

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G190	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER GOLFVIEW DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9555 WEST GOLF ROAD DES PLAINES, IL 60016		
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W 382	Continued From page 4 subcutaneous twice daily per sliding scale: 150-200 = 2 Units, 201-250 = 4 Units, 251-300 = 6 Units, 301-350 = 8 Units, > 350 to call Medical Doctor. Per record review of the current Administering Medications policy undated but stated as the policy since 2009 by E2 (Assistant Director of Nursing) is written during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Per interview with E1 (Licensed Practical Nurse) on 9-18-12 at 5:30 P.M. when asked when she administered the Humalog Insulin for R15 and with the Humalog being left out were you supposed to lock it up, E1 replied "I probably should have locked it up".	W 382			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 350.620a) 350.1210b) 350.1235a)3)4) 350.3240a) 350.1420a) 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	W9999			

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W9999	<p>Continued From page 5</p> <p>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.</p> <p>Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:</p> <p>b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.</p> <p>Section 350.1235 Life-Sustaining Treatments</p> <p>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:</p> <p>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;</p> <p>Section 350.1420 Compliance with Licensed Prescriber's Orders</p>	W9999			

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W9999	<p>Continued From page 6</p> <p>a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These regulations are not met as evidenced by:</p> <p>Based on interview and record review a facility nurse failed to monitor vital signs and administer anti seizure medication to one of one individual (R8) as ordered by the physician. R8 had been having a grand mal seizure for longer than five minutes. The nurse failed to administer CPR (Cardio Pulmonary Resuscitation) to R8 when he did not have a pulse. R8 was taken to the hospital and expired within less than 1 hour.</p> <p>Findings include:</p> <p>According to the facility Incident Report Investigation dated 7/25/12, R8 was a 61 year old male whose diagnoses include Severe Mental Retardation, Seizure Disorder and Epilepticus.</p>	W9999			

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W9999	<p>Continued From page 7</p> <p>On 7/21/2012 at approximately 3:45 p.m. Training Counselor E7 found R8 having a seizure on the toilet in the bathroom located in his room. E7 went immediately to find the nurse, E5. E8, training counselor and E6 supervisor arrived at the scene with E5. When E5 arrived in the room R8 was still seizing with froth and blood coming from his mouth. E5 instructed the training counselors to put R8 on the bed. It was reported that E5 stated, "I think he is faking he wants more attention, please put him in the bed." It was further reported that E5 had no blood pressure cuff with her, and that she did not take any of R8's vital signs. The investigation noted that E5 was aware that R8 had been having a grand mal seizure for more than five minutes, but failed to administer Diazepam as ordered by R8's physician, to control the seizure. E5 did not call 911 until approximately 30 minutes after being notified of R8's condition. E5 did not administer CPR, although she acknowledged R8 did not have a pulse before the paramedics arrived. The paramedics initiated CPR shortly after they arrived at approximately 4:20 p.m. Nursing notes dated 7/21/12 document the hospital called the facility at 5:00 p.m. to report R8's death.</p> <p>The Incident Investigation concluded that E5 did not provide appropriate care and services to R8 in accordance with his Care Plan, the facility's policies and procedures, and good nursing practice by failing to timely and appropriately respond to R8's seizure, including failure to administer his seizure medication, take his vital signs and initiate CPR.</p> <p>During the investigation when E3, Administrator interviewed E5 on 7/24/12 after the incident on</p>	W9999			

