STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G233	A. BUILDING ______ B. WING ______	C 02/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS TERRACE	**324 EAST DOUGLAS AVENUE** **JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
W 149	Continued From page 8 the call to E3 until EMS arrived to relieve him.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)2)3) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. Section 350.3240 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)	W9999		

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W9999	Continued From page 9	W9999		

These Regulations were not met as evidenced by:

Based on record review, interviews, and observation, the facility failed to implement their policies to prevent neglect for 1 of 1 (R1) found unresponsive and expired on 2/8/09 when the facility failed to:

1) Ensure the implementation of its written policy "Physical Injury and Illness/Individual Medical Emergencies."

2) Ensure the implementation of its written policy "Resident Death within Facility."

3) Ensure that staff administered effective and timely CPR (cardiopulmonary resuscitation) to R1.

Findings include:

The 8/14/08 ISP (Individual Service Plan) identifies R1 as a 69 year old verbal ambulatory male who is 5'8'" tall and weighs 140 pounds. The ISP further states that R1 functions in the Moderate range of Mental Retardation and has diagnoses of Hypertension, Depression, Neurogenic Bladder with Urinary Retention, Urinary Incontinence, Benign Prostatic Hypertrophy and Atonic Bladder. R1 had surgery for a suprapubic catheter related to Atonic Bladder in February 2004 and has his catheter changed every 6 weeks.

R1's ISP states "A DNR (Do Not Resuscitate Order) is not being considered at this time per

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W9999	Continued From page 10 guardians." A 2/8/09 Progress Note written by E4/ DSP (Direct Support Person) states, "I (E4) started med pass by 6:00 AM or so R1 was the last person I did med pass takes at least 45 minutes to an hour to do. I went in to wake R1 and he was unresponsive I checked 3 places for a pulse and did not find one his body felt warm I called 911 Emergency and E3 to hurry in to help assist and started CPR She arrived minutes before paramedics." During interview on 2/17/09 at 2:00 PM, E4 confirmed that he was the only person on duty on the midnight shift going into the morning of 2/8/09. E4 stated that at 6:00 AM he was getting residents up to give medications. E4 stated "We wake them all up and they sit up in the day room and wait for meds (medications), then they go back to bed." E4 stated that he found R1 unresponsive, "it was after 6:00 AM about 6:15 AM. I checked for a pulse, there was no pulse so I called 911, then I called E3 and told her she needed to get here." E4 confirmed that he started CPR after he called 911 and E3. A 2/8/09 Progress Note written by E3 states, "Had a call about 6:20-6:25 from E4. E4 reported he found R1 unresponsive called 911 and was administering CPR. I arrived approximately 1 or 2 minutes later and assisted E4 giving CPR to R1. Minute or so later paramedics arrived and took over CPR." During interview on 2/17/08 at 12:30 PM, E3 stated "I had a frantic call from E4 saying, "Get Here, there's a problem with R1." E4 stated she got to the facility before the paramedics arrived	W9999		

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W9999	Continued From page 11 and that R1 was in his bed with E4 doing CPR to R1. E3 said she joined in on giving CPR until the paramedics arrived. A 2/8/09 Progress Note written by E2/QMRP (Qualified Mental Retardation Professional)states "At approximately 6:30 AM I received a phone call from E4 regarding R1 in distress and currently being administered CPR from the paramedics. E4 reported that he had entered R1's room to awaken him for medication pass. E4 found R1 unresponsive and then checked him for pulse and signs of life. E4 immediately called 911 for assistance and begun (typed as written) CPR. E3 arrived moments later and assisted with CPR on R1. Seconds later paramedics arrived and took over the CPR." During an interview on 2/17/09 at 12:10 PM, E2 stated that E4 worked the midnight shift 2/7/09 11:30 PM to 2/8/09 9:30 AM and that E3 was scheduled to work 2/8/09 7:30 AM - 3:30 PM but was called to come in earlier. E2 confirmed that day shift does not come in until 7:30 AM on the weekends. E2 stated that employees are taught that if there are no signs of life, they are to call 911 and start CPR immediately. Final Report- R1 faxed to IDPH (Illinois Department of Public Health) from E1/Administrator on 2/12/09 states the following: "On 2/8/09 staff went to wake R1, (69 year old male) for his 7 AM medication. R1 was not responsive. Staff checked vitals and called 911. He then began CPR and continued until paramedics took over. Paramedics treated R1 for about 45 minutes. He was pronounced dead. The coroner was called. Cause of death was due	W9999		

