STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. BUILDING _____ B. WING _____	04/18/2008

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ST AGNES HC AND REHAB CENTER	1725 SOUTH WABASH CHICAGO, IL 60616

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F 520	Continued From page 187 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to have a Quality Assurance Committee that identified and implemented appropriate plans of action to correct identified quality deficiencies. Findings Include: 1. E2 (DON), E7 (Social Service Director), E29 (Restorative Nurse), E44 (Respiratory Therapist), E45 (Housekeeping/Laundry Supervisor) and Z4 (Medical Director) names appear on list as being part of the facility's Q.A. committees. 3/20/08, they were interviewed concerning this committee. Everyone stated that the committee met on a quarterly basis. However, there was a difference as to what the committee addressed during the meetings. E7, E29, E44 and E45 stated that everyone at the meeting would give a synopsis of	F 520		

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F 520	Continued From page 188 what was occurring in their respective departments for the past 3 months. They did not identify concerns and as group come up with corrective actions to be taken. E2 and Z4 are the only two members that mentioned working on problems such as falls.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.1030b) 300.1210a) 300.1220b) 300.1220b)2) 300.1220b)7) 300.1220b)8) 300.1620a) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. (B)	F9999		

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F9999	Continued From page 189 Section 300.1030 Medical Emergencies 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. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. 7) Coordinating the care and services provided to residents in the nursing facility. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and	F9999		

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F9999	Continued From page 190 programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. 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 Requiremetns are not met as evidenced by: Based on observations, staff and family interviews and record reviews the facility failed to: 1). Respond timely and appropriately to two medical emergencies involving two residents, (R12 and R53), one inside of the sample and one outside of the sample. The facility failed to assess the residents' respiratory status (R53),	F9999		

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F9999	Continued From page 191 administer oxygen (R53) and provide nursing interventions (R12) while life threatening symptoms (tachycardia and elevated blood pressure) were present and identified. a) Follow their policy and procedure of fully and adequately evaluating a resident's condition (R53's respiratory status) during the post ictal period (following a seizure). b) Follow their policy and procedure to use the crash cart in the event of a resident having a seizure. c) Administer oxygen in a timely manner to one resident (R53) in the post ictal period due to the oxygen not being stored with the appropriate connector in place. 2) Notify one resident's (R5) physician regarding extremely elevated blood glucose results and obtaining additional insulin coverage. In addition, no additional BGM (blood glucose monitoring) was done when R5's blood sugar was determined to be extremely low on 3/4/08 and R5 was given orange juice and sugar. These failures resulted in R5's blood glucose remaining/becoming elevated. 3) Assess, treat, monitor and re-evaluate one resident's (R12) level of pain and follow-up on other physical complaints; and to obtain complete report from transferring hospital following readmission to this facility. Critical lab values for a post seizure resident were not obtained. 4) Provide inservice training to licensed nursing staff within the past year regarding the appropriate response to medical emergency	F9999		

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F9999	Continued From page 192 situations according to the facility's own policies and procedures. 5) Provide proper treatment and care of one resident (R74) outside of the sample who is on a ventilator to maintain life. R74's ventilator settings were changed/reset by a nurse's aide who does not have education, training, or knowledge to operate respiratory ventilators. The settings that were set by a pulmonologist according to the resident's disease process and fluctuating in oxygen levels, clinical symptoms and lab results. 6) Maintain clinical tracking records of infections in the facility and failed to provide medical treatments on a consistent basis for infections for 7 out of 16 residents (R9, R10, R17, R18, R54, R71, and R72) who were diagnosis with resistant infections. These residents were compromised with breathing, (ventilators assistance) and alternative feeding (gastrostomy tubes). R10 died from urosepsis with inconsistency in antibiotic treatments; R9, R17 and R54 were transferred to an acute care hospital related to delays in antibiotic treatments with known infections; R18 and R71 had delays in medical antibiotic treatments with physician orders for medical treatments; and R72 had no medical treatments with known infections and antibiotic orders from a physician. The facility also failed to have their employees maintain isolation techniques while delivering nursing care. Findings Include: 1. When interviewed, E11(LPN) said R53 had a seizure in the dining room of the fourth floor. E11 said R53 was brought to her room, put in bed and	F9999		

