STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G097	A. BUILDING _____ B. WING _____	C 04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW LIVING CENTER	**7270 SOUTH SHORE DRIVE CHICAGO, IL 60649**

(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 000	INITIAL COMMENTS Incident Report Investigation: Incident of 3-1-10 (IL46495)	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the policy for neglect was implemented for 1 of 1 client in the facility who expired (R1) when the facility failed to supervise R1 every 15 minutes as a precaution for seizures, ensuring timely emergency treatment as needed. Findings Include: The 9/16/09 Individual Program Plan (IPP) identifies R1 as a 63 year old female whose diagnoses include Profound Mental Retardation, Seizure/Epilepsy (Temporal Lobe), Psychosis NOS, and Anemia. The IPP describes R1 as ambulatory with a slight gimp, talkative, outspoken, and opinionated . Level of Supervision is listed as close. E2 (Assistant Administrator) stated on 3/15/10 at 2:30 p.m. close supervision is checking R1 every 15 minutes. Surveyor interviewed E11 (facility physician) on 3/16/10 at 12:45 p.m. The supervision level was probably because of seizures as a safety precaution.	W 149		5/7/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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W 149	Continued From page 1 E3 (Health Services Supervisor) was interviewed on 3/15/10 at 2:40 p.m. E3 said the reason (R1) was on close monitoring was because of her Seizure Disorder. The 24 hour Nursing Communication Report dated 2/28/10 for the 7A-7P shift has an entry, " (R1) monitor for SOB (shortness of breath), poss seizure." E3 (Health Services Supervisor) stated on 3/29/10 at 10:05 a.m. nurses use the report to communicate information to each other and support staff . The facility Policy titled Abuse and Neglect Program Revision Date December 2009 defines "Neglect - failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness." Facility policy for Levels of Supervision revised 10/17/09 defines: "1. General Supervision: All staff is responsible for the CARE; WELFARE; SAFETY & SECURITY, for all the residents this facility serves. It is your responsibility to know where the residents are that your are assigned to and that they are free from abuse and neglect. 2. Close Monitoring: This includes all of the above as well as keeping the resident whereabouts known at all times. The resident may move about independently but staff will monitor through direct observation at a minimum every 15 minutes. (documentation may be assigned)."	W 149		

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W 149	Continued From page 2 Review of Accident/Incident Report completed by E4 (Licensed Practical Nurse / LPN) states, "Date of incident: 3-1-10 Time of incident 6:15 a.m. T/L (team leader) (E5) try to wake client for A.M. care. Client unresponsive et (and) cold to touch. Nurse notified examined client, (no) pulse noted, body cold et (and) unresponsive to name et (and) movement when shaken; arm & legs stiffening when moved." Surveyor reviewed the Paramedic report dated 3/1/10. The note reads "Patient found lying in bed unresponsive, upon exam, patient DOA (Dead on arrival), Rigger/lividity noted, nurse stated last time she talked to patient was around 10:00 PM last night. Nurse stated she went to give patient her medication this morning and found patient unresponsive not breathing. No trauma noted." Surveyor reviewed written statements obtained by E2 (Assistant Administrator) during the Investigative follow up dated March 8, 2010: DSP (Direct Support Person) E7's statement states "After dinner (on 2/28/10) I start noticing that (R1) was looking unhappy a little. She started paceing (pacing) in the day room a couple of times and, I ask (R1) to have a set (seat) for safety it appear to me that (R1) might have a seizure so I (cont) to let (R1) stay in the day room to be monitor and watch movies for the end of my shift. I left the floor between 9:30 - 9:31 my shift was over and (R1) was in the chair in the dayroom with staff (E8)" Surveyor interviewed E7 on 3/16/10 at 3:10 p.m.	W 149		

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W 149	Continued From page 3 E7 confirmed written statement. E7 said R1 did not have a seizure on 2/28/10 during E7's shift. DSP E8's statement states , "(2/28/10) staff (E7) had said she (R1) might be going to have a seizure at some point...(R1) was in the dayroom until about 9:35, at that time she went to her room. At 9:50 p.m. nurse (E4) came & ask me to come to (R1's) room & get her & bring her to (middle) day room with me cause she has went to bathroom six times. When I got to her room she was lying awake in bed & nurse (E4) said she was out of breath. She appeared to be breathing a little out of breath, like walking up stairs. I (E8) called (R1's) name, after 10 to 12 x she wouldn't respond, but she was awake. I then notified the nurse (E4) that there was no response. Nurse came in the room called her name twice and said well we (know) she's not dead cause she's breathing. Nurse (E4) said well I'll keep eval on her. After she said that I went back to dayroom. The nurse went back to office & sat down. I (E8) worked 2nd shift 2pm - 10pm." Surveyor interviewed E8 on 3/16/10 at 2:55 p.m. E8 said, "I was assigned to (R1) on 2/28/10 at 9:30 p.m. (R1) usually fights seizures by pacing. (E4) nurse wanted me to bring (R1) to me due to pacing. E4 said she was out of breath from pacing the floor. (R1) was always out of breath lately. I went to R1's room at 9:50 p.m. Usually if you called her name she would respond. (R1) was alive at 9:50 p.m., I told (E4) she is not responding to me calling her name. The nurse said she would look after her. I left R1's room." (Evening shift Supervisor on 2/28/10) E14's statement states, " I (E14) am writing this	W 149		

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W 149	Continued From page 4	W 149		

statement in regards to (R1). I (E14) checked on (R1) at 8:58 pm. (R1) was sitting in the middle day room watching TV with peers and staff (E7) and (E8). She appeared to be fine."

Follow up interview with E14 conducted by E2 (Assistant Administrator) dated 3/2/10, noted E8 never informed E14 that (R1) was out of breath and (E8) called her name 10 - 12x.

DSP E9's statement notes E9 did bed check on 2/28/10 from 9:15 P to 10:15 P. (R1) was lying in bed asleep. E9 reported doing bed check from the doorway. E9 said E9 never saw (R1) getting up out of bed going to the bathroom. E9 stated R1 was snoring loudly. E9 stated at one time R1 was laying flat on her back, and another time she was on her side with her face resting against her arm (normally how she sleeps).

E9 was interviewed on 3/16/10 at 2:36 p.m., E9 confirmed the information given in his statement. E9 said he observed R1 from the door of the bedroom because male staff don't usually work with women.

