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	145420	A. BUILDING ______ B. WING ______	C **04/17/2012**

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BRIDGEWAY CHRISTIAN VILLAGE REHAB & SNF	**111 EAST WASHINGTON BENSENVILLE, IL 60106**

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F 309	Continued From page 8 H. Education on the Code Response policy will be held annually and as a part of orientation for licensed nurses. All in-service attendance and audits will be reviewed at the Quality Assurance committee meetings monthly for the next 3 months and annually to assure compliance is maintained. Director of Clinical Compliance will be responsible to monitor and report to the committee.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.610c)2) 300.1030a)1)2) 300.1030b) 300.1035a)3)4)5) 300.1210b) 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 9	F9999		

c) These written policies shall include, at a minimum the following provisions:
2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

Section 300.1030 Medical Emergencies

a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:
1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).
2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.

Section 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

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F9999	Continued From page 10	F9999		

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 300.1210 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 care needs of the resident.

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 REQUIREMENTS WERE NOT MET AS

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F9999	Continued From page 11	F9999		

EVIDENCED BY:

Based on record review and interview, the facility failed to:

1) initiate cardiopulmonary resuscitation (CPR) and access the emergency life support system (EMS) in a timely manner.

2) follow the facility policy for Code Response for one (R1) of three residents sampled for neglect.

3) ensure that an emergency protocol for life threatening situations was in place, and emergency equipment was readily available on all units for life threatening emergencies.

4) ensure staff are familiar with identifying the code status of the resident; and

5) initiate emergency procedures such as the application of resuscitative (ambu) oxygen mask and to continue with CPR until the emergency medical personnel arrived.

On 3/15/12 at 5:00 AM, R1 was found unresponsive, not breathing and without pulse. The facility failed to identify R1's code status, who was a Full Code. The facility failed to initiate CPR and access the emergency medical system in a timely manner. R1 expired on 3/15/12 in the hospital. These failures of staff to initiate timely emergency medical care and follow the Code Response policy placed other residents in the facility at risk.

Findings include:

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F9999	Continued From page 12 Review of closed clinical record indicated, R1 was readmitted to the facility on 8/14/11 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Dementia, Hypertension, Coronary Artery Disease, History of Abdominal Aortic Aneurysm with Repair, Partial Gastrectomy and Deep Vein Thrombosis. R1 was alert with periods of confusion, forgetfulness and lethargy. R1 was on continuous oxygen therapy at 2 - 3 liters per minute thru nasal cannula. The admitting face sheet reflected that R1 was a Full Code Status. The Initial Incident Investigation Report dated 3/15/12 at 5:15 PM, documented that E6 (Certified Nursing Assistant -CNA) found R1 in bed at 5:00 AM on 3/15/12 unresponsive, without pulse and respiration and with emesis on R1's gown. No CPR record was found. At 5:15 AM, the paramedics arrived at the facility and transported R1 to the hospital. The Summary of the Investigation of Unanticipated of Death for R1 indicated the following: 3:40 AM - Resident found sleeping by E6 (CNA). 5:05 AM - E6 found resident with vomit on the gown, unresponsive, no respirations/pulse, color pale. Immediately summoned the nurse. E3 (Nurse on Duty) listened for heartbeat with stethoscope - no pulse and no respirations noted. E6 cleaned the emesis and gown of the resident. 5:07 AM - E3 called E5 (B Unit Nurse) who said she would come over and get E4 (C Unit Nurse) to come. 5:10 AM - E3 tried to call Unit E Nurse to page overhead for Code Blue - no answer. E4 & E5 got the crash cart and went to the room.	F9999		

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F9999	Continued From page 13 5:11 AM - E3 tried to call Unit E again - no answer. E3 went back to the room and noted E4 doing chest compressions. E5 went to copy medical records for paramedics. 5:12 AM - E3 called 911 and went back to the room. E4 left the room and instructed E3 to do chest compressions. 5:15 AM - Paramedics arrived. E4 handed paramedics the medical records. Paramedics took over care of the resident. 5:30 AM - Resident transported to the hospital. The local Fire Protection District Patient Care Report dated 3/15/12 documented the following: EMS (Emergency Medical System) called to the scene for full arrest. EMS was directed to the D Wing instead of B Wing as originally stated to the Dispatch. EMS found patient (PT) lying supine on bed with caretaker (E6) standing over patient. Caretaker stated that she found patient unresponsive about 15 - 20 minutes before calling EMS. Caretaker stated she thought PT was a full code. Caretaker stated she did not start CPR because PT was gone. EMS noted no pulse or respirations. EMS started CPR. E3 stated during phone interview on 3/27/12 at 2:25 PM, E6 found R1 to be dead at 5:00 AM. E6 summoned E3 to check the resident. E3 went to the room and found R1 unresponsive, without pulse and respiration. E3 stated that she then left the room to check R1's code status in the clinical record at approximately 5:10 AM. When E3 determined that R1 was a Full Code, she called Unit E to announce code blue. According to E3, it is only in Unit E that has the capability to page an overhead code during the night shift. E3 stated no one answered the phone in Unit E. E3 then	F9999		