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F9999	Continued From page 193 vital signs were taken. The blood pressure was 200/120, heart rate was 120, oxygen saturation level was at 90%. When asked what the respiratory rate was E11 said it had not been taken. E11did not take the respiratory rate after surveyor prompting. There was no crash cart present in the room or in the corridor outside of the room. An oxygen concentrator was sitting beside the bed. The surveyor asked E11 if oxygen was going to be administered. E11 said that she was waiting for E12 (RN Manager) to bring a "tree" (a connector which connects the bubble tubing to the flow of oxygen from the concentrator so that the resident can receive it). When E12 did not bring a connector into the room within a minute or two this surveyor left the room to assess the delay in securing the connector. E11 followed this surveyor out of the room and yelled down the corridor to tell E12 (who was exiting the community toilet) to find a connector. E12 looked in the medication room and did not find a connector there. E11 then told E12 that there was a connector on the medication cart. E12 looked on one of two medication carts on the fourth floor. No connector was found on the first locked med cart. E12 then obtained a connector from the second locked medication cart when prompted by E11, using E11's keys to unlock the med cart, and oxygen was then administered to R53. The time elapsed between the surveyor's initial observation of the lack of oxygen administration until the oxygen was administered was three to four minutes. When paramedics arrived about three minutes later they stated that they obtained a pulse oxygenation reading of 89% to 90% upon their arrival.	F9999		

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F9999	Continued From page 194 E11 was asked what she does with the keys to the medication cart containing the connectors when she leaves the unit for lunch or for other reasons. She replied that sometimes she holds the keys of the other nurses' med cart when they leave the floor. A review of staff training and inservice records provided by the facility to its staff within the last year did not include training on responses to medical emergency situations. 2. On 03-19-08 at 9:45AM R12 was observed in a wheelchair in her room lethargic and moaning with her head down with E13 (LPN) in attendance. R12 was admitted to the facility on 03-10-08 with diagnoses which include Sezure Disorder and a recent Fracture of the right wrist, and was wearing a cast. Oxygen was brought in by E12 (unit manager) and started at 2LPM (liters per minute) via a nasal cannula using an oxygen concentrator. The crash cart was not present in the room or corridor as per facility policy. E12 said R12 had a seizure on the second floor. E12 and E13 both said they did not witness the seizure. E13 said they were waiting for help from another staff, a CNA (certified nursing assistant), to put R12 in bed (R12 is very heavy and was unable to assist with her transfer). At 9:59AM (14 minutes later) a third staff person (CNA) entered the room to assist with the transfer. During the transfer R12's cast was accidentally pulled off her right forearm as E13 attempted to pull her out of the wheelchair while holding her right arm. At 9:59AM E13 told E12 to take R12's pulse oxygenation level. E12 left the room and returned at 10:02AM. When interviewed as to the delay in bringing the pulse oxygenator to the room E12	F9999		

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F9999	Continued From page 195 said she had to go to another floor to get it. On 03-19-08 at 10:10AM during an interview E64 (a CNA on the second floor) said she saw R12 on the elevator alone having a seizure as the door of the elevator opened on the second floor. E64 said R12's entire body was shaking "real bad" and R12's head was turned to the side. E64 said R12 lost bladder control during the seizure. E64 said she called E14 and together they pulled R12 off of the elevator. E14 when interviewed said that when she first saw R12 she had begun to come out of the seizure and was moaning. E12 said she was getting an oxygen concentrator when E39 (social service worker) came along and took R12 back up to the fourth floor. E14 said E64 was not accompanied by nursing staff when she took R12 to the fourth floor. The facility failed to have licensed staff in attendance during the transport to the fourth floor. On 03-19-08 at 11:00AM E41 (respiratory therapist) was interviewed. During the interview E41 said that the only pulse oximeter (an instrument used to measure blood oxygenation levels) that the facility has is kept locked in her desk on the third floor. E41 said that she alone has the key to the desk where it is kept. E41 was asked by the surveyor what is done with the key when she leaves the third floor for lunch or breaks. E41 stated that she never leaves the third floor during her work hours. At the end of the interview E41 was observed to get on the elevator and leave the third floor. The surveyor asked the R42 (second respiratory therapist) if E41 left the keys to the desk where the pulse oxygenator is stored with her. E42 said no, she	F9999		

