STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING _____ B. WING _____	C 08/20/2010

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EVERGREEN HEALTH CARE CENTER	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

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F 490	Continued From page 26 the Discharge and Transfer policy was revised to include a staff member remaining with the resident until emergency transport team arrives. 2. Licensed Nurses in-serviced on Discharge and Transfer policy revision. 3. Education will continue to be provided upon hire and quarterly for 1 year, then annually thereafter. Ongoing Monitoring The Quality Assurance committee will review the results of the Quality Improvement unplanned discharge audit tool during the monthly meeting. A subcommittee(daily afternoon "Round-Up" team) will continue to report to the administrator any trends identified with the unplanned discharge audit tool. The QA committee will meet additionally at the discretion of the administrator until the issue is resolved. trends requiring additional revision of existing policy or procedure will be implemented as indicated. Further plan of correction upon receipt of the 2567 includes nursing in-services scheduled with the following objectives. 1. Compliance with Emergency Transfer Discharge policy 2. Review of Evergreen's opportunity for improvement Reviewed with Medical Director on August 12, 2010. Reviewed with QA Committee on August 12, 2010	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 27 300.610a) 300.1210a) 300.1210b)4) 300.1220b)2) 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. 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. b) General nursing care shall include at a minimum the following and shall be practiced on	F9999		

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F9999	Continued From page 28 a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. 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. 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 regulations are not met, as evidenced by the following: Based on record review, and interview, the facility failed to: A) prevent 1 of 11 sampled residents (R6), from being transferred to the local hospital without the following: A. Physician Order. B. Resident Consent. This failures resulted in R6 feeling violated and frightened. B) follow the physician order to transfer 1 of 12 sampled residents (R7) to the hospital via "911" due to an unknown cause of tachycardia. This	F9999		

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F9999	Continued From page 29 failure resulted in the delay of R7 receiving medical services. These failures have the potential to affect all 142 residents in the facility. Findings Includes: A) A review of R6's record indicates that R6, a 78 year old male who is alert and oriented to person, place, and time, was transported to the local hospital by fire department paramedics on 7-24-10 at 6:45am. The fire department paramedics were supposed to transfer the roommate of R6, (R7), to the hospital because of tachycardia. Evidence indicates that when the fire department paramedics arrived at 6:40am, they proceeded to enter the room of R6 and R7. They proceeded to assess and prepare R6 to be transported to the hospital. During this process, R6 was repeatedly telling the fire department paramedics that he was not in any distress, and that they have the wrong patient. Despite R6's actions, the fire department paramedics proceeded to transfer R6, from the bed, to the cart, and out of the facility. There is no evidence to indicate that during the actions of the fire department paramedics, that staff interventions were implemented to prevent R6 from being taken to the hospital. Evidence indicates that no licensed staff were present in the room when R6 was being prepared for transport by the fire department paramedics. Evidence indicates that prior to exiting the facility with R6, the fire department paramedics stopped	F9999		

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F9999	Continued From page 30	F9999		

at the nursing station, and received the transfer documentation belonging to R7. The transfer documentation was given to the fire department paramedics by E9(Licensed Practical Nurse). There is no evidence to indicate that facility staff actually saw R6 on the transport cart as he was leaving the facility. R6 left the facility at 6:45am.

Evidence indicates that the facility was not aware that R6 was transported from the facility, until E7(Registered Nurse), upon making rounds at 7:05am, noted that R7 was still in his bed and that R6 was not in his bed.

Review of the local hospital emergency room report where R6 was transferred indicates that R6 arrived at 7:36am. The History Of The Present Illness section of the report states the following: "The patient is a 78 year old black male who comes to the Emergency Department from the nursing home apparently another patient was suppose to be transferred to the Emergency department but this patient was sent instead by mistake from the nursing home. The patient said the nurses came into his room and told him he was going to the hospital for evaluation. When he asked them why they said because his heart rate was high. The patient had absolutely no complaints. He says he feels fine and was not sure why he was coming. He was concerned because he thought that the person next door to him was the one that needed to come because he was complaining all night. The patient states he has no complaints and is not sure why he is here. On further evaluation of the patient we determined that this is actually the wrong person that is here. We called the nursing home to find out that apparently a different patient was suppose to be coming and this patient was sent

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F9999	Continued From page 31	F9999		

in his place. Again the patient has no complaints." R6 returned to the facility at 9:54am.