LPN E4's statement reads as follows; "2/28/10 ...9:30 p - (R1) got up to go to bathroom (and) I took her to bed. 9:40 p. - (R1) got up again to go to bathroom et (and) back to bed. 9:50 p - (R1) got up once more but I stop her (at) the bathroom door (and) walk her back to her bed telling her to lay down and go to sleep. I sat her on her bed took off her shoes and pants...she lay down facing the window about 10 to 15 mins I saw her turning around toward the door. I felt she wasn't going to sleep (at) this time so I walk to the middle day room and ask (E8) to come (and) escort (R1) to middle day room (and) let

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W 149	Continued From page 5 her sit there until she gets sleepy or dozing off. (E8) came to her room turn on the light (and) ... told her to get up about 3 times. Then (E8) said to me that (R1) was non-responsive. When she (E8) said that I thought (R1) had stop breathing. I went to the room and notice that (R1) was breathing, her breathing wasn't shallow or labored and she was sleeping and not awake as I thought. I told (E8) that (R1) was alive and breathing and not to get her up but let her sleep. The light was turn off and we left the room that was about 10:15 p. I came back to (R1's) room around 11p to get her vitals p(pulse)-80 R (respirations) 20 B/P (blood pressure) 149/82 (best I can remember). After taking her vitals I took a blanket out the linen closet (and) covered her up because she was lying on top of her sheets. Around 11:30 before going down stairs I look in on (R1) and she was still sleeping...I glance into (R1's) room (and) saw she was sleeping around 1:30 a. or so...Around 6 - 6:15A (E5) called me to look (at) R1 because she wouldn't wake up. I went to (R1's) room (and) felt for a pulse on her wrist (and) then her neck. - there was none. I also notice that (R1) was cold, bluish in color (and) her limbs - arms (and) legs were stiff and no longer easily to bend (at) the elbow (and) knees her eyes were fixed and dilated. I saw no chest movement or felt her breath against my face." Surveyor interviewed E4 on 3/16/10 at 9:45 a.m. E4 said she called E8 to sit with R1, when R1 was restless and up walking, to calm R1 down. (R1) had done this before, got up and walked around when anxious, I didn't want her to do this because of her breathing. When E8 came to the room, E8 called R1 three times. E8 said R1 was unresponsive. E4 said, "I checked her, (R1)	W 149		

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W 149	Continued From page 6 was sleeping and I could see her breathing. " E4 said she took R1's vital signs at 11:00 p.m. because R1 had symptoms like she had the last month or month and a half. When over exerted she would have to sit down and calm down. If she got up walking around too much she would be short of breath like someone running too much. . Overnight DSP E6's written statement was reviewed. The initial written statement reads in part as follows; "I did bed check every thirty minute. I always start on (R1's) end when I do bed check I check her room and she was sleep. Every time I went to her room she was sleep. When the morning staff com (come) in to get her up (R1). She would get up that is when I heard that it was some wrong with her. One of the staff call the nurse." A follow up staff interview with E6, was conducted for the investigative follow up dated 3/3/10. The follow up interview was conducted by E2 (Assistant Administrator). The follow up interview reads as follows; "quest: How often did you complete the bed (check) on 2/28/10 for 3rd shift? Ans. every 15 minutes ques: what time frame did you do bed (check) Ans: starting @ 10:30 pm - 5:30 am ques: How are bed (checks) completed? Ans: I opened the door, turned on the lights, walked in the room & looked around ques: where were you standing at? Ans: at the end of (R1's) bed	W 149		

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W 149	Continued From page 7 ques: while completing bed (checks) did you notice (R1's) chest going up & down? Ans: I did not notice. question: What position does (R1) sleep in? Ans: always lays on her side question: Did you notice any changes in sleeping position during your bed (check) Ans: No changes were noted" Surveyor interviewed E6 on 3/17/10 at 7:45 a.m. E6 stated bed check is done every 15 minutes. E6 said, "I go room to room, cut on light and go around room. (R1) looked like she was asleep. Cover pulled up around neck on her side. Face turned toward door. After she was found (R1) still looked like she was asleep. E6 said, "I asked has (R1) been sick?" -" had trouble with her breathing, (E5) said." E6 said, "there was a call off on the night she passed. I could do the job didn't need/ask for help. Everything went smoothly, everyone slept all night." (Night shift supervisor on 3/1/10) E10's statement reads, "At around 10:45 I went to the second floor I ask (E6) if she needed me to do anything. She said no... I ask if she wanted me to do bed check she said no. She said she was okay. I told if needed any thing let me know I would be on the floor monitoring for a while. I was talking to (E4) the nurse. She said that (R1) kept getting in and out of the bed. She said she talked to her and told her to go to sleep. She put a blanket on her she went to sleep. I asked how (R1) was doing she said she's okay." Follow up interview with E10, conducted by E2	W 149		

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W 149	Continued From page 8 (Assistant Administrator) dated 3/2/10, noted E10 did not return to the floor after 3:30 a.m. E5's, (program supervisor) written statement reads, " I (E5) call out to (R1) and didn't get no responds. I called out to a second time and still didn't get no responds. At this time I walk over to her and touch her, leg blanket over body and her body was stiff and I still didn't get no respond. I (E5) called for the nurse (E4) to come to take a look at (R1) that she is none responding. (E4) the nurse came in the room and check her and said that she had past away."	W 149		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate health care monitoring for 1 of 1 client (R1) who expired in March 2010 when the facility failed to: A. Ensure adequate supervision of client every 15 minutes as per Individual Program Plan. B. Ensure individual with a history of seizures is monitored appropriately when pre-seizure activity is observed. C. Initiate Cardiopulmonary Resuscitation as per facility policy. D. Ensure nursing evaluates and makes recommendations for client with known seizure activity.	W 318		5/7/10

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W 318	Continued From page 9 Findings Include: Refer to deficiencies cited at: W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of client. W331 - The facility must provide clients with nursing services in accordance with their needs.	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate health care monitoring for 1 of 1 client (R1) who expired in March 2010 when the facility failed to: A. Ensure adequate supervision of client every 15 minutes as per Individual Program Plan. B. Ensure individual with a history of seizures is monitored appropriately when pre-seizure activity is observed. C. Initiate Cardiopulmonary Resuscitation as per facility policy. D. Ensure nursing evaluates and makes recommendations for client with known seizure activity.	W 331		5/7/10

