STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G116	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND HOUSE	**6701 SOUTH MORGAN CHICAGO, IL 60621**

(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 331	Continued From page 17 House staff will be re-trained annually on CPR and First Aid using The American Red Cross re-fresher curriculum (see attached). Additionally, Hammond House staff will receive random training on resident emergency scenarios, test and/or quizzes to ensure their understanding of CPR and First Aid. This random testing will occur quarterly. The Staff Trainer, Nurse and Resident Service Director will be responsible for compliance. The Resident Services Director, Administrator, Nurse and Staff Trainer will monitor for compliance. Completion date for CPR/First Aid re-training is March 31, 2012.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.610a) 350.1210 350.1230d)1)2)3) 350.3240a) Section 350.610 Management Policies a) The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served. 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	W9999		

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W9999	Continued From page 18 d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. 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 are not met as evidenced by the following: Based on record review and interviews, the facility failed to ensure health care services are provided for 1 of 1 individuals in the sample (R3), who was found unresponsive, after being left unattended in a bathtub, when the facility failed to: 1) Ensure that staff provide the necessary medical services to an unresponsive client. 2) Develop a medical emergency protocol that gives directions to facility staff for ensuring that Cardiopulmonary Resuscitation (CPR) procedures are implemented in a timely manner. Findings Include: On 2/28/12 at 3:30 PM, when R3 was found unresponsive, after being left unattended in a bathtub; facility staff were not able to determine if CPR was provided for a client who was found	W9999		

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W9999	Continued From page 19	W9999		

unresponsive; and when the facility failed to develop a policy and procedure that addresses medical emergencies that require the use of CPR.

E1 (Resident Services Director) was notified.

R3, per the General Information Form dated 12/1/11, has diagnoses that include Profound Mental Retardation, Epilepsy, Autism and Scoliosis. The Individual Service Plan (ISP) dated 12/1/11, documented that R3 requires extensive assistance with activities of daily living. R3 requires assistance with hair care, oral hygiene and bathing. The Individual Service Plan also documented, "High Recommendations: Supervise during shower/bath time due to diagnoses of seizures." The Daily Program Schedule instructed staff to supervise R3 during morning hygiene and evening baths/showers. The facility Attended/Unattended Bathing document dated 12/1/11, stated that R3 "is not capable of bathing unattended."

On review of the Incident Report Form dated 12/11/11 at 12:17 AM, E2 (Program Aide) documented, "I was in the dining area when I heard one of the clients making noise. I came running out of the dining area and saw one of the clients dragging R3 by her arm. I instructed her to stop. I started calling R3's name she didn't respond, when I bent down to check her breathe (sic) and pulse R3 was not breathing. I called 911 and my supervisor, while E3 (Program Aide) performed CPR until the paramedics arrived."

The Incident Report Form dated 12/11/11 at 1:28 AM, E3 (Program Aide) documented, "I was in the

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W9999	Continued From page 20	W9999		

dining room administering medication and my co-worker (E2) called my name. As I came around the corner I saw R3 laying on the floor. I called her name and there was no response. I immediately began CPR. CPR was given for 10-20 minutes when the paramedics arrived they continued CPR."

On 2/28/12, the surveyor obtained a copy of the Ambulance Report for the incident of 12/11/11. The report stated that paramedics were dispatched to the facility on 12/11/11 at 7:50 PM and arrived on the scene at 7:56 PM. The report stated when the paramedics arrived on the scene, "found patient unresponsive, in care of E54 (Engine 54 Paramedics)" and "patient was completely naked lying on floor, per care takers on scene patient fell to floor and became unresponsive after leaving shower." The report also indicated that facility staff were not able to provide paramedics with pertinent information. Facility staff were not able to give paramedics any information related to the clients medical history, allergies or medications. The report also documented, "staff did not provide crew with name of patient. The Ambulance Report listed R3 as "Jane Doe." R3 was transferred to the hospital. R3 left the facility via ambulance at 8:14 PM and arrived at the hospital emergency room at 8:18 PM.

On review of the Emergency Room Physician's Report dated 12/11/11, the physician documented that R3 was, "brought in by EMS, cardiac arrest; EMS state patient was in shower at care facility and had collapsed; unknown down time." The physician further documented, " When EMS arrived to care facility, patient did not have a

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pulse, no spontaneous respirations, asystole on monitor, EMS intubated patient...." The Emergency Room Physician documented that R3 was "dead on arrival."

E3's Incident Report dated 12/11/11, indicated that she initiated CPR, which she continued "for 10-20 minutes when the paramedics arrived they continued CPR." According to the Ambulance Report, paramedics arrived on the scene within 6 minutes. E3's statement and timeline conflicts with the Ambulance Report.

On review of the Ambulance Report, the documentation did not support that CPR was in progress when the paramedics arrived at the facility. On 2/28/12 at 12:45 PM, Z1 (Fire Department Medical Records Staff) was interviewed via telephone, regarding the Ambulance Report dated 12/11/11. Z1 confirmed that she reviewed the Ambulance Report dated 12/11/11, where paramedics were dispatched to the facility in response to a medical emergency. Z1 stated during the interview, "CPR was not done before paramedics arrived because the paramedics wrote 'unresponsive' when they arrived. If staff was doing CPR they would write staff doing CPR."

On 2/25/12, E1 (Resident Services Director) presented the facility Emergency Medical Policy/Procedures. The policy included a protocol for Resident Illness/Emergency in the Facility, which states, "in the event a resident needs immediate medical attention, you will do the following: 1) stay calm; 2) call 911; 3) if required and it is appropriate, give first aid until the paramedics arrive and 4) once the situation is

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W9999	Continued From page 22 stable, notify the supervisor, nurse and follow instructions (notification procedures)." The Emergency Medical Policy/Procedure does not include a protocol for CPR. E1 also presented the Medical Emergencies Policy. The Medical Emergencies Policy stated, "in the event a medical emergency occurs: 1) stay calm; 2) call 911; 3) if immediate emergency care is needed, then a trained staff person will provide care and taking precautions by first putting on personal protective equipment; and 4) trained staff will provide care until the paramedics arrives and takes over." The Medical Emergency Policy does not include a protocol for CPR. During an interview on 2/25/12 at 3:45 PM, E1 stated that the facility does not have a policy or procedure that "specifically addresses CPR protocol." E1 could not provide any documentation to support that the facility has developed guidelines for medical emergencies that include a protocol for CPR. The facility failed to provide the necessary medical services to a client who was found unresponsive. (A)	W9999		