STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. BUILDING _____ B. WING _____	C 12/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE, THE	**150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069**

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F 309	Continued From page 5 The surveyor confirmed that the following Immediate Jeopardy abatement plan was initiated: 1. Ensure 100% compliance for CPR certification for RN's and LPN's. (38 staff re-certified starting on 12/11/06.) 2. Increase CPR certification classes for CNA's. 3. In-service staff on Policy and Procedure regarding CPR/DNR. (Began on 12-11-06) 4. Review and revise Policy and Procedure regarding response to emergency situations and in-service staff. 5. Provide mock emergency situation drills for all shifts immediately to assess employee's response and performance to emergency situations. 6. Maintain written performance evaluation of all employees involve in the mock emergency drills. These evaluation will be sent to the Quality Assurance committee for their review and recommendations.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1035a)3)4)5) 300.1210a) 300.3240a) Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' 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. Included within this policy shall be:	F9999		

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F9999	Continued From page 6 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These REGULATIONS are not met as evidenced by: Based on record review and interview, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) on a resident with Advanced Directives for a full code. This is for 1 resident in a sample of 6	F9999		

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F9999	Continued From page 7 (R1). This failure resulted in the resident being found in Cardiopulmonary Arrest upon arrival of the local Police Officers and minutes later when the local paramedics arrived. R1 was pronounced dead at the hospital upon arrival assessment. Findings include: The record of R1, an 80 year old male admitted to the facility on 11-28-06 with a diagnosis of Alzheimer Dementia with Agitated behavior, was reviewed on 12-8-06. The record of R1 contained Advanced Directives for a "full code." R1's record contained Nursing Notes dated 12-3-06 at 4:30 PM that stated, "Called to activity room per multiple staff stating resident's nose was bleeding. Ran to check resident, noted respirations shallow and color dusky. Brought to room and placed in bed with head of bed elevated. Oxygen per nasal cannula started. Carotid pulse absent. Blood pressure not palpable. 911 called. Board placed under resident. Ambu bag in place. CPR initiated. Wife notified of husband's change in condition..... 4:37 PM, police here....defibrillator/monitor hooked up to resident...4:38 PM, paramedics here. CPR again initiated after lack of pulse, respiration, and BP.... 5:10 PM, to hospital per paramedics. Message left on M.D.'s answering machine...6:45 PM, hospital phoned. Report taken--resident expired." R1's emergency room record contained documentation that R1 was pronounced dead from "Cardiopulmonary Arrest at 5:20 PM." The EMS rescue and Ambulance report contains	F9999		

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F9999	Continued From page 8	F9999		

documentation that, "On arrival crew was met by police who had their AED attached to pt. and stated that no shock was advised. CPR and ALS care initiated. Monitor--asystole. CPR continuously throughout arrest. Followed asystole protocol...."

Telemetry report from the hospital for R1 stated "Asystole (no heartbeat) and some idioventricular heartbeats (electrical activity only)." The police "closed incident report" contained documentation that the police dispatched a police officer to the facility on 12-3-06 at 4:20 PM when they received the 911 call.

In an interview with Z5, R1's physician, Z5 stated that R1 was a full code, and that facility staff should have begun CPR immediately.

On 12-7-06, in an interview with Z1, a police officer dispatched to the facility, Z1 stated that on arrival to the facility at approximately 4:23 PM, she entered R1's room (411) and saw 4 or 5 staff standing around resident's bed. Z1 stated she asked staff if CPR was begun and was told by E6 (a nurse) that CPR was not started. Z1 stated that R1 had only a diaper on when she arrived. Z1 stated that when asked how long the resident had been in "this condition," E6 replied "about eight minutes." Z1 stated that when the paramedics arrived, the facility staff left the room and did not return.

On 12-12-06 in an interview with Z2, a police officer dispatched to the facility, Z2 stated that when he arrived at the facility on 12-3-06 at approximately 4:23 PM and entered room 411, he saw 4 facility staff at the bedside looking at the resident. Z2 stated that 1 RN was in the

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F9999	Continued From page 9	F9999		

room moving furniture around. R1 had a tongue depressor in his mouth and was ashen in color and not breathing. Z2 asked if resident was a "DNR," and E6, the nurse replied "I don't know," left the room, and returned with a "No" answer. Z2 stated that the paramedics asked pertinent medical questions, like "what is the resident's history?" E6 did not know and left the room again to "get the chart." Z2 stated that when E6 returned, he looked up the needed information in R1's record for the paramedics.

On 12-18-06 in an interview with Z3 (a paramedic), Z3 stated that he was dispatched to the facility on 12-3-06. Z3 stated that he arrived in the facility at approximately 4:26 PM. While Z3 was in route to the facility, he was advised by his dispatcher that CPR was begun. But when he arrived in R1's room, no facility staff was in the room--just the police officers. Z3 stated that the police officers had their AED on the resident, and that it registered that "no shock required," and he stated that the heart monitor read asystole.

On 12-18-06 in a interview with Z4 (the lead paramedic), Z4 stated that he was dispatched to the facility on 12-3-06 and arrived there at approximately 4:26 PM. Z4 stated that when he came into R1's room, he saw two police officers and no facility staff in the room. Z4 stated that the monitor on the resident showed "asystole." He and Z3 began CPR and ALS and transported R1 to the hospital doing CPR along the way.

On 12-8-06 in an interview with E3 (a Certified Nurse Assistant/CNA on the 3-11 shift), E3 said she saw the nurse bring R1 to his room. Then the nurse came out to the nurses station and called 911, and then she asked me to get the oxygen.

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F9999	Continued From page 10 E3 stated that when she returned, the police and then paramedics were in the room, and she left. In an interview with E1 (the administrator) on 12-8-06, E1 stated that, "I am just sick about the incident with R1" and stated that "according to what the police said, E6 did not perform her duties." E1 also stated that she would get another background check done on E6. Several attempts were made to contact E6. E6 did not respond to telephone messages left. E2 stated on 12-8-06 that E6 was suspended pending the outcome of an incident investigation. On 12-14-06, E2 stated that E6's employment was terminated. In an interview with E2 (the Director of Nursing), E2 stated that she was in the building on 12-3-06 and was asked by the owner of the facility why the police and paramedics were at the facility. E2 then went to the "Cape Cod" wing where R1 resided, and she saw E6 at the nurses station and asked her if the family and physician were called. E2 stated that E6 replied that she had called the MD and wife of R1. E2 stated that she did not know that CPR had not been initiated until the police officer came back the next day to investigate the incident and tell the facility that IDPH had been contacted. E2 stated that the investigation failed to reveal anyone that saw CPR initiated by E6 or anyone else until the police and paramedics arrived. The personnel files of all staff working on 12-3-06 on the 3-11 shift were reviewed on 12-8-06. None of the on the "Cape Cod" unit had current CPR certification. On 12-3-06 on the 3-11 shift, one nurse had current CPR certification but was	F9999		