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W 331	Continued From page 10 Findings include: A. The 9/16/09 Individual Program Plan (IPP) identifies R1 as a 63 year old female whose diagnoses include Profound Mental Retardation, Seizure/Epilepsy (Temporal Lobe), Psychosis NOS, and Anemia. The IPP describes R1 as ambulatory with a slight gimp, talkative, outspoken and opinionated . Level of Supervision is listed as close. E2 (Assistant Administrator) stated on 3/15/10 at 2:30 p.m. close supervision is checking every 15 minutes. Annual Review of Advanced Directives for R1 dated January 01, 2008, states the current status is FULL RESUSCITATION. R1's State of Illinois Certificate of Death states R1 died on 3/1/10. Immediate cause of death is Acute Myocardial Infarction due to Atherosclerotic Heart Disease. Person completing cause of death is listed as E11 (facility physician). Review of Accident/Incident Report completed by E4 (Licensed Practical Nurse / LPN) states, "Date of incident: 3-1-10 Time of incident 6:15 a.m. T/L (team leader) (E5) try to wake client for A.M. care. Client unresponsive et (and) cold to touch. Nurse notified examined client, (no) pulse noted body cold et (and) unresponsive to name et (and) movement when shaken; arm & legs stiffening when moved... 911 called at 6:16 a.m.; paramedics arrived (at) 6:24 a. Police arrived (at) 6:32. Paramedics exam client et (and) said she expired...Physician notified (E11) at 6:37 a.m. (E11) said he'll be there as soon as he can to pronounce client dead. arrived at 8:53 A."	W 331		

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W 331	Continued From page 11 Surveyor reviewed the Paramedic report dated 3/1/10. The report documents Dispatch at 06:24 , At location 06:28 At patient 06:31, Departed scene 07:04. The note reads "Patient found lying in bed unresponsive, upon exam, patient DOA (Dead on arrival), Rigger/lividity noted, nurse stated last time she talked to patient was around 10:00 PM last night. Nurse stated she went to give patient her medication this morning and found patient unresponsive not breathing. No trauma noted." The Findings portion of form notes no spontaneous respirations, lung sounds absent, no chest wall expansion, level of consciousness unresponsive lying on side skin warm lividity/pooling. Management and reassessment portion of form notes pupils non-reactive and dilated. ECG rhythm asystole - multiple leads. Review of Investigative follow-up report dated March 8, 2010, completed by E2 (Assistant Administrator / Residential Services Director) states , "Resident interview was completed with the following individuals: (R4 - R13) R2, R3 -(roommates) none of whom had witnessed any incident..Staff written statements, and interviews were held with the following staff: (E12), AM Facility Supervisor, (E10) - night shift supervisor, (E4) LPN, (E13) LPN, (E6) DSP (Direct Support Person), (E9) DSP, (E7) DSP, (E14) - Evening shift facility supervisor, (E8) DSP, E15 DSP, E3 HSS (Health Services Supervisor) (E16) Program Supervisor, (E17) DSP, (E5) Program Supervisor."...An environmental review was completed, and revealed that as per attending physician (E11) who came to the facility at 8:30 am on March 1, 2010 to review the incident, examine (R1's) body, and confer with (E2)	W 331		

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(Assistant Administrator), (E3) HSS, and (E4) LPN confirm that cause of death for (R1) was acute Myocardial Infarction...The facility's plan of action is (1) confer with guardian regarding funeral arrangements, (2) schedule a special IDT (interdisciplinary team) meeting to review the incident (3) refer incident to Human Rights Committee for review, (4) re - inservice staff regarding policy and procedures, (5) re - in service nursing staff regarding facility protocol."

Surveyor reviewed written statements obtained by E2 (Assistant Administrator) during the Investigative follow up dated March 8, 2010:

DSP E7's statement states "After dinner (on 2/28/10) I start noticing that (R1) was looking unhappy a little. She started paceing (pacing) in the day room a couple of times and, I ask (R1) to have a set (seat) for safety it appear to me that (R1) might have a seizure so I (cont) to let (R1) stay in the day room to be monitor and watch movies for the end of my shift. I left the floor between 9:30 - 9:31 my shift was over and (R1) was in the chair in the dayroom with staff (E8)"

Surveyor interviewed E7 on 3/16/10 at 3:10 p.m. E7 confirmed written statement. E7 said R1 did not have a seizure on 2/28/10 during E7's shift.

DSP E8's statement states , "(2/28/10) staff (E7) had said she (R1) might be going to have a seizure at some point...(R1) was in the dayroom until about 9:35, at that time she went to her room. At 9:50 p.m. nurse (E4) came & ask me to come to (R1's) room & get her & bring her to (middle) day room with me cause she has went to bathroom six times. When I got to her room she was lying awake in bed & nurse (E4) said

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she was out of breath. She appeared to be breathing a little out of breath, like walking up stairs. I (E8) called (R1's) name, after 10 to 12 x she wouldn't respond, but she was awake. I then notified the nurse (E4) that there was no response. Nurse came in the room called her name twice and said well we (know) she's not dead cause she's breathing. Nurse, (E4) said well I'll keep eval on her. After she said that I went back to dayroom. The nurse went back to office & sat down. I (E8) worked 2nd shift 2pm - 10pm."

Surveyor interviewed E8 on 3/16/10 at 2:55 p.m. E8 said, "I was assigned to (R1) on 2/28/10 at 9:30 p.m. (R1) usually fights seizures by pacing. (E4), nurse, wanted me to bring (R1) to me due to pacing. E4 said she was out of breath from pacing the floor. (R1) was always out of breath lately. I went to R1's room at 9:50 p.m. Usually if you called her name she would respond. (R1) was alive at 9:50 p.m., I told (E4) she is not responding to me calling her name. The nurse said she would look after her, I left R1's room."

DSP E9's statement notes E9 did bed check on 2/28/10 from 9:15 P to 10:15 P. (R1) was lying in bed asleep. E9 reported doing bed check from the doorway. E9 said E9 never saw (R1) getting up out of bed going to the bathroom. E9 stated R1 was snoring loudly. E9 stated at one time R1 was laying flat on her back, and another time she was on her side with her face resting against her arm (normally how she sleeps).

