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	145969	A. BUILDING _____ B. WING _____	C 10/17/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILLION OF FOREST PARK	**8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 490	Continued From page 42 that no CPR was initiated. 3. A review of the facility census of September 5 , 2005 reveals that the third floor had 61 residents and of those 61 residents 8 were on vents. The staffing for that day on the second shift (3:00pm to 11:00pm) was 2 nurses, 6 certified nurse assistants and 1 Respiratory Therapist. The facility had one nursing supervisor for the whole building, E10. E10 has only been a practical nurse for 3 months and has limited experience in working with residents on ventilators. E7 is also a practical nurse and the remaining nurse was one from the agency and had not worked at the facility before September 5 , 2005. There was inadequate staffing to fulling assess and provide prompt care to not only R16 but the other residents on the unit. Administration failed to ensure that an adequately trained nurse supervised the care and treatment of residents in the absence of the Administrator and or Director of Nursing. 4. The administration failed to provide adequate staffing to pass medications in a timely manner and without errors to residents as evidenced by medication error rate of 34.92%. The facility took the following steps to remove the Immediate Jeopardy on October 14, 2005: 1. Nursing staff will be in serviced on October 14, 2005 on Change of condition policy, calling 911 versus standard transportation, revised DNR procedure, notification of DON and or designee of emergency situations, follow up on lab values including respiratory values, and the facility code procedure. 2. Communication of the DNR order and the	F 490		

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F 490	Continued From page 43 procedure for identifying DNR residents including a color coded name plate on the resident's door. 3. Lab reports have been audited for accuracy and monthly audits will be conducted. 4. Audits will be done on all residents with change of conditions to ensure adherence to facility policy. 5. Regular CPR classes and return demonstration along with monthly mock emergency codes. 6. All new agency staff will be mandated to attend orientation which will be conducted two hours prior to the first scheduled shift. THe orientation will include the facility's change of condition policy and code policy and communication of code status. 7. Staffing has been adjusted to include a Registered Nurse Unit Manager to oversee the day to day operations on the unit and communicate nursing needs to the DON. Staffing levels have been adjusted to meet needs and will be maintained. Staffing will be monitored daily by management staff and weekly by the regional office staff.	F 490		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATION 300.1030 a) 300.1030 a)1) 300.1030 c) 300.1030 d) 300.1210 a) 300.1210 b) 300.1210 b)2)	F9999		

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F9999	Continued From page 44 300.1210 b)3) 300.1220 b) 300.1220 b)1) 300.1220 b)2) 300.1220 b)3) 300.1230 a) 300.1230c) 300.3220 f) 300.3240 a) Section 300.1030 Life Sustaining Treatments a) 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. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be counted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one	F9999		

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F9999	Continued From page 45 person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. 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 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

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F9999	Continued From page 46 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1230 Staffing a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident needs on each shift of the day. This determination shall be made separately for both licensed and nonlicensed nursing personnel. c) It is the responsibility of each facility to determine the staffing needed to meet the needs	F9999		

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F9999	Continued From page 47 of its residents. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 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) Based on interview and record review, the facility failed to ensure that residents were free from neglect by: 1. Failing to initiate Cardiopulmonary Resuscitation (CPR) for 1 resident (R2) who was a Full Code Status; 2. Failing to promptly obtain a lab report, promptly act upon and notify a physician of a critical lab value and failing to promptly send 1 resident (R16) to the emergency room when the resident's status changed. Findings include: 1) Review of the facility's Final Incident Investigation Report (completed by E1-Assistant Administrator) notes that R2 was a 71 year old with the following diagnoses: Diabetes Mellitus,	F9999		

