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	146116	A. BUILDING ______ B. WING ______	C 09/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	**1380 NORTH 27TH ROAD** **OTTAWA, IL 61350**

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F 309	Continued From page 14 3. 09/07/10- The Director of Nursing and Assistant Director of Nursing conducted mandatory cardiopulmonary resuscitation (CPR) inservices including the color-coded system. The appropriate use of an AED was discussed in detail. This inservice was provided to all nursing staff both licensed and unlicensed. 4. 09/07/10-Residents with a valid order for a DNR are designated on the resident roster. A list of residents with a DNR is posted at the nurse's station and on the medical cart.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.2040c) 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.	F9999		

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F9999	Continued From page 15	F9999		

Continued From page 15

Section 300.2040 Diet Orders

c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is changed. Each change shall be ordered by the physician. The diet order shall include, at a minimum, the following information: name of resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to dietary, name of physician ordering the diet, and the signature of the person transmitting the order to the food service department.

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 were not met as evidenced by:

Based on record review and interview, facility staff failed to accommodate a resident's need to avoid foods with bananas due to an allergy for one of two residents (R3) with identified food allergies in a sample of 11 residents. R3 had a reaction to the bananas in the dessert served requiring hospitalization for treatment of the allergic reaction.

Findings include:

The POS (Physicians Order Sheet) for R3 dated 08/01/10 documents the following diagnosis: Spina Bifida. The same POS documents R3 has a food allergy to the following: nuts, bananas,

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F9999	Continued From page 16 and grapes. The care plan for R3 dated 06/24/10 documents the following: Problem- Is allergic to Latex, Penicillin, Sulfa, Iodine, Banana, and Nuts; Intervention- Notify kitchen of food allergies; check food trays for food that will cause reaction as needed. The dietary card for R3 received from the facility dietary manager on 08/31/10 documents that R3 has allergies to nuts, bananas, and grape jelly. The nurses notes for R3 dated 08/10/10 at 5:45PM documents the following: "Resident approached nurse at the desk and stated (R3) ate banana cake before realizing it contained bananas. Kitchen employee confirmed real bananas were used in the cake. Resident complained of being light headed, extremely cold and was having difficulty breathing. Oxygen was started at 2 liters by nasal cannula. 911 was called to transport to emergency room." Hospital emergency room record for R3 dated 08/10/10 documents the following: "Patient complained of having eaten food product containing bananas then shortly after feeling cold and drowsy. Patient has a history of severe allergic reaction. Patient was given Epinephrine by ambulance staff on route to hospital emergency room." Same record for R3 documents that at 6:35PM R3 was given Solumedrol 125mg (milligrams) IVP (Intravenous Push) and Benadryl 50mg IVP. R3 was discharged back to the facility at 11:00PM. Hospital Record for R3 dated 08/10/10 documents the following: "Diagnosis: Allergic Reaction; Follow up orders: Prednisone 40mg every 24 hours for 4 days. Return if worsens. Follow up with physician in 1 month."	F9999		

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F9999	Continued From page 17	F9999		

On 09/02/10 at 3:40PM Z2 (Attending Physician) for R3 stated, "(R3) has had this happen twice. It takes a pretty severe reaction to need the medications (R3) was given to offset this reaction. I don't remember the reaction (R3) had a year ago but this recent one caused a rapid reaction."

Nurses notes for R3 dated 08/10/10 at 11:00PM document the following: "Returned to facility with new order for Prednisone for 4 days which is to start on 08/11/10. Resident states he is still having some difficulty breathing. Lungs are clear."

On 08/31/10 at 2:35PM E7 (RN/Registered Nurse) stated, "I worked that night. After (R3) came to me with complaints of shortness of breath and said what (R3) had eaten, I went to the kitchen and asked if there was bananas in the banana cake (R3) was served. The dietary supervisor said yes, there were real bananas in the cake. I immediately called 911. I also called (R3's) medical doctor.

Facility dietary spreadsheet for 08/10/10 documents that banana cake was the dessert for the evening meal.