E9 was interviewed on 3/16/10 at 2:36 p.m., E9 confirmed the information given in his statement. E9 said he observed R1 from the door of the bedroom because male staff don't usually work

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W 331	Continued From page 14 with women. LPN E4's statement reads as follows; "2/28/10 ...9:30 p - (R1) got up to go to bathroom (and) I took her to bed. 9:40 p. - (R1) got up again to go to bathroom et (and) back to bed. 9:50 p - (R1) got up once more but I stop her (at) the bathroom door (and) walk her back to her bed telling her to lay down and go to sleep. I sat her on her bed took off her shoes and pants...she lay down facing the window about 10 to 15 mins I saw her turning around toward the door. I felt she wasn't going to sleep (at) this time so I walk to the middle day room and ask (E8) to come (and) escort (R1) to middle day room (and) let her sit there until she gets sleepy or dozing off. (E8) came to her room turn on the light (and) ... told her to get up about 3 times. Then (E8) said to me that (R1) was non responsive. When she (E8) said that I thought (R1) had stop breathing. I went to the room and notice that (R1) was breathing, her breathing wasn't shallow or labored and she was sleeping and not awake as I thought. I told (E8) that (R1) was alive and breathing and not to get her up but let her sleep. The light was turn off and we left the room that was about 10:15 p. I came back to (R1's) room around 11p to get her vitals p(pulse)-80 R (respirations) 20 B/P (blood pressure) 149/82 (best I can remember). After taking her vitals I took a blanket out the linen closet (and) covered her up because she was lying on top of her sheets. Around 11:30 before going down stairs I look in on (R1) and she was still sleeping...I glance into (R1's) room (and) saw she was sleeping around 1:30 a. or so...Around 6 - 6:15A (E5) called me to look (at) R1 because she wouldn't wake up. I went to (R1's) room (and) felt for a pulse on her wrist (and) then her neck. -	W 331		

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W 331	Continued From page 15 there was none. I also notice that (R1) was cold, bluish in color (and) her limbs - arms (and) legs were stiff and no longer easily to bend (at) the elbow (and) knees her eyes were fixed and dilated. I saw no chest movement or felt her breath against my face." Surveyor interviewed E4 on 3/16/10 at 9:45 a.m. E4 said she called E8 to sit with R1, when R1 was restless and up walking, to calm R1 down. (R1) had done this before, got up and walked around when anxious, I didn't want her to do this because of her breathing. When E8 came to the room E8 called R1 three times. E8 said R1 was unresponsive. E4 said, "I checked her, (R1) was sleeping and I could see her breathing. " E4 said she took R1's vital signs at 11:00 p.m. because R1 had symptoms like she had the last month or month and a half. When over exerted she would have to sit down and calm down. If she got up walking around too much she would be short of breath like someone running too much. E4 said the blanket placed on R1 at bedtime was not removed when R1 was checked at 6:15 a.m. E4 was asked why Cardio Pulmonary Resuscitation (CPR) was not attempted when R1 was found at 6:15 a.m. on 3/1/10. E5 said R1 was cold and rigor mortis set in. R1's arms were stiff. Everything was cold, there was no pulse. E4 said she assumed R1 was gone for awhile when she saw her. E4 said she called 911, the paramedics came and said she was gone. Overnight DSP E6's written statement was reviewed. The initial written statement reads in part as follows; "I did bed check every thirty minute. I always start on (R1's) end when I do bed check I check her room and she was sleep.	W 331		

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W 331	Continued From page 16 Every time I went to her room she was sleep. When the morning staff com (come) in to get her up (R1). She would get up that is when I heard that it was some wrong with her. One of the staff call the nurse." A follow up staff interview with E6, was conducted for the investigative follow up dated 3/3/10. The follow up interview was conducted by E2 (Assistant Administrator). The follow up interview reads as follows; "quest: How often did you complete the bed (check) on 2/28/10 for 3rd shift? Ans. every 15 minutes ques: what time frame did you do bed (check) Ans: starting @ 10:30 pm - 5:30 am ques: How are bed (checks) completed? Ans: I opened the door, turned on the lights, walked in the room & looked around ques: where were you standing at? Ans: at the end of (R1's) bed ques: while completing bed (checks) did you notice (R1's) chest going up & down? Ans: I did not notice. question: What position does (R1) sleep in? Ans: always lays on her side question: Did you notice any changes in sleeping position during your bed (check) Ans: No changes were noted" Surveyor interviewed E6 on 3/17/10 at 7:45 a.m. E6 stated bed check is done every 15 minutes.	W 331		

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E6 said, "I go room to room, cut on light and go around room. (R1) looked like she was asleep. Cover pulled up around neck on her side. Face turned toward door. After she was found (R1) still looked like she was asleep. E6 said, "I asked has (R1) been sick?" -" had trouble with her breathing, (E5) said." E6 said, "there was a call off on the night she passed. I could do the job didn't need/ask for help. Everything went smoothly, everyone slept all night."

E5's (program supervisor) written statement reads, " I (E5) call out to (R1) and didn't get no responds. I called out to a second time and still didn't get no responds. At this time I walk over to her and touch her, leg blanket over body and her body was stiff and I still didn't get no respond. I (E5) called for the nurse (E4) to come to take a look at (R1) that she is none responding. (E4) the nurse came in the room and check her and said that she had past away."

Surveyor interviewed E5 on 3/16/10 at 11:11 a.m. E5 confirmed the information in her written statement. E5 said when she found (R1) she was laying on her arm on the right side with the blankets up. No one moved the blankets. E5 said she was trained in CPR. R1's body was so stiff she had been gone for awhile. I was shocked, I would have started CPR, I got the nurse. No CPR was done. E5 said the paramedics said (R1) had been gone for awhile. E5 said (R1) had a hernia, it was difficult for her to walk to take her breath.

