STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. BUILDING ______ B. WING ______	C 06/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE NURSING PAVILION	**2242 NORTH KEDZIE CHICAGO, IL 60647**

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F 455	Continued From page 10 notified immediately. 4. The administrator and or designee will monitor the logs of the daily (for the next two weeks, then weekly) inspections and monthly tests of the emergency generator. If any problems are identified, the facility's emergency generator contractor will be notified immediately. Administrator will monitor and weekly checks of the emergency generator. A log of these checks will be kept. Completion Date: May 28, 2008	F 455		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3140h) 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 300.3140 Electrical Requirements	F9999		

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F9999	Continued From page 11 h) Emergency Electrical Requirements 1) To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. 2) The source of this emergency electrical service shall be one of the following: A) An emergency generating set when the normal service is supplied by only one central station transmission line. B) Automatic battery operated systems or equipment that will be effective four or more hours and will be capable of supplying power for lighting for exit signs, exit corridors, stairways, nurses' stations, communication system, and all alarm systems, including the nurses' call system. C) An approved dual source of normal power. Such a dual source of normal power shall consist of two or more electrical services fed from separate generator sets or a utility distribution network having multiple power input sources and arranged to provide mechanical and electrical separation so that a fault between the facility and the generating sources will not likely cause an interruption of more than one of the facility service feeders. An automatic transfer switch is required between the facility service feeders. 3) Provide emergency electrical service for: A) illumination of means of egress as necessary for corridors, passageways, stairways,	F9999		

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F9999	Continued From page 12	F9999		

landings and exit doors and all ways of approach to and through exits including outside lights,

B) exit signs and exit directional signs,

C) fire alarm systems and detection systems,

D) communication systems which are used for issuing instructions,

E) task illumination in the nurses station,

F) nurse call system.

These REGULATIONS are not met as evidenced by:

Based on observations, interviews, and record review, the facility failed to supply emergency electrical power when the general supply was off in the area. This failure resulted in a forty minute delay in obtaining emergency electrical power to the facility thus placing all residents in the facility at risk for harm due to the lack of emergency power.

In addition, the failure placed residents needing mechanical devices such as oxygen concentrators, tube feedings, and suction machines at risk for harm and resulted in R5, R6, and R10 requiring emergency services and hospitalization.

Findings include:

On May 28, 2008, at 9:40am, the facility was noted to lose all electrical power. The power outage was noted in a large residential area of

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F9999	Continued From page 13 the city including the facility. The generator was noted not to start. The facility was noted without any electrical power including the exit signs, emergency outlets, and stairwell lighting. Staff were noted to attempt to move residents on oxygen to the hallway near the red emergency outlet. However there was no power. Staff were observed to be unsure of the appropriate action to take for residents on oxygen concentrators or needing suctioning. Finally after prompting, the staff began to place residents on portable oxygen tanks and monitor their saturations. Flash lights were not available on the first floor. The staff had to retrieve the flash lights from the basement level. Surveyors had to prompt the staff to evaluate high risk residents and move residents with low air loss mattresses that had deflated. The survey team had to prompt the staff to open curtains and doors to allow natural light in the hallway to make it lit. Emergency services (local fire department) was not called until 10:18am. During this time, none of the exit signs were visible, the fire detection system was not functional, and there was no "fire watch" in place until the fire department arrived. Every resident was placed at risk. A review of the facility's policy for "Fire Watch Procedure" states the following: "A fire watch will be initiated when there is a significant impairment in the fire alarm system." The facility failed to implement the fire watch policy until prompted by the local fire department. A review of the disaster policy indicates that one person shall take command. However the house	F9999		

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F9999	Continued From page 14 supervisor (E3) did not coordinate services or staff response during the disaster. The observation by the survey team was that staff, including management, were totally unaware of proper procedure. A tour of the facility was conducted at approximately 9:40am on 5/28/08 after the facility emergency generator failed. The following residents on the skilled unit were observed and revealed the following: R10 has a G-Tube and was observed in bed with large amounts of mucus coming from the mouth. E3 (nurse/house supervisor) attempted to use the suction machine. After prompting by surveyor, E3 was reminded that the facility did not have electrical service. E3 did not have a manual means of providing suction for R10. The facility obtained physician orders and called 911 to have the resident removed to a hospital setting for evaluation. R10's physician orders in part denotes: aspiration precautions; NPO. R5 has a diagnosis including Acute Respiratory Failure and was observed in bed. R5 has a physician order for O2 (oxygen) at 40% per trach collar. The facility staff was prompted to bring a portable oxygen tank. R5's physician ordered: send resident to emergency room for evaluation and treatment. R6 was observed on a G-Tube that was not operating by battery. R6's physician order depicts Jevity 1.2 @ 75ml./hr. per G-Tube X (times) 20 hours. R6 is on hospice and was sent out per the physician for medical evaluation.	F9999		

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F9999	Continued From page 15	F9999		

E1 (administrator) was interviewed on 5/29/08 at approximately 2:00pm and stated "R10 and R6 returned to the facility on the evening of 5/28/08, and R6 is due back today."

E1 was interviewed on 5/28/08 at approximately 12:00 noon and stated "contractors are on their way to look at the generator, switcher not working, and E13 (maintenance supervisor) should have pushed it manually."

Z1 (contractor) and Z2 (contractor) were interviewed on 5/28/08 at approximately 2:45pm and in part stated, "separate stop switch was not in the run position and not making contact. Therefore the run from the automatic transfer switch could not operate."

Interviews with staff on 5/28/08, indicated the following:

E13 (Director of Maintenance) and E14 (Maintenance Worker) were interviewed and both E13 and E14 confirmed that the emergency generator did not work. Both E13 and E14 stated and demonstrated to the surveyors that the switch would not work and stated, "system failure." Both E13 and E14 were unaware of the method to start the emergency generator and had no working knowledge of how to get the generator to function. Not one staff on duty was aware of how to get the generator to work. Finally, E1 (Administrator) arrived and was able to start the sytem. During interview, E1 stated that the facility had recently converted to a new system and that E13 and E14 did not know the new system.

E6 (First floor Nurse) stated that she did not

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F9999	Continued From page 16	F9999		

Continued From page 16

have a flash light on her unit and had to send staff down to the basement to retrieve one.

E9 (Nurse Aide) stated that she asked the nurse for a flash light, that she was not aware the emergency generator had failed, and she had no training in what to do in such an emergency situation.

E7 (Nurse) was interviewed about the situation. E7 stated that she had not been offered training in the facility. However she had been trained in a previous position. E7 stated that the residents sent out during the emergency were sent out because the facility could not properly suction due to lack of electrical power.

E12 (Nurse Aide) was interviewed and stated she was unaware that the emergency generator did not work and she did not recall having training on this emergency procedure.

E20 (Nurse Aide) was interviewed and stated that she did not know which outlet was used for emergency power. E20 was unaware of any in-service education regarding this type of emergency and was not aware that the emergency power did not work.

(A)