STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

PLEASANT VIEW	0042416
Facility Name	I.D. Number
500 NORTH JACKSON STREET, MORRISON, ILLINOIS 61270	
Address, City, State, Zip	
22344	APRIL 22, 2008
Reviewed By	Date of Survey
COMPLAINT 0811782/IL34613	13240
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

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):

300.1030a)b)c)d)
300.1035a)3)4)5)

Section 300.1030 Medical Emergencies

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).
2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).
3) Traumatic injuries (for example, fractures, burns, and lacerations).
4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).
5) Other medical emergencies (for example, convulsions and shock).

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.

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 conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements.

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d) When two or more staff is 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 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 300.1035 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:

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.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to use the facility emergency cart for a resident in cardiopulmonary arrest. The facility failed to ventilate a resident with no spontaneous respirations, and failed to ensure that the code status of each resident is accurately documented to prevent delays in life saving interventions. These failures resulted in R1 not having an established airway, and not receiving oxygen during a cardiopulmonary arrest. R1 did not receive ventilations for 6 minutes until Emergency Medical Services arrived. R1 died in the hospital emergency room on 3/30/08.

This applies to 1 of 12 residents in the facility (R1) who were designated as a Full Code if cardiac arrest occurs and 4 of 49 residents whose code status documentation was inaccurate (R2, R3, R4, and R5).

The examples include:

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1. R1 has diagnoses of Weakness, Pneumonia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Chronic Lymphocytic Leukemia (in remission) per R1's General Information Sheet dated 3/29/08. The Minimum Data Set (MDS) of 3/30/08 shows that R1 had no short or long term memory deficits and was independent in her ability to make decisions. Progress Notes dated 3/29/08 document that R1 is a full code.

The Resident Flow Record dated 3/30/08 at 10:40 AM, documents that the nurse was summoned to R1's room by resident's son. R1 was dusky and had labored breathing. The Resident Flow Record states, "Resident was thrashing and grasping for air ...Resident suddenly clamped teeth down and her body went limp. This nurse and resident's son lowered R1 to the floor. Nurse called 911. Nurse went back to room and initiated CPR... "

The Emergency Medical Services (EMS) Run Sheet dated 3/30/08 states under Scene Information/History of Present Illness,"Found patient laying on floor of room with no CPR being done, nursing staff unknown of DNR status, Patient placed on monitor and found to be in sinus bradycardia at approximately 20 beats per minute (normal 60 to 80 beats per minute), with no palpable pulse, CPR initiated by EMS ...On arrival patient was down approximately 5 to 6 minutes with no CPR."

On 4/16/08 at 11:08 AM, E4 (LPN) stated, "I went out and got her breathing treatment and went back to her room. I gave her the breathing treatment and was trying to calm her down when she went limp. R1's son helped me get her to the floor. The son told me to do CPR. I was very nervous and stressed out. The son was screaming at me it was very hard. When I assessed R1 she was not breathing and did not have a palpable pulse."

On 4/16/08 at 1:45 PM E8 (LPN) stated, "Staff came down to my unit and said E4 needs you right away. I went down to help and found E4 kneeling beside R1 doing chest compressions. I got down beside her and asked if she had given any breaths. E4 said no because she did not have a protective barrier. I took over compressions for E4 until the paramedics arrived. When the paramedics arrived and knocked on the door I got up so they could get into the room."E8 was asked if she attempted to ventilate prior to EMS arriving and E8 said "No." E8 confirmed that the emergency cart was never brought to R1's room on 3/30/08 when she started to have respiratory distress.

On 4/16/08 at 12:05 PM E6 (CNA) and E7 (CNA) confirmed that the emergency cart was not used for R1 on 3/30/08. E6 and E7 said that they went down to the room to see if the nurses needed any help and they were told that they had it under control.

On 4/16/08 at 1:00 PM both emergency carts were inspected at both nurses' stations. Both carts were observed to be fully equipped with oxygen, airways and a disposable ambu-bag.

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The American Heart Association Adult Basic Life Support 2005 Guidelines state, "Give 2 rescue breaths, each over 1 second, with enough volume to produce visible chest rise. This recommended 1- second duration to make the chest rise applies to all forms of ventilation during CPR, including mouth to mouth and bag-mask ventilation and ventilation through an advanced airway, with and without supplementary oxygen. During CPR the purpose of ventilation is to maintain adequate oxygenation ..."

The facility was unable to provide any policies and procedures related to how staff is to respond to a resident in cardiopulmonary arrest. E1 (administrator) confirmed that there were no current policies to address staff response to residents in cardiopulmonary arrest.

2. The code status of all 49 residents was reviewed during entrance tour on 4/16/08. Four residents (R2, R3, R4 and R5) did not have an accurate code designation at all of the specified locations. The facility currently has a resident's code designation on the chart and in the room on the bathroom door. A green dot means do CPR and a red dot means DNR (Do Not Resuscitate). R2 had no code designation to include a red or green dot on care card on the bathroom door. R2's chart shows that R2 is a no code. R3 had a green dot on her care card in her room meaning she was a full code. R3's chart showed that she was a no code (Do Not Resuscitate). R4 is a full code and the chart did not have a green "Full Code" sticker. R5 is a no code and the chart did not have a red (DNR) sticker on the chart spine.

E2 (Director of Nursing) verified the inconsistent documentation of the designated code status of R2, R3, R4, and R5. E2 accompanied this surveyor during entrance tour on 4/16/08.

The facility was unable to provide any policies and procedures related to monitoring the accuracy of each resident's code status designation.

(A)