E1 (Administrator) stated during interview on 8-10-10 at 1:00pm that the fire department took the wrong patient, and once the facility was made aware of the mistake, the doctor, hospital, fire department, and the families of R6 and R7 were all notified. E3 (Director of Nursing) stated on 8-10-10 at 1:15pm sthat even though the fire department made a mistake, a nurse should have been in the room with the paramedics during the transfer.

E4 (Assistant Director of Nursing) stated during interview on 8-10-10 at 1:30pm that typically during a "911" call nursing staff are always in the room to assess/treat the resident up until the paramedics arrive. E4 further stated that the nurse usually gives report to the paramedics at the bedside of the resident. E7 (Registered Nurse) stated during interview on 8-10-10 at 10:25am that E9 asked her to tell R7 that he was going out to the hospital. "I did. After that, when the paramedics arrived, I was at the nursing station. The paramedics asked me why was the resident was going out to the hospital? I told them because of tachycardia. I was just starting my shift when all of this occurred. I do not believe that a nurse went into the room of R6 and R7 during the transfer. I saw E9 hand the transfer documentation to the paramedics from the nursing station. At around 7:05am, while making rounds, I discovered that R6 was gone, and R7 was still in his bed. At this time, I told E9. E9 proceeded to page the supervisor. I also informed E9 to call the hospital of the error."

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F9999	Continued From page 32	F9999		

E8 (Registered Nurse) stated during interview on 8-10-10 at 11:30am that she started her shift a little before 7:00am. "I overheard E9 giving report in relation to R7 going out to the hospital. I was not in the room of R6 and R7 when the fire department arrived in the facility. I believe that E7 told R7 that he would be going out to the hospital. I do not recall any nurses in the room of R6 and R7 when the fire department paramedics entered the room. I do recall E9 giving report from the nursing station to the paramedics. When R6 returned from the hospital, he was very upset."

R6 stated during interview on 8-10-10 at 3:30pm that on 7-24-10, "the fire department came into my room and took me to the hospital. I told them that I was ok and that they were making a big mistake. The fire department continued to place me on the cart and took me to the hospital. Once I got to the hospital, they began to take some blood. I tried telling them, too, that this was a big mistake. Finally, I was brought back to the nursing home." When asked how did this occurrence made him feel, R6 responded, with tearful eyes, by saying "I felt violated and frightened." I further asked R6 how was he currently feeling? R6 stated, "I don't trust them." When asked whether the staff tried to prevent this from occurring, R6 stated "no." During the interview of R6, the resident eyes were tearful, and he appeared nervous and anxious when asked to relive the previous events.

Z2 (Attending Physician) stated on 8-12-10 at 12:00pm that he did not see any changes related to R6's mental outlook. Z2 further stated that R6 never complained to him about having any problems. Z2 further stated that "there is no

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F9999	Continued From page 33 medical or clinical evidence of harm from the incident." E9 (Licensed Practical Nurse) stated on 8-12-10 at 1:45pm that she was assigned to R7. "I noted that R7 heart rate was elevated. I notified the doctor (Z1). After checking the heart rate a second time, Z1 gave orders to send R7 out via 911. I told R7 that his heart rate was high. After this, I proceeded to go to the nursing station to call 911, and to start the transfer documentation. I told E7 to inform R7 that he would be going to the hospital. At this time, I am also calling the family. When the paramedics arrived, I was at the nursing station. I stated the name, room, and bed number of R7 to the arriving paramedics. While still at the nursing station, I am completing the transfer documentation, and still talking to the family of R7. At this time, the paramedics are still in the room of R6 and R7. When the paramedics exited the room, from the nursing station, I handed them the transfer documentation. While still at the nursing station at 7:05am, E7 informed me that R7 was still in his bed and that R6 was not. At this time, I proceeded to call the fire department, the doctor, the receiving hospital, and the nursing supervisor." When asked at anytime was she present in the room with the paramedics, E9 stated, "no, but a nurse should have been present." R7 stated during interview on 8-12-10 at 2:00pm that, "I did not recall the paramedics taking R6 to the hospital on 7-24-10 because I was sleep. I was not concerned about being delayed regarding the hospital." Z1 (Attending Physician) stated during interview on 8-10-10 at 11:45am that, "I wanted R7 to go to	F9999		