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F9999	Continued From page 196 did not have the key and could not open the desk, and that she did not have access to the pulse oxygenator. 3. R5 has a diagnosis of diabetes mellitus. Review of R5's MAR (medication administration record) reflects that on 3/6 and 3/10, R5's BGM (blood glucose monitoring) result was read as "H." Per interview with E2 (DON), E2 stated that an "H" means over 550. Review of R5's POS (physicians order sheet) contains an order for sliding scale coverage, which includes an order to give 12 units if above 250, and to call the physician if above 250. There is no documentation that R5's physician was contacted for additional insulin coverage on either 3/6 or 3/10, so R5 only received 12 units of insulin. This resulted in R5's blood glucose level still being elevated on 3/11, when it was 405. At that time, R5's MD was contacted, and 16 units of insulin was ordered. Also, R5's glucose remained elevated on 3/7, at 316, after only receiving the 12 units of insulin and no additional insulin coverage was obtained because R5's physician was not called as ordered. On 3/4, R5 was heard calling out and found thrashing around in bed. Upon checking of her BGM, it was found to be extremely low, at 46. R5 was given orange juice and sugar. There is no further documentation in the nursing notes of any monitoring of R5's blood glucose until 3/5 at 4:30pm, when her BGM was found to be extremely elevated. 4. On 3/19/08, R12 was transferred out to the hospital due to a grand mal seizure. Upon her return to the facility, later on 3/19/08, the staff failed to obtain a complete report from the	F9999		

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F9999	Continued From page 197 transferring hospital which would have included lab results, until prompted by the surveyor. Upon questioning by the surveyor, E12 called the hospital to obtain lab results, which were determined to be critically low laboratory values indicating low levels of R12's anti-seizure medication. E12 called Z2(physician) on 3/20/08 and reported the following laboratory results, after obtaining them from the hospital: Phenobarbital (anti-seizure medication) normal range 15-40 results 10.0 Dilantin (anti-seizure medication) normal range 10-20 results 2.8 Valproic Acid (anti-seizure -medication)normal range 50-100 results 8.0 An interview was conducted with Z2 on 3/20/08 at 12:30PM. Z2 confirmed that the critically low laboratory results from Mercy Hospital for R12 did contribute to her seizures and Z2 gave new orders. During interview with E2 (DON) on 3/21/08, E2 stated that E12 should have gotten a complete report on R12's hospital stay, which would have included getting her lab values. The documentation in R12's record did not reflect that the staff was monitoring R12's pain, following up on the effectiveness of the pain medication, monitoring the diarrhea and following up with the laboratory results when she returned to the facility. 5) Upon initial tour of the facility on 3-11-08 on the skilled unit, surveyor observed E20 (nurse's aide), in R74 room providing activities daily living. R74 was lying on her back in bed and the upper part of her body was jerking up and down off of the bed. While R74's upper part of	F9999		

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F9999	Continued From page 198 her body was jerking the tracheostomy tube, (a tube which supplies and regulates oxygen to the body) was clogged with mucus. The alarms on the ventilator were going off and E20 continued pressing different buttons on the ventilator machine. As E20 was pressing the buttons continuously R74 was continuously having jerking episodes and the tube was still clogged with mucus and no oxygen was passing through the tracheostomy tube. E19, (respiratory therapist) directly observed the need of R74 after being called by E21 (charge nurse). E19 immediately assessed R74 and began to suction R74's airway. R74 was suctioned several times. E19 assessed the tracheostomy tube and than assessed the machine for correct settings and then reset the ventilator for R74. After this was done by E19, R74 began to breath according to the settings on the ventilator and R74 was no longer in respiratory distress. Interview with E20 on 3-11-08 in R74's room, E20 told surveyor that she always resets the ventilators for the residents on the floor. E20 further went on to tell surveyor that she was taught by respiratory therapy to continuously press the reset button until the alarm goes off. E20 would not give the name of the respiratory therapist that taught her how to operate the ventilator. Review of R74 clinical records reveals that R74 is an 84 year old female re-admitted to the facility on 11-14-07 with related complications to respiratory status. R74 has the current diagnosis which includes pulmonary fibrosis, emphysema, hypoxia, ventilator and tracheostomy dependent.	F9999		