E12's written statement reads, "Approx: 6:15 A nurse (E4) LPN called to front desk. Overnight supervisor (supervisor) (E10) answered phone by speaker nurse stated (R1) is gone (dead) call

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W 331	Continued From page 18 911. @ that time not sure of time was seconds I called 911 report to dispatcher we had individual that was unresponsive. Approx. 6:24 A I let the Par(a)medic in facility run up stairwell to 2nd Fl. Nurse (E4) was in bedroom (R1) was in bed with covers on her up to her shoulder laying on the right side she was not breathing skin pale blue around both eyes and mouth." Surveyor interviewed E12 on 3/16/10 at 11:02 a.m. E12 confirmed her written statement Physician Progress record completed by E11 (facility physician) on 3/1/10, reads as follows " Got a call that patient found (without) vitals this morning around 6:15 AM. Came to pronounce pt. at 8:30 a.m. Pt cold, pale & pupils dilated. Most probable cause of death is Acute MI (Myocardial Infarction) (secondary) to Atherosclerotic Cardio vascular Disease. Pt. also has a large fixed Hiatal Hernia which make her breath(e) harder & unable to compensate much." Surveyor interviewed E11 (facility physician) on 3/16/10 at 12:45 p.m. E11 was asked why the cause of death on the death certificate is listed as Acute Myocardial Infarction. E11 replied, it was the only thing I could think of that would cause sudden death. E11 said there was no problem before that. E11 said R1 was already cold, the staff told me. The paramedics wouldn't touch her she was already cold with rigor. E11 said the time of death probably was late in the night, assumed she might have died a few hours before. The close supervision was probably because of seizures as a safety precaution. "The last time I saw R1 she was up walking around and talking."	W 331		

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W 331	Continued From page 19 The 24 hour Nursing Communication Report dated 2/28/10 for the 7A-7P shift has an entry, " (R1) monitor for SOB (shortness of breath), poss seizure." E3 (Health Services Supervisor) stated on 3/29/10 at 10:05 a.m. nurses use the report to communicate information to each other and support staff During the Daily Status Meeting on 3/15/10 at 3:25 p.m. with E1 (Administrator), E2 (Assistant Administrator), and E3 (Health Services Supervisor), surveyor asked about corrective action after the death of R1. E4, E8, and E9 were suspended. Bed check protocol was changed. All DSPs were inserviced on the new protocol. The protocol requires use of a flashlight to see if the individual's chest is rising, and falling. Staff must walk to each individual's bed. E3 (Health Services Supervisor) was interviewed on 3/15/10 at 2:40 p.m. E3 said the reason (R1) was on close monitoring was because of her Seizure Disorder. E3 was asked why nursing staff was being inserviced as a result of the investigative follow up. E3 said nursing should always initiate CPR. No CPR was initiated by nursing or staff. The nurse, E4, was asked why and no reason was given. The nurse was suspended due to violation of facility policy and procedure specific to failure to meet job performance standards including initiating CPR. The undated Staff Nurse Job Description includes the following duties: Make periodic checks to ensure that prescribed treatments are being properly administered by direct care staff and to evaluate the resident's physical and emotional status.	W 331		

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W 331	Continued From page 20 Monitor and assess residents as needed. The undated Emergency Care - Basic Policy and Procedure states, "Cardiac Arrest 1. Determine the resident's code status. 2. If the resident has a do not resuscitate order, contact the physician 3. If the resident does not have a do not resuscitate order, contact the emergency medical system. 4. Begin cardiopulmonary resuscitation per protocol. 5. Contact the physician. B. R1's clinical record was reviewed. Nurse's notes dated 2-10-10 7:45 P note "seen by (E11) (with) new orders noted." Physician's orders dated 2/10/10 are for Chest x-ray PA and lateral CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Profile). "easy SOB - R/O (rule out) pulmo" Laboratory work dated 2/16/10 marked as STAT on the results note CO2 level as critical low. Chest Xray results dated 2/16/10 state Large fixed hiatal hernia is seen. Lungs are clear. There is no pneumonia, pleural or pericardial effusion. E4 (LPN) stated 3/16/10 at approximately 9:45 a.m. she took R1's vital signs at 11:00 p.m. (on 2/28/10) because R1 had symptoms like she had the last month or month and a half. When over exerted she would have to sit down and calm down. If she got up walking around too much she would be short of breath like someone	W 331		

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W 331	Continued From page 21 running too much. E8 (DSP) stated 3/16/10 at approximately 2:55 p.m. "(R1) was always out of breath lately, (I was) informed a couple of weeks before death, she had hernia in chest, can't lay down after eating." E6 (DSP) stated 3/17/10 at approximately 7:45 a.m. After she was found (R1) still looked like she was asleep. E6 said, "I asked has (R1) been sick?" -" had trouble with her breathing, (E5) said." E5 (DSP) stated 3/16/10 at approximately 11:11 a.m., (R1) had a hernia, it was difficult for her to walk to take her breath. Surveyor interviewed E11 (facility physician) at 12:45 p.m. E11 said, "I did not get any call about (R1) in the last few weeks." E11 said "I never got called about a critical low lab level for CO2. If I was informed, I would have the lab re-check it." Surveyor reviewed nursing in-service training attendance record dated 3/5/10. Summary of meeting states, "Importance of notifying MD of lab results documenting on 24(hour) report also in nurses notes of any elevated or critical levels, making sure to get representative's name from lab when results are called over" Surveyor interviewed E3 (Health Services Supervisor) on 3/29/10 at 10:05 a.m. regarding delay in obtaining lab work and chest x-ray on 2/16/10 that was ordered 2/10/10. E3 said sometimes there was an issue with lab at the local hospital, the issue is resolved. On 3/29/10 at 10:05 a.m. .E3 said E11 was	W 331		

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W 331	Continued From page 22 notified of the breathing problems (2/10/10) that is why he ordered the chest Xray. There is no information regarding further notification to E11 of R1's breathing issues. E3 said R1 was supposed to sit up for 1/2 hour after eating due to the hiatal hernia. This information was given to direct support staff by nursing and written in the Daily 24 hour report. There is no documentation in the clinical record and no notation of the abnormal lab work in the nurse's notes	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1210b) 350.1230d)1) 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. These services include, but are not limited to, the following:	W9999		

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W9999	Continued From page 23 b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 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) Section 350.1235 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. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate health care monitoring for one client (R1) who expired in March 2010 when the facility failed to: A. Ensure adequate supervision of R1 every 15 minutes as per Individual Program Plan.	W9999		