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W9999	<p>Continued From page 8</p> <p>7/21/12, it appeared that E5 was under the influence of alcohol. At that time, E13, Chief Executive Officer (CEO) asked E5 to submit to an alcohol test. E5 refused and walked out before the interview could be concluded. During the facility's interviews with staff regarding the July 21, 2012 incident no one reported that they suspected E5 was under the influence of alcohol, nor was there any evidence found during the investigation to suggest E5 was impaired on 7/21/12. Nevertheless, E5's employment was terminated after refusing to submit to an alcohol screen. The facility reported this incident to the Department of Financial and Professional Regulations and to the Cook County Sheriff.</p> <p>Review of the facility Policy and Procedure for Seizure Incidents states: "1. Any staff member witnessing a resident experiencing a seizure will contact the nurse on duty so a medical assessment can be completed. the nurse will document her assessment in the nursing progress notes to include the type of seizure and its length.</p> <p>2. the nurse on duty will provide any necessary first aid....</p> <p>5. If a seizure continues more than 10 minutes call 911."</p> <p>Review of the facility timeline video notes: 3:43 p.m. E7 looking for E5 3:45 p.m. E5, E6 and E8 entered R8's room 4:13 p.m. E5 left R8's room and went to the nursing station E5 left the nursing station with the oximeter. 4:16 p.m. E5 left R8's room and went to the nursing station and appeared to use</p>	W9999			

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W9999	<p>Continued From page 9 the phone to call 911. 4:18 p.m. E5 returned to R8's room 4:19 p.m. E5 went to the nursing station 4:21 p.m. E5 got the oxygen and went to R8's room 4:21 p.m. paramedics got off the elevator. 4:22 p.m. E5 went to the nursing station 4:30 p.m. the paramedics leave the facility with R8</p> <p>Interviews with E6 (at 1:12 p.m.), E7 (2:15 p.m.) and E8 (2:05 p.m.) on 9/18/12 confirmed the information provided in the facility incident investigation and the information discovered on the timeline video. E7 said he stayed in the room with the nurse and R8 until the paramedics arrived. E5 did not instruct him to assist her after R8 was in bed.</p> <p>Review of the paramedic report from the incident of 7/21/12 documents initial call received at 4:16 p.m. team arrived at facility at 4:20 p.m. The report states , "found 61 (year old) pt (patient) unresponsive, lying in bed. Crew was called due to the witnessed seizure; however, crew found pt to be unresponsive, pulseless and not breathing. CPR was started and pt was placed on monitor which displayed asystole. (without a heart beat)"</p> <p>Review of the facility interview with E5 on 7/24/12 at 2:00 p.m. documents the following information: "1. what time were you notified of (R8's) condition? 3:50 2. where was (R8) when you got to his room? In the (bathroom)b/r on toilet leaning over the tank. 3. what time did you get to his room? as soon as they called me I went to his room. stat. The T.C. said R8 was having a seizure.</p>	W9999			

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W9999	Continued From page 10 4. Was (R8) seizing when you got to his room? yes, in the b/r. 5. What treatment did you provide to (R8) when you got to his room? Had them take him out of b/r & into bed. 6. If (R8) was seizing when you got to his room, what type of seizure was he having? Grand Mal 7. How long was he seizing? 7 - 8 min. Grand Mal all that time? yes 8. In your nursing notes you charted he was seizing for 7 - 8 minutes? yes 9. Does (R8) have an order for medication to treat a prolonged seizure? Yes Diastat 10. Did you give Diastat rectally to (R8) ? no 11. If not, why not? Everything happened so fast, I couldn't leave him, his condition was too serious. 12. You charted that his breathing became labored, did you take his vital signs? what was his respiratory rate? Couldn't take [blood pressure] b/p because he was shaking so bad. 13. What was his heart rate? 82 I think 14. what was his blood pressure? I couldn't take b/p he was shaking too bad 15. If you did not take his vitals, why didn't you? I took his (oxygen saturation). 16. what time did you call 911? not sure 17. what time did you notify the Dr.? I talked to Dr. I did not chart 18. what time did you notify the guardian? I talked to his sister... 22. Upon review of (R8's) chart I noticed that on August 24, 2011 R8 was having a prolonged seizure and you administered Diastat at that time, what was different this time, that you failed to administer the Diastat? I knew R8 was dying and I had to monitor him... 24. Did (R8) have a pulse before the paramedics got here? no	W9999			

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W9999	Continued From page 11 25. why didn't you start CPR? E5 did not answer 26. why didn't you give him (oxygen)? I did A	W9999		