

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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 323	Continued From page 7 training and CPR records to ensure compliance with facility standards and will report on these audits as part of her quarterly quality improvement project.	F 323			
F9999	The facility Administrator will monitor these programs to ensure all identified Resident dining needs are met including appropriate level of supervision. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 300.1220b)2)3) 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			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 8</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 9 seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidenced</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 10 by:</p> <p>Based on record review and staff interview, the facility failed to supervise one resident of 14 residents on the 4th floor requiring mechanical soft diet meals. On 1/12/12 at 5:25PM, R3 was found choking on food. R3 expired in the hospital on 1/13/12 of Aspiration and Cardiovascular Collapse.</p> <p>Findings include:</p> <p>R3's January 2012 Physician Order Sheet documents R3 as an 88 year old female admitted to the facility on 3/23/07. She had a diagnosis including Alzheimer's and Osteoporosis. R3 had orders for "Do Not Resuscitate." A mechanical soft diet was ordered. The resident resided on the 4th floor of the facility.</p> <p>R3's Minimum Data Set (MDS) dated 1/12/12 assesses R3 as "needing supervision/oversight, encouragement or cueing during meals." R3 has dentures.</p> <p>On 7/31/11 (onset date) R3 was evaluated for treatment for swallowing therapy because of coughing at meal times. The recommendations were as follows: "Continue mechanical soft diet and thinned liquids. Compensation strategy training, Patient/Caregiver/staff education and Patient will require assistance at meals." The plan for swallow precautions was: "One bite at a time, small bites, slow pace and alternate liquids and solids."</p> <p>R3's quarterly nutrition review dated 8/12/11 documents "difficulty swallowing, self feeding but</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 11 needs assistance."</p> <p>No care plan was found to address the resident's swallowing problem or swallowing recommendations, or that the resident needed assistance during meals.</p> <p>Document review of the facility incident report states the following: 1/12/12 at 5.25 PM, R1 was eating her dinner in the hallway on the 4th floor next to the dining room. E4 (Registered Nurse) observed resident was up in chair when E4 noticed R1 with a large amount of bread sticking out of her mouth. Her face was red. R1 could not speak . E4 performed the Heimlich maneuver several times with no success. Resident was placed on the floor and Heimlich thrusts were done. 911 was called. A small amount of food was removed from mouth. An Ambu bag was used to increase oxygenation. Resident coughed and expelled a small amount of undigested food. Paramedics arrived and suctioned resident, an IV was started and R1 was transported to the hospital.</p> <p>The hospital discharge summary dated 1/13/12 documents the resident was admitted for a choking episode with altered mental status. The documentation shows R3 was found choking while eating a piece of orange in the nursing home. Heimlich maneuver was initiated by the nursing staff, but was unsuccessful. Paramedics were called and the orange piece was removed with forceps.</p> <p>Z1 (Medical Director) stated on 3/29/12 that R1 expired from Aspiration and Cardiovascular Collapse in the hospital. Z1 did not provide any</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 12 further information.</p> <p>R3's Certificate of Death, issued on 1/20/12, documents Cardiovascular Collapse and aspiration as the cause of death on 1/13/12.</p> <p>E4 (Registered Nurse) stated on 3/28/12 she was passing meds when she saw R1 choking. She did a mouth sweep and a Heimlich twice with R1 in her chair. She called out to E5 (Certified Nurse Aid) for help. E5 did the Heimlich but could not get any results. Both E4 and E5 lowered R1 to the floor, took her dentures out, and did abdominal thrusts. At this time paramedics arrived.</p> <p>E5 (Certified Nurse Aid) stated on 3/27/12, "I was with another resident assisting him to his bed. E14 (Certified Nurse Aid) called out for me to help. E14 was doing Heimlich on R1. I tried to do the Heimlich 4 or 5 times with no results. E4 was there at this time with other CNA's. The nurse was called and 911 was called. We lowered her to the floor and did abdominal thrusts. Some food came out. R1 was unresponsive. E3 came with the crash cart. Oxygen was administered. Paramedics arrived."</p> <p>E3 (Registered Nurse) stated on 3/27 that a CNA called her on the phone and said R3 was choking. "When I arrived E4 was doing the Heimlich on R1. E5 and E4 lowered R1 to the floor and did a mouth sweep. E4 did abdominal thrusts. They turned R1 to her side and did another mouth sweep. R1 was still unresponsive We used an Ambu bag and put her on oxygen. The ambulance rescue team arrived. They pulled out a piece of food that was orange in color. R1</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2012
NAME OF PROVIDER OR SUPPLIER NORWOOD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 6016 NORTH NINA AVENUE CHICAGO, IL 60631		
(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	<p>Continued From page 13 was taken from the facility."</p> <p>E14 (Certified Nurses Aid) stated on 3/28/13 the following: "We were passing trays when I heard E4 say: "spit up come on spit it up." E4 started doing the Heimlich maneuver. R1 was unconscious and blue in the face. I also attempted to do Heimlich . We yelled out to dial 911. Other staff arrived. E5 attempted to do the Heimlich with no results. We lowered her to the floor and attempted to do thrusts with no results. She was still unconscious. E5 was also there trying to help. Paramedics arrived."</p> <p>The facilities dietary spread sheet week 3, day 5, (1/12/12) documents that a fresh orange wedge was included in the dinner menu for the mechanical soft diets.</p> <p>Per facilities standardized recipe, a fresh orange wedge with the rind is included in the mechanical soft diet.</p> <p>The diet manual for the facility recommends only canned citrus sections should be served to mechanical soft diets, and to avoid fruits with a tough skin.</p> <p>The facility failed to correctly prepare a menu to avoid fruits with a tough skin in its mechanical soft diets. There were 14 residents residing on the 4th floor at the time of this survey on prescribed mechanical soft diets.</p> <p>E13 (dietician) stated on 3/27 at 11:55am that it was all right for R3 to have a fresh orange wedge and "was fine to eat by herself." E13 also said that fresh orange wedges were allowed for</p>	F9999			