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F9999	Continued From page 48 Hypertension, End Stage Renal Disease, G-tube, Vent, Respiratory Failure, Dialysis and Hepatitis C. On 09.10.2005, at approximately 7:25pm, E2 (Respiratory Therapist) found R2 without a pulse, located E5 (CNA, who was not available for interview during this investigation) and they went to locate a nurse. E3 (LPN) went to room and noted absence of pulse and cold to touch then left room to inform E4 (LPN-Nursing Supervisor) of situation. E4 went to assess R2(found resident unresponsive, cold to touch with no vital signs) while E3 contacted R2's physician. R2's physician called back and instructed E3 to follow policy and send the resident out. E3 called administration to verify policy and was instructed to call 911. Paramedics arrived; R2 was pronounced dead at 9:01pm by doctors at hospital. E1(Assistant Administrator) stated (during telephone interview on 10.11.2005 from 11:55am -12:15pm) that she initiated a neglect investigation because R2 was a full code; staff's response should have been immediate; there was a time gap in the Nurses Notes and staff failed to follow facility policy and procedure. During interview (via telephone on 10.06.2005 from 11:05am-11:35am) E2 stated that on 09.10. 2005 at the start of her 7:00pm rounds she entered R2's room and noted that resident's mouth was not moving (R2 had involuntary mouth movement all the time). E2 took a pulse oximeter reading, found R2's oxygen saturation to be 70% (normal=95-100%) and pulse rate to be zero. E2 found E3 who initially stated "he's not	F9999		

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my resident." E3 assessed R2 and found R2 to be cold to touch and pulseless and stated " there's nothing we can do for him, he's cold and stiff." E2 did not know that R2 was a full code until she was informed by the paramedics. E2 further stated that she believed if a thorough assessment had been done earlier, staff would have noted that R2 was dead.

E3 stated (during telephone interview on 10.03. 2005 from 3:00pm to 3:45pm) she assessed R2 (after being notified by R2) and found him to be pulseless and cold to touch. E3 then went to the Nurses Station to determine R2's code status. Upon finding out that R2 was a full code, E2 then went to the 2nd Floor to have E4 come up and assess R2. E3 stated that she stayed on the 2nd Floor and began making phone calls to R2's physician and Administration "to find out what we were going to do." E3 stated that E1 instructed her to call 911.

E3, who started her shift at 3:00pm, stated that she did not see R2 until approximately 7:25pm when notified by staff that something was wrong with R2. E3 stated that she was the only nurse on the unit until an agency nurse showed up at approximately 7:15pm. E3 further stated that she did not feel that there were enough nurses on the unit to meet the needs of the residents.

E4 was interviewed on 10.06.2005 via telephone from 10:05am to 10:40am. E4 stated that E3 came to the 2nd Floor between 7:20pm and 7:30 pm on 09.10.2005 to ask for her assistance in assessing R2 who was found pulseless and cold to touch. While she went to the 3rd Floor assess R2, E3 stayed on the 2nd Floor to notify R2's

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physician. E4 found R2 to cold to touch, without vital signs, left pupil fixed and dilated, incontinent of urine. E4 stated that R2 was a full code and that she came back to the 2nd Floor to call Administration to "find out what to do in this situation."

Z1 (Physician) was interviewed on 10.10.2005 from 11:30am to 11:45am via telephone. Z1 stated that the nurse called him (sometime between 7:30pm and 8:00pm on 09.10.2005) and told him that R2 "was cold/blue, appears to be dead." Z1 asked the nurse if R2 was a DNR (Do Not Resuscitate) to which the nurse responded " no." Z1 told the nurse that R2 needed to be sent out, to call 911.

Per review of the facility's CPR policy: "In the event a resident does not have a "CPR" directive, or the directive is not known, a licensed nurse will provide immediate temporary basic life support to the extent available and call for emergency ambulance transfer for the continuation of medical care."

Review of R2's medical record (Resident Transfer Form dated 08.21.2005 and Notice to Facility dated 08.18.2005) documents that R2 was a full code status. Review of Nurse's Notes dated 09.10.2005 document that there was a 55 minute delay before 911 was contacted and that no CPR was initiated.

