents know about dinner. R4 went to dinner and then went back up to the 6th floor. E30 did rounds again at 6pm and knocked on R4's door and R4's roommate answered that they were "OK". E30 went to lunch from 7-8pm, and then relieved the receptionist from 8-9pm. She returned to the 6th floor around 9:05pm. E30 helped with gathering R4's belongings and talked with family members only.</p> <p>E31(CNA) was interviewed on 6/22/04 and stated</p>	F9999			

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F9999	<p>Continued From page 21</p> <p>that on 5/19/04 at about 3pm, she asked R4 if she had an ink pen. R4 acted "kind of spacey, not her normal behavior." E31 told E13 and she checked on R4. E31 did not see R4 again until after 6pm. At 7:30pm, E31 was doing rounds and asked R4 about coming to one of her favorite activities, but R4 stated she wanted to be left alone. E31 went on break at 8pm and when she returned was informed that R4 had died. E31 went to the room and saw R4 lying on the bed with her clothes still on. The nurses (E13, E14) asked her to clean up R4. E31 took R4's clothes off and put them in a bag. The nurses were doing other things and it was very "chaotic".</p> <p>E29 (CNA) was interviewed on 6/22/04 and stated that she knew R4 "pretty well" and that R4 seemed happy on 5/19/04. On 5/19/04 she was called to the 6th floor after 8:30pm to help E12. When she entered R4's room she saw R4 still in the chair, slumped to the side with her eyes still open. She and E12 cleaned up around her and were told by the nurses to get her ready for viewing by the family. E14 came into the room but then went out to make calls. E29 thinks she remembers the nurses checking R4's pulse. Things moved very quickly as far as cleaning up the room and preparing the body. E29 could not remember the names of other staff who helped with R4.</p> <p>E28 (LPN on-call 5/19/04) was interviewed on 6/17/04 at 12:30pm and stated that E14 had called her between 6-10:30pm (could not remember an exact time) and notified her of R4's death. E28 told E14 to follow the Presumed Death Policy and to call the family and physician. E28 had no other involvement after this. E28 did state that</p>	F9999			

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F9999	<p>Continued From page 22</p> <p>the facility follows this policy if a resident is found without vital signs.</p> <p>E1 (Administrator) stated upon interview on 6/17/04 at 11:55am that she did not remember if staff notified her the evening of 5/19/04 of R4's death. The facility has an on-call nurse who is called by the supervisors on the evening and night shifts for problems. E1 stated that there are 3 RN's (Registered Nurses) and 1 LPN that take call daily .</p> <p>E1 stated she talked with E14 after the surveyors had interviewed her, and E14 told E1 that she had followed the facility's Presumed Death Policy for R4 but she had failed to document that R4 had fixed and dilated pupils. E 1 also stated that she felt there was "nothing unusual about this death, so 911 was not called. Age does not have any bearing on it if there are no vital signs present. If she had felt that the staff had done something wrong she would have come to the facility that night" " No facility investigation was done. E1 was made aware by surveyors that the documentation for R4 was incomplete that that no RN had done an assessment or signed the nursing notes.</p> <p>E2 (Director of Nurses) was interviewed on 6/17/04 at 11:30am and stated that she was on leave when R4 expired. E2 did stated that if a resident is found with no vital signs and not breathing and without other signs of injury, the Presumed Death Policy is followed. Age or diagnosis does not play a part in this decision. Incident reports are not made out or reported if it is a death and the facility did not consider reporting R4's death because it was not unusual.</p>	F9999			

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F9999	<p>Continued From page 23</p> <p>The facility Presumed Death Policy states that:</p> <p>I. CPR will not be performed after an unwitnessed cardiac arrest if the following is present:</p> <ul style="list-style-type: none"> A. Pupils fixed and dilated B. Mottled discoloration of the body C. Absence of reflexes D. Bowel and bladder sphincter control gone E. Absence of vital signs (pulse and blood pressure) with the presence of the other symptoms listed above. <p>II. Before a decision to not resuscitate is made, A through E must be verified by two licensed nurses, one of which shall be a Registered Nurse .</p> <p>III. The findings shall be documented in the nursing notes, along with the signature of both licensed nurses. The Attending Physician will be notified.</p> <p>Review of the nurses notes from 5/19/04 from 8:30pm - 11:30pm state only that R4 was found unresponsive with no pulse or respirations. None of the required assessment and documentation per above facility policy was done. All of the entries during this time are signed by E13 and E14 who are LPN's. E28, who was on-call, was also an LPN. Review of staffing for the 3-11pm shift for 5/19/04 showed that there were no RN's on duty that evening. Therefore, there were no available RN's in the facility to assess death and make a final decision on the initiation of resuscitation measures.</p> <p>Review of two other residents records (R's 9, 10), in which the facility used this Presumed Death</p>	F9999			