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W9999	Continued From page 24 B. Ensure individual with a history of seizures is monitored appropriately when pre-seizure activity is observed. C. Initiate Cardiopulmonary Resuscitation as per facility policy. D. Ensure nursing evaluates and makes recommendations for client with known seizure activity. Findings include: A. The 9/16/09 Individual Program Plan (IPP) identifies R1 as a 63 year old female whose diagnoses include Profound Mental Retardation, Seizure/Epilepsy (Temporal Lobe), Psychosis NOS, and Anemia. The IPP describes R1 as ambulatory with a slight gimp, talkative, outspoken and opinionated. Level of Supervision is listed as close. E2 (Assistant Administrator) stated on 3/15/10 at 2:30 p.m. close supervision is checking every 15 minutes. Facility policy for Levels of Supervision revised 10/17/09 defines: "1. General Supervision: All staff is responsible for the CARE; WELFARE; SAFETY & SECURITY, for all the residents this facility serves. It is your responsibility to know where the residents are that your are assigned to and that they are free from abuse and neglect. 2. Close Monitoring: This includes all of the above as well as keeping the resident whereabouts known at all times. The resident may move about independently but staff will monitor through direct observation at a minimum	W9999		

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W9999	Continued From page 25 every 15 minutes. (documentation may be assigned)." Annual Review of Advanced Directives for R1, dated 1/1/08, states the current status is FULL RESUSCITATION. R1's State of Illinois Certificate of Death states R1 died on 3/1/10. Immediate cause of death is Acute Myocardial Infarction due to Atherosclerotic Heart Disease. Person completing cause of death is listed as E11 (facility physician). Review of Accident/Incident Report completed by E4 (Licensed Practical Nurse / LPN) states, "Date of incident: 3-1-10 Time of incident 6:15 a.m. T/L (team leader) (E5) try to wake client for A.M. care. Client unresponsive et (and) cold to touch. Nurse notified examined client, (no) pulse noted body cold et (and) unresponsive to name et (and) movement when shaken; arm & legs stiffening when moved... 911 called at 6:16 a.m.; paramedics arrived (at) 6:24 a. Police arrived (at) 6:32. Paramedics exam client et (and) said she expired...Physician notified (E11) at 6:37 a.m. (E11) said he'll be there as soon as he can to pronounce client dead. arrived at 8:53 A." Surveyor reviewed the Paramedic report dated 3/1/10. The report documents Dispatch at 06:24 , At location 06:28 At patient 06:31, Departed scene 07:04. The note reads "Patient found lying in bed unresponsive, upon exam, patient DOA (Dead on arrival), Rigger/lividity noted, nurse stated last time she talked to patient was around 10:00 PM last night. Nurse stated she went to give patient her medication this morning and	W9999		

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W9999	Continued From page 26 found patient unresponsive not breathing. No trauma noted." The Findings portion of form notes no spontaneous respirations, lung sounds absent, no chest wall expansion, level of consciousness unresponsive lying on side skin warm lividity/pooling. Management and reassessment portion of form notes pupils non-reactive and dilated. ECG rhythm asystole - multiple leads. Review of Investigative follow-up report dated 3/8/10, completed by E2 (Assistant Administrator/Residential Services Director) states , "Resident interview was completed with the following individuals: (R4 - R13) R2, R3 -(roommates) none of whom had witnessed any incident..Staff written statements, and interviews were held with the following staff: (E12), AM Facility Supervisor, (E10) - night shift supervisor, (E4) LPN, (E13) LPN, (E6) DSP (Direct Support Person), (E9) DSP, (E7) DSP, (E14) - Evening shift facility supervisor, (E8) DSP, E15 DSP, E3 HSS (Health Services Supervisor) (E16) Program Supervisor, (E17) DSP, (E5) Program Supervisor."...An environmental review was completed, and revealed that as per attending physician (E11) who came to the facility at 8:30 am on March 1, 2010 to review the incident, examine (R1's) body, and confer with (E2) (Assistant Administrator), (E3) HSS, and (E4) LPN confirm that cause of death for (R1) was acute Myocardial Infarction...The facility's plan of action is (1) confer with guardian regarding funeral arrangements, (2) schedule a special IDT (interdisciplinary team) meeting to review the incident (3) refer incident to Human Rights Committee for review, (4) re - inservice staff regarding policy and procedures, (5) re - in service nursing staff regarding facility protocol."	W9999		

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W9999	Continued From page 27 Surveyor reviewed written statements obtained by E2 (Assistant Administrator) during the Investigative follow up dated 3/8/10: DSP E7's statement states, "After dinner (on 2/28/10) I start noticing that (R1) was looking unhappy a little. She started paceing (pacing) in the day room a couple of times and, I ask (R1) to have a set (seat) for safety it appear to me that (R1) might have a seizure so I (cont) to let (R1) stay in the day room to be monitor and watch movies for the end of my shift. I left the floor between 9:30 - 9:31 my shift was over and (R1) was in the chair in the dayroom with staff (E8)" Surveyor interviewed E7 on 3/16/10 at 3:10 p.m. E7 confirmed written statement. E7 said R1 did not have a seizure on 2/28/10 during E7's shift. DSP E8's statement states, "(2/28/10) staff (E7) had said she (R1) might be going to have a seizure at some point...(R1) was in the dayroom until about 9:35, at that time she went to her room. At 9:50 p.m. nurse (E4) came & ask me to come to (R1's) room & get her & bring her to (middle) day room with me cause she has went to bathroom six times. When I got to her room she was lying awake in bed & nurse (E4) said she was out of breath. She appeared to be breathing a little out of breath, like walking up stairs. I (E8) called (R1's) name, after 10 to 12 x she wouldn't respond, but she was awake. I then notified the nurse (E4) that there was no response. Nurse came in the room called her name twice and said well we (know) she's not dead cause she's breathing. Nurse, (E4) said well I'll keep eval on her. After she said that I went back to dayroom. The nurse went back to	W9999		