2) R16 was a 52 year old resident with a full code status. R16 had the following diagnoses: Respiratory Dependency, Seizure Disorder, Vegetative State, Sepsis, Anemia, Hypertension, and Diabetes. On September 2, 2005 the

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attending physician (Z4) ordered that an Arterial Blood Gas (ABG) be drawn that day by the Respiratory Therapist (RT). On September 5, 2005 Z4 ordered a chest x-ray, a complete blood count (CBC), urine analysis, and a basic metabolic panel. The facility was called by the lab about a critical value of bilateral infiltrates in the lungs. The nursing supervisor (E10) paged Z 4 at 8:00pm and shortly thereafter, the RT reported to the nurse that R16's oxygen saturation levels were unstable. Z4 was paged twice and the regular ambulance service was called to transport the resident. The ambulance was called per nursing notes about 8:25pm. Per nursing notes the ambulance arrived at 8:50pm and the resident coded and the ambulance attendants started CPR and the ambulance left the facility at 9:00pm. R16 was pronounced dead in the Emergency Room upon arrival.

A review of R16's medical record indicates that an ABG was never drawn on R16. This was confirmed by E9 (Respiratory Consultant) and E1 (assistant administrator) on October 11, 2005 during interview at 2:30pm. The last Oxygen level was noted to be 75% (normal level is 95 to 100%).

Z3 (Director of Emergency Services for Hospital) was interviewed by phone on October 12, 2005 at 9:00am. Z3 stated that the hospital was concerned since the facility did not call 911 and waited for the regular ambulance to take R16 to the Emergency Room. Z3 stated that the hospital was contacted by the telemetry unit of another hospital that took the ambulance readings from R16. The ambulance reported that the resident was in full arrest at 2100 hours (9:00

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pm). The facility gave report to the hospital emergency room at 2119 (9:19pm) and reported only that the resident was in respiratory distress. Z3 stated that the resident was pronounced dead in the Emergency Room. Z3 stated, "my staff was very concerned that the facility did not call 911 and why did they wait so long."

Z4 (attending physician) was interviewed by phone October 12, 2005 at 12:15pm. Z4 stated that he was never notified of the failure of the facility to obtain the ABG. Z4 stated that he rarely orders blood gases and it was critical for him to have that information. Z4 also stated that based on the condition of the resident on September 5, 2005 the nurses should have sent R16 out via 911. Z4 stated the x-ray results of bilateral infiltrates required immediate action and that alone was grounds to send R16 out.

Surveyor interviewed E10 on October 11, 2005 at 3:30pm in the conference room. E10 stated that he had just completed his nurse's training in June and had only been employed at the facility for three months. E10 stated he was made the house supervisor that day since it was a holiday and none of the other staff would take the assignment. E10 stated that he was helping the floor nurse out since it was so busy on the unit. E10 stated, "I was assisting E7, I usually work on 2nd floor" "E7 had a lot going on and staffing was crazy" "I am scared of the 3rd floor." E10 stated that they were also having problems with another resident on the floor at the same time R16's condition was declining. E10 stated that 911 was not called because R16 still had signs of life. E 10 also stated that the ambulance company had told him that a unit was in their building on

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another floor. The unit in the facility did not have advanced life support and R16 needed transport with advanced life support. E10 continued to call the ambulance company and they finally arrived and R16 went into full arrest.

Surveyor interviewed E7 (floor nurse) on October 12, 2005 at 3:30pm in the conference room. E7 stated he had been employed since July of 2005 but had previously worked for the facility. E7 stated that September 5, 2005 he worked a double shift on the third floor and the other nurse was an agency nurse. E7 stated that it was " busy and a lot was going on." E7 stated that he did not call 911 because the ambulance unit was in the building and he thought it would be faster for them to transport. E7 stated the unit in the building was not advanced life support and that R 16 needed that type. E7 stated that he was worried that the agency nurse would leave and he would have to do the whole floor, so he was also helping her. E7 stated there were at least 60 residents on the floor and only two nurses and one RT. E7 also stated that another resident was having problems at the same time R16 was declining. E7 stated that E2 (Respiratory Therapist) was at the bedside and monitoring the resident's condition. E7 stated the facility used to staff the unit with 3 nurses and a unit manager but on that weekend only 2 nurses were working. E7 stated that, "I feel bad, I feel we should have got her out sooner but I thought it would be faster to let the regular ambulance take her since they were already here." E7 also stated he told the ambulance that R16 was on a ventilator and needed advanced life support. E7 stated that he knew R16 was a full code and that when he works he checks the charts and marks on his