STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G318	A. BUILDING _____ B. WING _____	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNWOOD TERRACE	2317 EAST 207TH STREET LYNWOOD, IL 60411

(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 441	Continued From page 25 varied conditions. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct evacuation drills under varied conditions for the first shift in the past year, affecting 5 of 5 clients (R1 thru R5). Findings include: According to the Inspection Of Care Summary Form completed on 8/9/10, R1 and R5 have diagnosis of Moderate Mental Retardation (M.R.) R2 and R4 have diagnosis of Profound M.R. R3 has diagnosis of Severe M.R. Review of the First Shift evacuation drills conducted by the facility shows that only fire drills were conducted in the past year. The only Disaster Drill is a Tornado drill conducted in July 20, 2009 at 7:16 AM. The facility did not provide the surveyor with evidence that other disaster drills were completed by the first shift in the past year. Interview with E1(Qualified Mental Retardation Professional, QMRP) on 8/10/10 at 2:00 P.M. validated that only one first shift disaster drill was conducted in the past year.	W 441		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)3)	W9999		

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W9999	Continued From page 26 350.1235a)3)4)5) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 3) First aid in the presence of accident or illness. 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. 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	W9999		

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W9999	Continued From page 27 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 350.3240 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, the facility failed to ensure staff perform CPR (cardio pulmonary resuscitation) continuously and according to the American Red Cross guidelines and facility policies until relieved by paramedics for 1 of 1 resident outside of the sample who was found unresponsive by staff on 6/2/10 (R6) and expired in the emergency room on 6/2/10. The facility also failed to to fully dcoument and investigate the circumstances surrounding R6's death in accordance with facility policies. Findings include: According to Individual Service Plan (ISP) dated 12/9/09, R6 was a 47-year old male who requires 24-hour supervision with diagnoses of Moderate Mental Retardation, Mitral valve prolapsed pes planos, and Seizure Disorder. Facility Policy No. 5.57 states: "In case of a medical emergency, 1) notify the local emergency service... 2) ...and administer	W9999		

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W9999	Continued From page 28 CPR/First Aid, as needed." The EMS (emergency medical service) Report Form by Ambulance Service (dated 6/2/10) stated the following: "We were called to the scene for an unresponsive pt (patient)...we started CPR. and attached heart monitor...airway filled with copious fluids and required suctioning prior to intubation...CPR done throughout entire run without change in status." The EMS report form section on "treat(ment) prior to arrival" included the following options: None, CPR, First Aid, Extrication, DNR (do not resuscitate), Defi(rillation) and Other. The option "none" was selected on the EMS form. On 8/12/10, at 1:40 p.m., when asked if he saw staff performing CPR upon arrival at the facility on 6/2/10, Z1(Paramedic) stated "to best of my knowledge there were no staff in room with R6, and no one was doing CPR." Z1 added that there seemed to be a "lot of liquids and fluids and stuff in his (R6's) mouth...the airway was compromised." The Final Report of the Administrative Investigative Committee/Report of Resident Death (dated 6/7/10) stated the following: "It was determined that (R6) was not breathing. E3 (DSP) began CPR while E4 (DSP) called 911. The report added that the "Paramedics arrived and took over for staff who was performing CPR." However, on 8/12/10, at 3:50 p.m., when asked if the paramedics stated they'll take over the CPR, E3 stated, "No, they didn't tell me to stop or that they'll take over." On 8/12/10, at 1:40 p.m., Z1 stated that no staff was in the room with R6 and no one was doing CPR upon their arrival.	W9999		

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W9999	Continued From page 29 On 8/12/10, at 3:50 p.m., E3 stated that she initiated the CPR on R6 by "giving 2 puffs, pumping chest 15 times, giving 2 puffs again." E3 stated that when she was "pumping chest of R6 the 2nd time, 2 paramedics came," started asking questions and then told her to "get out of the room" and asked her to get "list of medication and profile information of R6." The EMS report completed and signed by the paramedics (dated 6/2/10) stated that no treatment was administered to R6 before their arrival. On 8/12/10, E3 also stated that she is not sure if the two people who came in the room wearing uniform were paramedics, police or firemen. According to the Ambulance Service, Police Department and Fire Department reports, on 6/2/10, the Paramedics arrived at the facility at 9:50 p.m. and the Fire Department and the Police arrived at the facility at 9:52 p.m. This timeline confirms that the paramedics were the first emergency medical service responders who arrived at the facility. On 8/12/10 at 3:50 PM, E3 stated she did not find anything in R6's mouth when she checked before performing the CPR. However, Z1 (paramedic) stated during telephone interview on 8/12/10 at 1:40 PM and via the EMS report (dated 6/2/10) that R6's mouth was filled with fluids. The statements provided by E3 and Z1 are not consistent. Review of sections from the American Red Cross Skills Card for Adult CPR/AED provided by E7 (facility trainer) on 8/20/10 confirms the following steps when: A. Checking an Ill or Injured Person: For Adult (Age 12 of older):	W9999		