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W9999	Continued From page 28 office & sat down. I (E8) worked 2nd shift 2pm - 10pm." Surveyor interviewed E8 on 3/16/10 at 2:55 p.m. E8 said, "I was assigned to (R1) on 2/28/10 at 9:30 p.m. (R1) usually fights seizures by pacing. (E4), nurse, wanted me to bring (R1) to me due to pacing. E4 said she was out of breath from pacing the floor. (R1) was always out of breath lately. I went to R1's room at 9:50 p.m. Usually if you called her name she would respond. (R1) was alive at 9:50 p.m., I told (E4) she is not responding to me calling her name. The nurse said she would look after her, I left R1's room." DSP E9's statement notes E9 did bed check on 2/28/10 from 9:15 P to 10:15 P. (R1) was lying in bed asleep. E9 reported doing bed check from the doorway. E9 said E9 never saw (R1) getting up out of bed going to the bathroom. E9 stated R1 was snoring loudly. E9 stated at one time R1 was laying flat on her back, and another time she was on her side with her face resting against her arm (normally how she sleeps). E9 was interviewed on 3/16/10 at 2:36 p.m., E9 confirmed the information given in his statement. E9 said he observed R1 from the door of the bedroom because male staff don't usually work with women. LPN E4's statement reads as follows; "2/28/10 ...9:30 p - (R1) got up to go to bathroom (and) I took her to bed. 9:40 p. - (R1) got up again to go to bathroom et (and) back to bed. 9:50 p - (R1) got up once more but I stop her (at) the bathroom door (and) walk her back to her bed telling her to lay down and go to sleep. I sat her on her bed took off her shoes and pants...she lay down	W9999		

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W9999	Continued From page 29 facing the window about 10 to 15 mins I saw her turning around toward the door. I felt she wasn't going to sleep (at) this time so I walk to the middle day room and ask (E8) to come (and) escort (R1) to middle day room (and) let her sit there until she gets sleepy or dozing off. (E8) came to her room turn on the light (and) ... told her to get up about 3 times. Then (E8) said to me that (R1) was non responsive. When she (E8) said that I thought (R1) had stop breathing. I went to the room and notice that (R1) was breathing, her breathing wasn't shallow or labored and she was sleeping and not awake as I thought. I told (E8) that (R1) was alive and breathing and not to get her up but let her sleep. The light was turn off and we left the room that was about 10:15 p. I came back to (R1's) room around 11p to get her vitals p(pulse)-80 R (respirations) 20 B/P (blood pressure) 149/82 (best I can remember). After taking her vitals I took a blanket out the linen closet (and) covered her up because she was lying on top of her sheets. Around 11:30 before going downstairs I look in on (R1) and she was still sleeping...I glance into (R1's) room (and) saw she was sleeping around 1:30 a. or so...Around 6 - 6:15A (E5) called me to look (at) R1 because she wouldn't wake up. I went to (R1's) room (and) felt for a pulse on her wrist (and) then her neck. - there was none. I also notice that (R1) was cold, bluish in color (and) her limbs - arms (and) legs were stiff and no longer easily to bend (at) the elbow (and) knees her eyes were fixed and dilated. I saw no chest movement or felt her breath against my face." Surveyor interviewed E4 on 3/16/10 at 9:45 a.m. E4 said she called E8 to sit with R1, when R1 was restless and up walking, to calm R1 down.	W9999		

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W9999	Continued From page 30 (R1) had done this before, got up and walked around when anxious, I didn't want her to do this because of her breathing. When E8 came to the room E8 called R1 three times. E8 said R1 was unresponsive. E4 said, "I checked her, (R1) was sleeping and I could see her breathing." E4 said she took R1's vital signs at 11:00 p.m. because R1 had symptoms like she had the last month or month and a half. When over exerted she would have to sit down and calm down. If she got up walking around too much she would be short of breath like someone running too much. E4 said the blanket placed on R1 at bedtime was not removed when R1 was checked at 6:15 a.m. E4 was asked why Cardio Pulmonary Resuscitation (CPR) was not attempted when R1 was found at 6:15 a.m. on 3/1/10. E5 said R1 was cold and rigor mortis set in. R1's arms were stiff. Everything was cold, there was no pulse. E4 said she assumed R1 was gone for awhile when she saw her. E4 said she called 911, the paramedics came and said she was gone. Overnight DSP E6's written statement was reviewed. The initial written statement reads in part as follows; "I did bed check every thirty minute. I always start on (R1's) end when I do bed check I check her room and she was sleep. Every time I went to her room she was sleep. When the morning staff com (come) in to get her up (R1). She would get up that is when I heard that it was some wrong with her. One of the staff call the nurse." A follow up staff interview with E6, was conducted for the investigative follow up dated 3/3/10. The follow up interview was conducted by E2 (Assistant Administrator). The follow up interview reads as follows;	W9999		

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W9999	Continued From page 31 "quest: How often did you complete the bed (check) on 2/28/10 for 3rd shift? Ans. every 15 minutes ques: what time frame did you do bed (check) Ans: starting @ 10:30 pm - 5:30 am ques: How are bed (checks) completed? Ans: I opened the door, turned on the lights, walked in the room & looked around ques: where were you standing at? Ans: at the end of (R1's) bed ques: while completing bed (checks) did you notice (R1's) chest going up & down? Ans: I did not notice. question: What position does (R1) sleep in? Ans: always lays on her side question: Did you notice any changes in sleeping position during your bed (check) Ans: No changes were noted" Surveyor interviewed E6 on 3/17/10 at 7:45 a.m. E6 stated bed check is done every 15 minutes. E6 said, "I go room to room, cut on light and go around room. (R1) looked like she was asleep. Cover pulled up around neck on her side. Face turned toward door. After she was found (R1) still looked like she was asleep. E6 said, "I asked has (R1) been sick?" -" had trouble with her breathing, (E5) said." E6 said, "there was a call off on the night she passed. I could do the job didn't need/ask for help. Everything went smoothly, everyone slept all night."	W9999		

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W9999	Continued From page 32	W9999		

E5's (program supervisor) written statement reads, " I (E5) call out to (R1) and didn't get no responds. I called out to a second time and still didn't get no responds. At this time I walk over to her and touch her, leg blanket over body and her body was stiff and I still didn't get no respond. I (E5) called for the nurse (E4) to come to take a look at (R1) that she is none responding. (E4) the nurse came in the room and check her and said that she had past away."

Surveyor interviewed E5 on 3/16/10 at 11:11 a.m. E5 confirmed the information in her written statement. E5 said when she found (R1) she was laying on her arm on the right side with the blankets up. No one moved the blankets. E5 said she was trained in CPR. R1's body was so stiff she had been gone for awhile. I was shocked, I would have started CPR, I got the nurse. No CPR was done. E5 said the paramedics said (R1) had been gone for awhile. E5 said (R1) had a hernia, it was difficult for her to walk to take her breath.