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F9999	Continued From page 199 Review of R74's respiratory therapy form dated from the month of 3/07 states the following: R74 diagnosis and condition is respiratory failure, ventilator and tracheostomy dependent. R74 is stable at times he does experiences periods of shortness of breath. Medication is given and needed for the mobilization of abnormal pulmonary secretions which enhances sputum clearance..... recommendations are to continue present therapy as ordered. Interview with E18 and E19 (respiratory therapists) on 3-11-08 on the skilled unit, E18 and E19 told surveyor that only the respiratory therapists and nurses are allowed to provide care to the ventilators. Interview with E21 (charge nurse) on 3-11-08, E21 told surveyor that if there is a problem with the ventilators, the nurses aides are suppose to immediately go and get help either from the respiratory therapist or the nurse. Interview with E29 E30 and E31 (all nurses aides), on 3-11-08, they all stated that they were supposed to go and get help from either the nurse or the respiratory therapist when care or issues and or concerns involving anything that is related to the ventilators. Phone interview with Z5 (attending physician), on 3-15-08, Z5 told surveyor that no one from the facility notified him about E20 resetting or adjusting the ventilator setting for R74. Z5 further went on to tell surveyor if someone would have notified him he would have given orders to consult with the Pulmonolgist.	F9999		

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F9999	Continued From page 200 Phone interview with Z3 (Pulmonolgist), on 3-15-08, Z3 told surveyor that a nurse's aide does not have the knowledge, training or education to operate a ventilator machine. Z3 told surveyor that he sets the different settings according to the pulmonary disease, his assessment of the lungs, the resident's capability of handling oxygen, and lab results. There should be no one else touching the settings unless it is done by him. Z3 further went on to tell surveyor that no one in the facility called him to tell him that R74's setting were possibly changed or disturbed. Z3 also said to surveyor that if a nurse's aide reset the ventilator that the nurse's aide was just playing with the numbers because she does not know what they mean. Interview with E18 (Respiratory therapist supervisor), on 3-11-08 and 3-15-08, E18 told surveyor that the nurses aides are trained only to notify the license staff to care for the ventilators. 6) R10 was observed in his bed on a ventilator for assistance with breathing, central intervenous line for medications, a colostomy, and feces draining directly on skin, indwelling urinary catheter draining dark yellow urine and multiple pressure sores varying from stage 2 to 4 and draining. R10 was unable to speak but his eyes were open. Review of R10's clinical records shows R10 is a 71 year old male admitted to the facility on 2-8-08 with the diagnosis which includes respiratory failure, bowel resection, congestive heart failure, history of bacteremia and urinary tract infection. Lab results dated 3-10-08 reveals R10 has a positive urine culture, with the diagnosis of	F9999		

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	145632	A. BUILDING _____ B. WING _____	04/18/2008

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F9999	Continued From page 201 urosepsis. According to documentation in R10's clinical records R10 was currently on antibiotics, daptomycin 500mg intravenously every 48 hours. This was ordered on 2-21-08 for a previous infection. The medication administration records show that R10 did not receive this antibiotic on 2-25-8 and 2-29-08. Another antibiotic was ordered on 3-4-08 for R10, daptomycin 6.2mg intravenously every 48 hours. This antibiotic was to be administered until 3-20-08. According to the medication administration records R10 did not receive the antibiotic doses on 3-6-0 and 3-10-08. According to documentation in the clinical records, R10 was transferred out of the facility on 3-15-08 to an acute care hospital where he died with the diagnosis of urosepsis. Interview with E21, (infection control nurse/charge nurse), on 3-12-08, E21 told surveyor that R10 had no intravenous access so his medication could not be given. E21 further went on to tell surveyor that she had to get consent for placement from family members and it took a few days. E21 did not notify the physician for other alternative methods to administer antibiotic medications for R10. 7) R9 was observed in bed on a ventilator for extensive assistance for breathing. R9's lower extremities were contracted to his chest and unable to move his lower extremities. R9 was able to speak in short sentences and answer simple questions.	F9999		

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F9999	Continued From page 202	F9999		

Review of R9's clinical records R9 was transferred to the hospital on 3-15-08 with the diagnosis of pneumonia, gastrostomy tube malfunction. There were no clinical labs in his records indicating that R9 was in need of acute hospital medical treatment.