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F9999	Continued From page 34 the hospital 911 because of an unknown cause related to tachycardia. The tachycardia was induced by pulmonary embolism. R7 should not have been delayed in going to the hospital." Review of the facility Discharge and Transfers policy, does not indicate procedures to ensure that licensed staff must be present during an emergency transfer to ensure that the correct resident will be transferred by the responding paramedics. Further review states that "Obtain physician's order for emergency transfer or discharge." There was a physician order for R7, not for R6. B) R7 is a 48 year old male with medical diagnosis which includes Positive HIV, Tachycardia, Venous Thrombosis and Embolism, Altered Mental Status, Diabetes, Anemia, and Acute Renal failure. On 7-24-10 at 6:35am, Z1 (Attending Physician) was informed by staff that R7's heart rate was at 128 beats per minute. Z1 instructed the facility to transfer R7 to the local hospital via "911." At 6:35am, E9 (Licensed Practical Nurse) called 911. The fire department arrived at 6:40am. The fire department left the facility at 6:45am. Evidence indicates that at 7:05am, it was discovered that R7 was still in the facility. The fire department transported R7's roommate(R6), instead of transporting R7. At 7:25am, R7 was taken to the hospital. Review of the hospital emergency room report indicates that R7 arrived at 8:04am, 89 minutes after the initial 911 call.	F9999		

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F9999	Continued From page 35	F9999		

Evidence indicates that when the fire department paramedics arrived at 6:40am, they proceeded to enter the room of R6 and R7. They proceeded to assess and prepare R6 to be transported to the hospital. During this process, R6 was repeatedly telling the fire department paramedics that he was not in any distress, and that they have the wrong patient. Despite R6's actions, the fire department paramedics proceeded to transfer R6 from the bed to the cart and out of the facility.

There is no evidence to indicate that during the actions of the fire department paramedics, staff interventions were implemented to prevent R6 from being taken to the hospital. Evidence indicates that no Licensed staff were present in the room when R6 was being prepared for transport by the fire department paramedics.

Evidence indicates that prior to exiting the facility with R6, the fire department paramedics stopped at the nursing station and received the transfer documentation belonging to R7. The transfer documentation was given to the fire department paramedics by E9 (Licensed Practical Nurse). There is no evidence to indicate that facility staff actually saw R6 on the transport cart as he was leaving the facility. R6 left the facility at 6:45am.

Evidence indicates that the facility was not aware that R6 was transported from the facility, until E7 (Registered Nurse), upon making rounds at 7:05am, noted that R7 was still in his bed and that R6 was not in his bed.

Review of the local hospital emergency room report where R6 was transferred , indicates that R6 arrived at 7:36am. The History Of The Present Illness section of the report states the

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F9999	Continued From page 36	F9999		

following: "The patient is a 78 year old black male who comes to the Emergency Department from the nursing home apparently another patient was suppose to be transferred to the Emergency department but this patient was sent instead by mistake from the nursing home. The patient said the nurses came into his room and told him he was going to the hospital for evaluation. When he asked them why they said because his heart rate was high. The patient had absolutely no complaints. He says he feels fine and was not sure why he was coming. He was concerned because he thought that the person next door to him was the one that needed to come because he was complaining all night. The patient states he has no complaints and is not sure why he is here. On further evaluation of the patient we determined that this is actually the wrong person that is here. We called the nursing home to find out that apparently a different patient was suppose to be coming and this patient was sent in his place. Again the patient has no complaints." R6 returned to the facility at 9:54am.

E1 (Administrator) stated during interview on 8-10-10 at 1:00pm that the fire department took the wrong patient, and once the facility was made aware of the mistake, the doctor, hospital, fire department, and the families of R6 and R7 were all notified. E3 (Director of Nursing) stated on 8-10-10 at 1:15pm sthat even though the fire department made a mistake, a nurse should have been in the room with the paramedics during the transfer.