E12's written statement reads, "Approx: 6:15 A nurse (E4) LPN called to front desk. Overnight supervisor (supervisor) (E10) answered phone by speaker nurse stated (R1) is gone (dead) call 911. @ that time not sure of time was seconds I called 911 report to dispatcher we had individual that was unresponsive. Approx. 6:24 A I let the Par(a)medic in facility run up stairwell to 2nd Fl. Nurse (E4) was in bedroom (R1) was in bed with covers on her up to her shoulder laying on the right side she was not breathing skin pale blue around both eyes and mouth."

Surveyor interviewed E12 on 3/16/10 at 11:02 a.m. E12 confirmed her written statement

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W9999	Continued From page 33 Physician Progress record completed by E11 (facility physician) on 3/1/10, reads as follows "Got a call that patient found (without) vitals this morning around 6:15 AM. Came to pronounce pt. at 8:30 a.m. Pt cold, pale & pupils dilated. Most probable cause of death is Acute MI (Myocardial Infarction) (secondary) to Atherosclerotic Cardio vascular Disease. Pt. also has a large fixed Hiatal Hernia which make her breath(e) harder & unable to compensate much." Surveyor interviewed E11 (facility physician) on 3/16/10 at 12:45 p.m. E11 was asked why the cause of death on the death certificate is listed as Acute Myocardial Infarction. E11 replied, it was the only thing I could think of that would cause sudden death. E11 said there was no problem before that. E11 said R1 was already cold, the staff told me. The paramedics wouldn't touch her, she was already cold with rigor. E11 said the time of death probably was late in the night, assumed she might have died a few hours before. The close supervision was probably because of seizures as a safety precaution. "The last time I saw R1 she was up walking around and talking." The 24 hour Nursing Communication Report dated 2/28/10 for the 7A-7P shift has an entry, " (R1) monitor for SOB (shortness of breath), poss seizure." E3 (Health Services Supervisor) stated on 3/29/10 at 10:05 a.m. nurses use the report to communicate information to each other and support staff During the Daily Status Meeting on 3/15/10 at 3:25 p.m. with E1 (Administrator), E2 (Assistant Administrator), and E3 (Health Services	W9999		

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W9999	Continued From page 34 Supervisor), surveyor asked about corrective action after the death of R1. E4, E8, and E9 were suspended. Bed check protocol was changed. All DSPs were inserviced on the new protocol. The protocol requires use of a flashlight to see if the individual's chest is rising, and falling. Staff must walk to each individual's bed. E3 (Health Services Supervisor) was interviewed on 3/15/10 at 2:40 p.m. E3 said the reason (R1) was on close monitoring was because of her Seizure Disorder. E3 was asked why nursing staff was being inserviced as a result of the investigative follow up. E3 said nursing should always initiate CPR. No CPR was initiated by nursing or staff. The nurse, E4, was asked why and no reason was given. The nurse was suspended due to violation of facility policy and procedure specific to failure to meet job performance standards including initiating CPR. The undated Staff Nurse Job Description includes the following duties: Make periodic checks to ensure that prescribed treatments are being properly administered by direct care staff and to evaluate the resident's physical and emotional status. Monitor and assess residents as needed. The undated Emergency Care - Basic Policy and Procedure states, "Cardiac Arrest 1. Determine the resident's code status. 2. If the resident has a do not resuscitate order, contact the physician 3. If the resident does not have a do not resuscitate order, contact the emergency medical system. 4. Begin cardiopulmonary resuscitation per	W9999		

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W9999	Continued From page 35 protocol. 5. Contact the physician. B. R1's clinical record was reviewed. Nurse's notes dated 2-10-10 7:45 PM note "seen by (E11) (with) new orders noted." Physician's orders dated 2/10/10 are for Chest x-ray PA and lateral CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Profile). "easy SOB - R/O (rule out) pulmo." Laboratory work dated 2/16/10 marked as STAT on the results note CO2 level as critical low. Chest Xray results dated 2/16/10 state Large fixed hiatal hernia is seen. Lungs are clear. There is no pneumonia, pleural or pericardial effusion. E4 (LPN) stated 3/16/10 at approximately 9:45 a.m. she took R1's vital signs at 11:00 p.m. (on 2/28/10) because R1 had symptoms like she had the last month or month and a half. When over exerted she would have to sit down and calm down. If she got up walking around too much she would be short of breath like someone running too much. E8 (DSP) stated 3/16/10 at approximately 2:55 p.m. "(R1) was always out of breath lately, (I was) informed a couple of weeks before death, she had hernia in chest, can't lay down after eating." E6 (DSP) stated 3/17/10 at approximately 7:45 a.m. After she was found (R1) still looked like she was asleep. E6 said, "I asked has (R1) been sick?" -" had trouble with her breathing, (E5) said."	W9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW LIVING CENTER	**7270 SOUTH SHORE DRIVE CHICAGO, IL 60649**

(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
W9999	Continued From page 36 E5 (DSP) stated 3/16/10 at approximately 11:11 a.m., (R1) had a hernia, it was difficult for her to walk to take her breath. Surveyor interviewed E11 (facility physician) at 12:45 p.m. E11 said, "I did not get any call about (R1) in the last few weeks." E11 said "I never got called about a critical low lab level for CO2. If I was informed, I would have the lab re-check it." Surveyor reviewed nursing in-service training attendance record dated 3/5/10. Summary of meeting states, "Importance of notifying MD of lab results documenting on 24(hour) report also in nurses notes of any elevated or critical levels, making sure to get representative's name from lab when results are called over." Surveyor interviewed E3 (Health Services Supervisor) on 3/29/10 at 10:05 a.m. regarding delay in obtaining lab work and chest x-ray on 2/16/10 that was ordered 2/10/10. E3 said sometimes there was an issue with lab at the local hospital, the issue is resolved. On 3/29/10 at 10:05 a.m., E3 said E11 was notified of the breathing problems (2/10/10) that is why he ordered the chest Xray. There is no information regarding further notification to E11 of R1's breathing issues. E3 said R1 was supposed to sit up for 1/2 hour after eating due to the hiatal hernia. This information was given to direct support staff by nursing and written in the Daily 24 hour report. There is no documentation in the clinical record and no notation of the abnormal lab work in the nurse's notes. (A)	W9999		