Interview with E (treatment nurse) on 3-18-08, E told surveyor that R9 was transferred out because of dehydration, and whitish secretions draining from his mouth for the past few days.

There was no documentation in the clinical records about symptoms that R9 had experienced in the past few days.

8) Observations of R17 on initial tour on 3-11-08, R17 was in bed on a ventilator. R17 was also observed with a gastrostomy tube, and an indwelling urinary catheter.

Review of R17's clinical records, R17 is a 98 year old female admitted to the facility 12-3-96 with the diagnosis which includes sepsis, pneumonia and congestive heart failure.

R17's lab results of a sputum culture dated 3-11-08 was positive for enterobacter species a multi-drug resistant organism, (MDRO). According to documentation in the clinical records R17 also experienced a low grade body temperature along with positive results of a sputum culture. R17's physician was not notified until 3-13-08. Documentation also reveals that R17 was transferred to an acute care hospital when the physician was notified. The admitting diagnosis was dehydration and pneumonia.

Phone interview with Z2 (medical attending), on

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F9999	Continued From page 203 3-13-08, Z2 told surveyor when the facility notified him about R17's lab results he immediately sent R17 out to the hospital. Z2 further went on to tell surveyor that the facility should know that R17 has had problems with breathing because she has history of chronic obstructive pulmonary disease. Z2 added that R17 was being treated in an acute care hospital for pneumonia. Interview with E21 on 3-13-08, E21 told surveyor that she does not know why the lab results were not communicated to the physician. E21 told surveyor that she did not notify the physician nor did she know who or when the physician was notified. E21 also told surveyor that the lab results are always a day late because they are faxed from the lab to a person who is not in the medical field and we do not receive the results until the next day. 9) Observations of R54 on 3-14-08, R54 was being transferred out of the facility by two ambulance attendants. R54 was connected to a portable ventilator and oxygen. Review of R54 clinical records shows that R54 is a 43 year old female with the diagnosis of fever secondary to sepsis. R54 is ventilator dependent. Further review of R54's clinical records shows R54 has methicillin-Resistant Staphylococcus Aures (MRSA), and Vancomycin Resistant Enterococci (VRE) of her urine. An antibiotic was ordered on 2-5-08 which was Zyvox 600mg per peg tube every 12 hours for 8 days. Review R54's medication administration records	F9999		

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F9999	Continued From page 204 reveals R54 did not receive her antibiotic until 2-22-08. According to R54's records R54 was transferred out to an acute care hospital on 3-13-08 with the diagnosis of sepsis and hypertension. 10) R71 was observed on initial tour lying in bed connected to a ventilator. R71 has a gastrostomy tube feeding infusing and an indwelling urinary catheter draining yellow urine. Review of R71's clinical records reveals that R71 is a 55 year old female admitted to the facility on 2-14-06 with the diagnosis which includes chronic respiratory failure, MSRA, extended spectrum beta lactamase, (ESBL) her in the urine, urosepsis and anoxic encephalopathy. Further review of R71's clinical records shows that R71's lab records dated 3-11-08 has a positive sputum culture of Enterobacter species (many in colony). The date that is written on the lab result is 3-18-08, and than scratched off. There were no orders on the physician order form to address R71's positive sputum culture. Interview with E21 on 3-18-08, E21 told surveyor the nurses are supposed to notify the physicians and get orders for the patients with positive cultures. E21 gave no reason as to why this was not done in a timely manner. 11) Observations of R18 on 3-11-08 and 3-12-08, R18 was lying in the bed with gastrostomy feeding infusing. R18's lower extremities were contracted to his abdomen. R18 would only answer simple questions and then would not speak any further.	F9999		