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W9999	Continued From page 12 to heart failure. R1's guardian had been called and was also present." Official document from the Police Department states that the 911 call was received on 2/8/09 at 6:48 AM. Communication Log from the EMS (Emergency Medical Service) that responded states that they received the call on 2/8/09 at 6:49 AM , the Fire department arrived on scene at 6:52 AM, ambulance arrived on scene at 6:56 AM, and the paramedics arrived on scene at 6:59 AM. NFRS (National Incident Fire Reporting System) provide by the Fire Department documents that they received the call on 2/8/09 at 6:50 AM and arrived on scene at 6:52 AM. EMS System First Response Non Transport Patient Report Form completed by the Fire Department, dated 2/8/09, states that the Fire Department were the first to arrive at the scene at 6:52 AM and found R1 in code upon arrival. Per interview on 2/19/09 at 11:35 AM, Z4 confirmed that the Fire Department were the first to arrive on scene. Z4 stated that there were 2 employees in R1's room administering CPR to R1 in his bed. "There was a male giving compressions and a female giving respirations per face shield." "We moved R1 to the floor and initiated CPR." Z5/EMS Coordinator stated per interview on 2/19/09 at 11:35 AM, that in order for CPR to be effective that the unresponsive individual must be on a firm surface for the compressions to be effective. Z5 further stated that he is a CPR	W9999		

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W9999	Continued From page 13	W9999		

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instructor for all levels taught and that it is in the American Heart guidelines that you must have a firm surface.

EMS System NON- Transport Patient Report Form completed by the paramedics who arrived at the scene at 6:59 AM, states:
"Found pt in care of (Fire Department) and (Ambulance Service) . Pt lying supine on floor CPR in progress. (Fire Department) stated "Staff was doing CPR on the bed. We moved him to the floor." (Fire Department and Ambulance Service) resumed CPR. We arrived pt was cyanotic, pale Pt intubated-- cords visualized. Staff stated pt is not a DNR. In talking to staff they had checked pt at 0200--coughing. Was doing med pass at 0600 no response. ? thought they felt a pulse. 911 was called at 0648."

EMS System Patient Assessment Radio Log (no date) under Assessment states: Bed check at 6 AM , (no) breathing, (no) pulse, Asystole, Intubated.

During an interview on 2/18/09 at 9:00 AM, Z2 stated "E4 said that he went in to wake R1 at 6:00 AM and we didn't get the call until 6:48 AM." Z2 confirmed that when she arrived on scene there were two employees working.

County Coroner Death Investigation Report/ Investigator's Form (dated 2/8/09) under Description of Circumstances states, "Found dead in bed - found 6:00 AM- EMS called 6:48 AM- CPR- Determined Dead." This form documents that the coroner was notified at 7:15 AM and visited the scene at 7:35 AM.

During interviews on 2/17/09 at 8:15 AM and

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W9999	Continued From page 14 2/18/09 at 11:48 AM, Z1 stated that the male staff who was on duty said he found R1 unresponsive at 6:00 AM. Z1 stated cause of death was determined to be Hypertension Heart Disease. During an interview on 2/17/09 at 3:00 PM, E2 was asked what staff are trained to do if they find an unresponsive individual in bed. E2 stated, "They (staff) would perform the CPR where they find the individual unless they need to move the individual from danger. Staff are trained not to move individuals because they may injure the individual. There may have been more harm done if he would have tried to move him by himself." E2 confirmed that staff would give the CPR in the bed if the unresponsive person was found in the bed. E2 confirmed that there is not a backboard available at the facility. The Journal of American Heart Association Part IV Adult Basic Life Support (dated 11/28/ 2005) under Activate the EMS System states: "If a lone rescuer finds an unresponsive adult (ie, no movement or response to stimulation), the rescuer should activate the EMS system (phone 911) and return to the victim to provide CPR." Further review of this publication under Open the Airway and Check Breathing it states: "To prepare for CPR, place the victim on a hard surface in a face up position. " On 2/19/09 at 11:05 AM mattresses at the facility was observed. Noted mattresses were placed on bed frames with a board, no bedsprings. This surveyor simulated CPR compression into the mattresses and was able to press down into the mattresses. Several mattresses were assessed with the same results. E3 stated at this time that R1's mattress had been disposed of, but	W9999		

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W9999	Continued From page 15	W9999		

confirmed that it would be the same as the other mattresses.

Reviewed policy "Resident Death within Facility" (Revised 11/08) under Procedure it states:

In event of the death of an individual in the facility the following steps shall be completed:
1. The staff person shall immediately call 911 and begin CPR and other first aid as needed.
Staff person shall notify QMRP or Administrator

Reviewed policy "Physical Injury and Illness/ Individual Medical Emergencies" it states:

POLICY: Individuals served by the agency shall receive timely and effective medical service for physical injuries and illnesses and medical emergencies.

DEFINITIONS: Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

PROCEDURE: In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following:
E. In case of a medical emergency,
1. Notify the local emergency service to transfer (use 911 or local emergency number)

E1 was interviewed on 2/20/09 at 10:00 AM regarding facility's policy, "Resident Death in Facility." E1 confirmed that if there is only one person on duty they would call 911 and start CPR. E1 stated that E4 should not have made the call to E3 until EMS arrived to relieve him.