STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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
F 514	Continued From page 27 Review of death certificate showed that R5 had expired at the facility on 5/24/2011 at 2:30 A.M. There was no documentation in the clinical record to indicate R5 was assessed, monitored and what was the medical condition that precipitated R5's death. E8 (CNA-certified nurse assistant) when interviewed on 6/28/2011 at 12:11 P.M., stated that R5 was found in a distress situation on 5/24/2011 at 12:36 A.M. E8 also added that on 1 and 1/2 hour later, R5 was found not breathing and was without a pulse. E8 added, that CPR was not performed , however, facility called paramedics. The concern that there was no documentation to indicate R5 was assessed, monitored, evaluated and provided with emergency medical interventions when R5 was found in distressed on 5/24/2011 was discussed with E1 on 6/27/2011 at 2:40 P.M. E1 confirmed that there was no documentation with the above concerns.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1035a)1) 300.1035b)2 300.1035)e) 300.1035g) 300.1210b) (formerly 300.1210a)) 300.1210d)3) (formerly 300.1210b)3)) 300.3240a)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 28 300.3240b) 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1035 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: 1) implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½, pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45]; b) For the purposes of this Section: 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 29 include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated. e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70] g) The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act. 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 30 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These requirements were not met as evidenced by: Based on interviews and record review, the facility failed to provide necessary care or services to one resident (R5) of three sampled for appropriate care, after he was observed with a significant change of condition on 5/24/2011. The lack of timely evaluation and provision of regular and emergency medical interventions resulted in further significant change in R5's condition. He was later found unresponsive and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 31	F9999		

without a pulse. The facility also failed to initiate emergency medical procedures (CPR-Cardiopulmonary Resuscitation). R5 was a full code status. Review of death certificate showed R5 expired on 5/24/2011 at 2:30 A.M.

Findings include:

R5 was a 79 year old male with diagnoses of Diabetes Mellitus, Hypertension, PVD (peripheral vascular disease), status post Gastrostomy tube insertion and ESRD (end stage renal disease).

R5 was admitted to the facility on 5/9/2011 from another facility. Review of R5's physician transfer order dated 5/9/2011 showed that R5 was a full code status. Review of clinical chart showed that R5 has an advance directive dated 1/1/2011 indicating that R5 had requested to have Cardiopulmonary Resuscitation (CPR) in the event that R5's heart or breathing stopped and that any and all measures will be taken to revive R5.

E8 (CNA, certified nurse assistant) stated on 6/28/2011 at 12:11 P.M. that on 5/24/2011 from the hour of approximately 12:10 A.M. to 12:36 a.m., E8 provided care to R5 by cleaning and changing bedding. E8 indicated that R5 was found to be drooling and gargling in the mouth. R5 was full of bowel movements from upper mid back all the way to the knees. E8 also stated that it was already 12:36 a.m. when she was done cleaning R5. E8 indicated that when she looked at R5, it did not sit right with her because R5 was not responding verbally and was drooling with foamy secretions coming from his mouth. As soon as E8 left R5's room E8 immediately went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 32	F9999		

to E5 (nurse on the floor) and told her about R5's significant change. E8 stated she did not see E5 go to the room to check and assess R5. E8 also stated that R5 definitely had a significant changed in medical condition since R5 had been alert and verbally responsive from previous nights.

E8 indicated that at 2:02 A.M., E8 went back to check R5. At this time, E8 stated she observed that R5 was still not responding, skin tone color had changed to yellow from a light/fair complexion and that R5 had brown vomitus all over top of chest area and mouth. E8 then came out and yelled in the hallway at E5 to come check R5. E5 responded she was passing medications and cannot leave medication cart. E8 then yelled loudly and in a panicked voice for E5 to see R5 right away. E8 added that E5 proceeded to come to the room and was not sure of what to do. E8 verbalized that she told E5 to check R5's vital signs (temperature/ pulse/blood pressure). E8 stated that E5 did not check pulse but went out of the room to the nurse's station, got a stethoscope, called E6 (registered nurse assigned from the first floor) via phone and checked clinical chart to see whether R5 was a Do Not Resuscitate status or a Full Code. E8 added that E5 then came back to the room, listened to R5's breathing and stated that R5 was not breathing and that R5 had passed away. E6 who came from first floor joined E5 and E8 in R5's room. E8 indicated that E5 and E6 were not doing CPR, so E8 asked what the facility's protocol was and why CPR was not initiated. E8 stated that E5 responded "what was the point of doing CPR, he (R5) is already gone and would not be revived." E8 added that she informed E5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

(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 33	F9999		

and E6 that they do not know what time exactly that R5 passed away and that CPR should be done. E8 indicated that E6 stated to call 911, bring the emergency cart into R5's room. E8 added that she was asked by E5 to leave the room to make some copies of R5's record for the paramedics. E8 stated she was told both by E5 and E6 that "this (incident) will not leave this room (R5) that they did not do CPR. They are not going to know CPR was not done, there will be no autopsy." E8 also added that she did not do CPR to R5 because she was a CNA and was under E5 and E6. As E8 added she reported this improper care to E7 (Director of Nursing) around 4 days after it had happened (5/27/2011). E8 added that as of 5/30/2011, E7 had not investigated fully the situation. E8 then informed E4 (Human Resource Director) of the situation. E8 also stated that she does not want to cause trouble to anyone, however felt that nurses should be trained and know facility's protocol for providing CPR.

On 6/30/2011 at 9:55 A.M., Z1 (attending physician) stated that R5 had multiple medical problems. Z1 also stated that R5 was a full code and should have been given CPR when he was found not breathing and without a pulse on 5/24/2011. Z1 further stated that he should have been notified when R5 was noted with significant medical change when R5 was noted drooling and with foamy secretions around the mouth area on 5/24/2011.

Review of death certificate showed that R5 had expired at the facility on 5/24/2011 at 2:30 A.M. There was no documentation in the clinical record to indicate that R5 was assessed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	C 07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER OF JOLIET	222 NORTH HAMMES JOLIET, IL 60435

(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 34	F9999		

monitored and how R5's medical condition was that precipitated his death.

Review of facility's protocol for "Presumed Death Policy" showed that assessment should be done to determine if CPR or no CPR is indicated. Further review of the policy showed that two nurses should determine and verified the presence of the following:
---Pupils fixed and dilated
---no spontaneous respiration
---mottled discoloration of the body
---no spontaneous movement
---absence of vital signs (apical pulse and blood pressure)
The policy also showed that above findings should be documented in nursing notes alone with the names of both nurses.

Facility could not show any documentation that protocol was followed. Staff did not assess R5 on 5/24/2011, when found unresponsive at 2:02 A.M. There was no documentation that vital signs were taken, nor checked for viability.

On 6/27/2011 at 2:40 P.M., E1(administrator) stated R5 had expired on 5/24/2011 at the facility. E1 added that E5 and E6 were terminated on 6/7/2011 and 6/8/2011 for not providing CPR to R5 on 5/24/2011. E1 also added that E7 was terminated on 6/8/2011 because E7 failed to follow facility's policy to address and investigate E5 and E6's failure to provide CPR to R5. E1 also added that E4 was terminated on 6/7/2011 for not reporting immediately the improper care to E1.

On 6/28/2011, surveyor asked E1 for the list of