On 08/31/10 at 2:58PM E6 (Evening Dietary Supervisor) stated, "I was serving the main meal that night and (E9/Dietary Aide) was serving desserts. We usually just take the desserts out on a tray and pass them out. (E9/Dietary Aide) gave (R3) a piece of cake. It was banana cake. Later, one of the nurses came to me and asked me if there was real bananas in the cake that (R3) was served. I called (E5/Cook), who had made the cake earlier that day, to verify that

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F9999	Continued From page 18 there was. (E5/Cook) told me that she had put real bananas in the cake for dessert that evening. I called (E8/Dietary Manager) after that, but I don't know what she did about it." On 08/31/10 at 1:35PM E5 (Cook) stated, "I got a call from the kitchen at home the evening of 08/10/10. (E6/Evening Dietary Supervisor) asked me if there were bananas in the banana cake I had made earlier that day. I told (E6/Evening Dietary Supervisor) yes and I laughed to myself. What else would be in banana cake? (E9/Dietary Aide) has been here long enough to know better." On 08/31/10 at 3:15 E8 (Dietary Manager) stated, "I heard about that problem. (E6/Evening Dietary Supervisor) called me upset because (E9/Dietary Aide) had served banana cake to (R3). (E9/Dietary Aide) was unaware it was banana cake even though it was on the menu and on (R3's) dietary card. When desserts are passed out to residents, the Dietary Aide is supposed to check the dietary card where the resident sits to make sure they get the appropriate dessert. This was serious. I followed up with (E9/Dietary Aide). (E9) did not realize she had done it. I told (E9) to be more careful. I have not inserviced the staff about dietary allergies as of yet. I'm still new to this position." On 08/31/10 at 4:30PM E9 (Dietary Aide) stated, "I though it was spice cake. I have worked here for 4 years and am usually pretty good on that and don't give (R3) things like that. I didn't know banana cake was on the menu. I didn't check the menu out that evening. No one has talked to me since this happened."	F9999		

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LA SALLE COUNTY NURSING HOME	1380 NORTH 27TH ROAD OTTAWA, IL 61350

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F9999	Continued From page 19 On 08/31/10 at 2:10PM R3 stated, "I was told it was spice cake. The people in the kitchen did not know it had bananas in it. I didn't taste bananas in it, more spice and there was a lot of frosting on it. I had not eaten bananas in over 12 years. I tasted mostly spice. As I left the dining room I stopped and read the menu posted there and saw that banana cake was the dessert. I started to feel light headed, dizzy, cold with chills, and real sleepy. Then I started to get short of breath. The nurse checked me out and called 911. In the emergency room they gave me some medications through my vein and watched me for awhile then sent me back here. I stayed in bed for 2 days after I got back. I just didn't feel good. This happened to me here also about a year ago. I was served a muffin with nuts in it and had to go to the hospital then also." The nurses notes for R3 dated 07/06/09 at 7:47AM documents the following: (R3) had allergic reaction to banana nut muffin. Shortness of breath noted. Anxiety noted and difficulty breathing. Epi-pen (Epinephrine) given in right thigh. Oxygen administered by nasal cannula at 2 liters. Blood pressure 149/93. Respiration 40 in one minute. Called 911 at 7:48AM and sent to hospital." (A) 300.1035a)3)4)5) 300.3240a) Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right	F9999		

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F9999	Continued From page 20	F9999		

to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:
3) procedures for providing life-sustaining treatments available to residents at the facility;
4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;
5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

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 were not met as evidenced:

Based on record review and interview, the facility failed to perform timely cardiopulmonary resuscitative measures for one of four residents sampled with full code status in a sample of 11. This failure has the potential to affect the other thirteen residents in the facility whose status is Full Code (R3, R4, R5, R7, R9, R12, R13, R14, R15, R16, R17, R18, and R19).

Findings include:

The POS (Physicians Order Sheet) for R1 dated 07/16/10 documents the following diagnoses:

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F9999	Continued From page 21 Primary Pulmonary Hypertension, Systolic Heart failure, and Atrial Fibrillation. The same POS for R1 documents that R1 has full code status. Facility Policy on Cardiopulmonary Resuscitation (undated) received on 09/02/10 from E4 (ADON/Assistant Director of Nursing) documents the following: "Cardiopulmonary Resuscitation (CPR) will be initiated on all patients for whom this intervention is indicated. CPR will be initiated by any member of the Nursing Department who has been trained in this procedure. Determine unresponsiveness by tapping or gently shaking resident and shouting, 'Are you okay?' Call out for help. Early access to 911 is critical to the survival of the adult victim." Facility Policy on Automated External Defibrillator (AED) (undated) received on 09/02/10 from E4 (ADON/Assistant Director of Nursing) documents the following: "Initiate CPR according to center procedure and bring the AED to the location." The facility nurses notes for R1 dated 07/17/10 at 10:45AM document the following: "Apical pulse 60 beats per minute, Respirations 24 per minute, blood pressure 80/40, and oxygen saturation 51 percent on 2 liters of oxygen by nasal cannula. Lung sounds audibly congested, more than earlier this morning. Son in room and states he feels (R1's) condition has declined considerably in the past hour. Paged doctor at 10:55AM. Orders received to send to the emergency room. Called 911. Son here and informed." Facility nurses notes for R1 dated 07/17/10 at 11:01AM document the following: "At nurses station getting transfer papers ready. (R1's) son came to the desk and said, 'I think we lost him.'	F9999		

