STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

BRIGHTON GARDENS - HOFFMAN ESTATES
Facility Name

0046144
I.D. Number

2150 WEST GOLF ROAD, HOFFMAN ESTATES, IL 60194
Address

Date of Survey: 11/10/2004

Complaint Investigation
Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

330.720a)1)
330.1125a)d)e)g)

No resident determined by professional evaluation to be in need of nursing care shall be admitted to, or kept in, a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.

Every facility shall respect the resident's right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights.

Any decision made by a resident, an agent, or a surrogate pursuant to subsection(c) above must be recorded in the resident's medical record. Any subsequent changes or modifactions must also be recorded in the medical record.

The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) above and may not discriminate in the provision of health cre on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for health Care Law, the Health Care Surrogate Act, or the right of Conscience Act (Ill.Rev.Stat.1991, ch.111 1/2, pars. 5301 et seq.) [745 ILCS 70]

The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience.

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(Cont.)

Based on record review and interview the facility has failed :

a.) to assess and provide one resident (R10) with proper nursing care which resulted in R10's death by not initiating CPR or calling 911 immediately. Staff called nurse off unit to discuss rather than call 911.
b.) to record and update end of life decisions and make changes in the record from a DNR status to a Full Code status. CPR was stopped on the basis of the wrong end of life decision presented to paramedics.

Findings include:
Facility is licensed as a sheltered care facility.
R10 is a resident that was residing on the Avon Unit (Dementia) 3rd floor locked unit, with a history of falls. R10 was an ambulatory but confused resident and fell 04/11/04 which resulted in resident going to a hospital for a fracture to her left hip and needing surgery.

R10 was then re-admitted to the facility from a skilled nursing home on 05/07/04 with Status Post Open Reduction Internal Fracture (ORIF), Sepsis, on contact precautions for C-Difficile with ongoing symptomatic Diarrhea, poor appetite, a Sacral decubitus stage 2 and 1 inch eschar on the left heel, Neurogenic bladder, Wound Infection, Dementia, Congestive Heart Failure, Chronic Atrial Fibrillation, Hx of CVA, Pneumonia, UTI. R10 was still on antibiotic therapy. Clinical record from skilled nursing home notes on 04/29/04 R10's Foley cathter was discontinued and she remains incontinent. 04/30/04 notes reveal R10 has left lower Edema and was sent to the hospital to rule out Deep Vein Thrombosis.

DNR (Do Not Resuscitate) orders were Changed to a Full Code per Physician's Order 04/28/04 per POA (Power of Attorney). So, at readmission the new full code orders were in effect. Readmission notes R10 is to have a care giver from VNA (Visiting Nurse Association) 2pm to 8pm daily. VNA nurse does dressing changes on decubs and reports on 05/10/04 that heel decub needs to be debrided and sacral decub is easily a stage 3. After 8pm, there are no nursing staff or nurses aides in the building to assist with any dressing care or medical needs associated with this resident's many skilled diagnoses.

Clinical record review according to nurses progress notes dated 05/11/04 at 2220 hrs. (10:20PM), and interview of E6 (Care Manager from Alzheimer’s Unit/1st floor) on 11/09/04 at 2:45PM, revealed that E2 (DON) received a phone call from E7(Care Manager scheduled to take care of R10 on 05/11/04). E2 was at home at the time. E7 informed E2 on the phone that R10 had foam and phlegm all around the mouth and in the mouth, and E7 was concerned. Per

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telephone, E2 instructed E6 bring the pulse oximeter up to 3rd floor and do pulse oximeter reading. E6 reported to E2 the pulse oximeter reading was 44 per cent and R10's pulse rate was 96-105/min. E2 thereafter called 911 from her home. 911 arrived at 2300 (11:00PM), CPR (Cardio Pulmonary Resuscitation)was initiated, and at that time resident was not responding and without vital signs. R10 was transported to the hospital and pronounced DOA (Dead on arrival) at 2325 11:25PM on 05/11/04.

Interview with E6 on 11/09/04 revealed she is the only care manager that was working that night that is still employed at the facility. E6 worked on the 1st floor Alzheimer unit and has been employed at the facility for 3 years. E6 further stated that E7 called for help because R10 "did not look good." E6 stated that they cannot call 911 without permission from a nurse and therefore E2 was called at home first and 911 not called. After paramedics arrived E6 copied an old DNR order dated 10/01/03 showing the paramedics that R10 was a DNR. CPR was stopped by the paramedics after call to their hospital based physician

This order was changed 04/28/04 to a Full Code. There was confusion to code status during this emergency, as medical records were not current and valid and as a result incorrect information was given the paramedics who had started CPR and then stopped it.

EMS (Emergency Medical Service) Report dated 05/11/04 responded to 911 call reveals upon arrival that R10 was found with no pulse and no respirations. R10 was given full ALS care and CPR. Facility staff could not relate a time that R10 stopped breathing and produced a DNR, and resuscitation was stopped. R10 was transported to hospital.

The facility did not provide a plan for this medically compromised resident (R10) after 8:00PM when facility is minimally staffed and no nurse on duty. Care Managers do not have the training to evaluate and treat this type of emergency situation. Valuable time and emergency measures were not given R10 by not calling 911 immediately. R10 was a Full Code and as such should have been resuscitated and CPR continued once started. Facility accepted a resident with needs beyond their license and staffing capacity and as such, failed to care and evaluate this resident during a cardiac arrest. Failure to properly assess residents for level of care poses threat to all residents in facility. Failure to allow staff to call emergency paramedics delay treatment.