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W9999	Continued From page 30 1. Check scene, then check person. 2. Tap shoulder and shout, "Are you okay?" 3. No response, CALL 9-1-1. 4. Open airway (tilt head, lift chin), CHECK for signs of live (movement and breathing) for no more than 10 seconds. 5. If no breathing, give 2 rescue breaths. 6. If breathing, place in recovery position and monitor Airway, Breathing and Circulation (ABCs). B. No Movement or Breathing: After checking an ill or injured person. To give a rescue breath: 1. Tilt head and lift chin, then pinch the nose shut. 2. Take a breath and make a complete seal over the person's mouth. 3. Blow in to make chest clearly rise. WHAT TO DO NEXT: IF BREATHS DO NOT GO IN--Go to PANEL D... E. No Signs of Life: After checking an ill or injured person: 1. Give cycles of 30 chest compressions and 2 rescue breaths. 2. Continue CPR until- -Scene becomes unsafe. -You find a sign of life. -AED is ready to use. -You are too exhausted to continue. -Another trained responder arrives and takes over. Review of E3 and E4's Adult-CPR certification confirms that they were both re-certified in the American Red Cross training course for Adult CPR on 3/16/10 by the facility trainer (E7). E7 confirmed on 8/20/10 approximately at 12:00 PM that the sections of the ARC Skills Card for Adult CPR/AED (faxed to the surveyor on 8/20/10) was	W9999		

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W9999	Continued From page 31 part of the re-certification training provided to E3 and E4 on 3/16/10. There is no evidence that E3 (DSP) performed CPR continously and according to the American Red Cross guidelines. Interviews with E3 confirmed she gave two 2-rescue breaths to R6 that did not cause any movement (chest rise) in R6. E3 also confirmed that she gave one cycle of 15 chest compressions to R6 (instead of the 30 compressions indicated in the guideline), and that she stopped CPR without verifying with the first emergency responders that they are going to take over CPR. The EMS report and interview also validates that no CPR was administered to R6 prior to their arrival to the scene. There is no evidence that the facility either obtained a copy of the paramedic/police/fire department report or interviewed the paramedics in order to ensure there are no discrepancies and clients are provided appropriate emergency treatment. Facility Policy (No. 5.24) of Investigative Committee (Revised 11/08) states that "any employee who witnesses injuries of unknown source..." shall "document a brief note regarding the incident on a progress note prior to leaving the shift." Facility Policy (5.57) of Physical Injury and Illness/Individual Medical Emergencies (Revised 4/09) states that the "progress note will be filed in the individual's case file for 3 months...." The Final Report of Administrative Investigative Committee/Report of Resident Death (dated 6/7/10) noted that E4 (Direct Support	W9999		

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W9999	Continued From page 32	W9999		

Professional, DSP) was a witness at the facility during the incident on 6/2/10 when R6 was found to be unresponsive.

On 8/9/10, R6's file did not include a progress note by E4 regarding the incident on 6/2/10.

On 8/9/10, at 3:45 p.m., E1 (Qualified Mental Retardation Professional, QMRP) stated that E4 "wrote a progress note that day. I don't see her statement and my supervisor does not have a record of it." Further, E1 clarified that she saw the progress note written by E4 and that the investigation file was part of R6's record. However, upon request of surveyor for the investigation file for R6, E1 clarified that the investigation file that was in R6's record was not in R6's record at time of surveryor's request. E1 confirmed that she had to call E2 (Executive Director) about the file and E2 ended up faxing all that he had to E1. The investigation file E1 obtained from E2 still did not include the progress note by E4.

Facility Policy No. 5.57 states that "Administrator shall conduct any necessary interviews...to establish the probable cause of the injury and document the finding on the Progress Note."

The Final Report of Administrative Investigative Committee/Report of Resident Death stated that the "committee convened on 6/3/10 to investigate the passing of R6. The committee interviewed all staff and residents at the facility."

On 8/9/10, the investigative interview of E4 done by the facility was not available in R6's file. The investigative interview of E4 and the progress note written by E4 was never produced by the