E4 (Assistant Director of Nursing) stated during interview on 8-10-10 at 1:30pm that typically during a "911" call nursing staff are always in the

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F9999	Continued From page 37	F9999		

room to assess/treat the resident up until the paramedics arrive. E4 further stated that the nurse usually gives report to the paramedics at the bedside of the resident. E7 (Registered Nurse) stated during interview on 8-10-10 at 10:25am that E9 asked her to tell R7 that he was going out to the hospital. "I did. After that, when the paramedics arrived, I was at the nursing station. The paramedics asked me why was the resident was going out to the hospital? I told them because of tachycardia. I was just starting my shift when all of this occurred. I do not believe that a nurse went into the room of R6 and R7 during the transfer. I saw E9 hand the transfer documentation to the paramedics from the nursing station. At around 7:05am, while making rounds, I discovered that R6 was gone, and R7 was still in his bed. At this time, I told E9. E9 proceeded to page the supervisor. I also informed E9 to call the hospital of the error."

E8 (Registered Nurse) stated during interview on 8-10-10 at 11:30am that she started her shift a little before 7:00am. "I overheard E9 giving report in relation to R7 going out to the hospital. I was not in the room of R6 and R7 when the fire department arrived in the facility. I believe that E7 told R7 that he would be going out to the hospital. I do not recall any nurses in the room of R6 and R7 when the fire department paramedics entered the room. I do recall E9 giving report from the nursing station to the paramedics. When R6 returned from the hospital, he was very upset."

R6 stated during interview on 8-10-10 at 3:30pm that on 7-24-10, "the fire department came into my room and took me to the hospital. I told them that I was ok and that they were making a big

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F9999	Continued From page 38	F9999		

mistake. The fire department continued to place me on the cart and took me to the hospital. Once I got to the hospital, they began to take some blood. I tried telling them, too, that this was a big mistake. Finally, I was brought back to the nursing home." When asked how did this occurrence made him feel, R6 responded, with tearful eyes, by saying "I felt violated and frightened." I further asked R6 how was he currently feeling? R6 stated, "I don't trust them." When asked whether the staff tried to prevent this from occurring, R6 stated "no." During the interview of R6, the resident eyes were tearful, and he appeared nervous and anxious when asked to relive the previous events.

E9 (Licensed Practical Nurse) stated on 8-12-10 at 1:45pm that she was assigned to R7. "I noted that R7 heart rate was elevated. I notified the doctor (Z1). After checking the heart rate a second time, Z1 gave orders to send R7 out via 911. I told R7 that his heart rate was high. After this, I proceeded to go to the nursing station to call 911, and to start the transfer documentation. I told E7 to inform R7 that he would be going to the hospital. At this time, I am also calling the family. When the paramedics arrived, I was at the nursing station. I stated the name, room, and bed number of R7 to the arriving paramedics. While still at the nursing station, I am completing the transfer documentation, and still talking to the family of R7. At this time, the paramedics are still in the room of R6 and R7. When the paramedics exited the room, from the nursing station, I handed them the transfer documentation. While still at the nursing station at 7:05am, E7 informed me that R7 was still in his bed and that R6 was not. At this time, I proceeded to call the fire department, the doctor, the receiving hospital,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING _____ B. WING _____	C 08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH CARE CENTER	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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
F9999	Continued From page 39 and the nursing supervisor." When asked at anytime was she present in the room with the paramedics, E9 stated, "no, but a nurse should have been present." R7 stated during interview on 8-12-10 at 2:00pm that, "I did not recall the paramedics taking R6 to the hospital on 7-24-10 because I was sleep. I was not concerned about being delayed regarding the hospital." Z1(Attending Physician) stated during interview on 8-10-10 at 11:45am that, "I wanted R7 to go to the hospital 911 because of an unknown cause related to tachycardia. The tachycardia was induced by pulmonary embolism. R7 should not have been delayed in going to the hospital." Review of the facility Discharge and Transfers policy, does not indicate procedures to ensure that licensed staff must be present during an emergency transfer to ensure that the correct resident will be transferred by the responding paramedics. Further review states that "Obtain physician's order for emergency transfer or discharge." There was a physician order for R7, not for R6. (A)	F9999		