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F9999	Continued From page 22 Went to (R1's) room. Unable to detect pulse. No breathing. No verbal response. Left son in room and went down to the lobby to get LPN (Licensed Practical Nurse). Told LPN I needed help. As we were running back to (R1's) room EMS (Emergency Medical Response) team arrived. CPR (Cardiopulmonary Resuscitation) started after returning to room. Attempts were unsuccessful. Resident was transferred to hospital emergency room and was pronounced dead upon arrival." On 09/01/10 at 9:15AM E3 (DON/Director of Nursing) stated, "I received conflicting stories. The nurse in charge of (R1) left the resident knowing this resident had no pulse. She came to the desk for help and took the other nurse back to the room with her. EMS (Emergency Medical Response) had already been called. The two facility nurses and EMS got to (R1's) room at the same time. CPR was initiated at that time and not before as it should have been. (R1) was transferred to the hospital and never regained a pulse. In investigation of this, I felt the nurse should have stayed with (R1) and initiated emergency care, yelled for help rather than leave (R1) to go get help. I terminated this nurse. In her initial story, the nurse told me she did not leave (R1); however, in talking to the other nurse that assisted her, she came to the nurses station for help. I don't know why she did not use the AED. It was appropriate to be used in situations like these. I have been here for 4 months now. We have not had any inservices on emergency care since I started here." On 09/01/10 at 2:00PM E12 (RN/Registered Nurse) stated, "I was doing the paperwork for (R1's) transfer. I had called the doctor earlier	F9999		

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F9999	Continued From page 23 about (R1's) declining condition. As I was working on paperwork for (R1's) transfer the son came to the nurses station and told me 'I think (R1) is gone.' I ran down the hall and checked for signs of life. There was no pulse or respirations. I left the son in (R1's) room and went down to the lobby to get help. I saw E13 (LPN/Licensed Practical Nurse) and told her I needed help. (E13/LPN) said 'okay' and I said, no I need help now. We both went back to (R1's) room and arrived at the same time as EMS. I've only been a nurse for 2 years and have never had anyone code on me. You can't start CPR alone so I ran and grabbed (E13/LPN). I am certified in CPR and AED use. I was aware the facility had an AED but had no idea where it was kept. I have not seen the facility policy on CPR or AED use. I was not aware of (R1's) heart condition. I didn't get a very good report on (R1) when I came on duty and spent a lot of time clarifying orders for (R1). This all happened near the end of working a 24 hour shift at the facility, and I was not thinking clearly. I stayed over my shift to do the documentation." On 09/01/10 at 2:25PM E13 (LPN) stated, "I was passing medications. (E12/RN) was at the nurses station. (R1's) son was standing near the nurses station and had a sad look on his face. (E12/RN) was going through some papers. I looked at (E12/RN) and asked if she needed me. I then saw the look on (R1's) son's face and took off down to the end of the hall to (R1's) room. (E12) followed me. I found (R1) unresponsive and just as I started to do CPR the EMS team arrived and took over. I am certified in CPR and in the use of the AED. It would have been appropriate to use the AED on (R1). I don't know why (E12/RN) didn't grab it."	F9999		

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F9999	Continued From page 24 On 09/08/10 at 2:20PM Z4 (R1's attending Physician) stated, "Any delay in CPR can have a negative outcome on a persons survival chances. Whether one minute or ten minutes had elapsed I cannot say whether this patient would have survived. I felt (R1) was discharged from the hospital before (R1) was well enough to go to the nursing home. I had been (R1's) doctor for over two years and knew (R1) wanted to be a full code. (R1) still had a wife at home and was worried about leaving her without any help. I explained to (R1) what CPR might do but those remained (R1's) wishes." On 09/04/10, E4 (ADON) provided a facility roster and a list with resident names highlighted in yellow. E4 stated the names on the facility roster highlighted in yellow are residents who have Full Code status. The names highlighted were R3, R4, R5, R7, R9, R12, R13, R14, R15, R16, R17, R18, and R19. (A)	F9999		