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F9999	Continued From page 14 called Unit B and asked for help at approximately 5:15 AM. E3 sent the other CNA to Unit E to announce Code Blue (Cardiac Arrest). E3 saw E5 (Unit B Nurse) going to R1's room and so E3 grabbed the crash cart and brought it to R1's room. E3 saw that E4 (Unit C Nurse) was already in the room performing chest compressions on R1. E3 then left the room and called 911 (approximately 15 minutes after R1 was found unresponsive, breathless & pulseless). E3 stated that she did not document anything in the CPR record. On 3/27/12 at 2:55 PM during a phone interview, E4 stated that E5 called her to go to Unit D. E4 went directly to R1's room and started chest compressions after placing the cardiac board with assistance from E5. E4 said that the ambu (resuscitative) bag did not have the face mask so she applied the non rebreathing mask instead. E4 also stated that E6 was in the room with the resident. When E3 came back to the room, E4 told E3 to continue chest compressions and E4 left the room. On 3/27/12 at 3:20 PM during a phone interview, E5 stated that E3 called on 3/15/12 in the morning to ask what procedure to follow when a resident expire. E3 told E5 that she did not find a DNR (Do Not Resuscitate) form in the clinical record. E5 instructed E3 to call for Code Blue overhead by calling Unit E. E5 then proceeded to Unit D and requested E4 (Unit C Nurse) to assist. E5 and E4 arrived in R1's room and did not observe any staff in the room. E5 also stated that she brought the crash cart to the room and applied the cardiac board with E4. The ambu bag (resuscitative) face mask was not in the cart so	F9999		

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F9999	Continued From page 15 E4 applied a non rebreathing or simple mask. E5 stated that E4 started chest compressions so E5 left the room. On 3/28/12 at 8:10 AM, E6 stated that she saw R1 in bed on 3/15/12 at 12:00 AM, sleeping. At 2:00 AM, she responded to R1's call light. R1 verbalized that she wanted to go home. E6 reassured R1 and informed her that she will call R1's family at 7:00 AM. E6 repositioned R1 in bed and left the room. At 2:30 AM, R1 called and verbalized again wanting to go home. E6 reassured R1 again and left the room. E6 responded to other call lights and checked on R1 at 3:40 AM. The resident appeared to be asleep in bed. Between 5:00 AM and 5:05 AM, E6 went to R1's room and smelled an unpleasant odor. E6 turned on the lights and called R1's name. R1 did not respond and observed vomit on her face and gown. E6 touched and shook R1 who did not respond. E6 notified E3 to check R1 at approximately 5:10 AM. Both nurses from Unit B & C arrived and brought the crash cart in the room. E6 left the room to attend to another resident while both E4 & E5 were in the room. E6 stated the paramedics and police department arrived between 5:17 AM & 5:18 AM. E6 did not know R1's code status. E6 also said that she did not start CPR because her certificate has expired. E6 stated that she did not observe E3 start CPR. The facility policy titled, "Code Response," dated 12/20/11 requires, "If a resident is a full code and stops breathing and/or has no pulse, the first staff member on the scene remains with the resident and summons help by announcing "CODE BLUE" until qualified staff arrives to the location of the	F9999		

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F9999	Continued From page 16 resident. 5. Staff with CPR credentials is expected to respond. EMS/911 will be activated. 6. The first CPR certified staff member on the scene initiates cardiopulmonary resuscitation after assessing resident for lack of pulse and/or respiration. 7. The licensed staff members on the scene is responsible for documenting all pertinent information related to the event such as time, resident response,etc. 8. CPR is continued until EMS staff arrives." The facility policy was not followed, therefore there was delay in initiating CPR. The lack of protocol for calling emergencies during the third shift, lack of staff knowledge of emergency protocol, and lack of availability of emergency equipment on the unit resulted in delay for provision of effective oxygenation and continued CPR until the paramedics arrived on the scene. (A)	F9999		