STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

(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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform the resident's legal representative and obtain consent for an outside agency in filing the residents' taxes. This deficient practice effected one resident (R2) in the sample of 16 reviewed for tax returns. Findings include: Record review of R2 revealed a 92 year old female with diagnosis that includes Vascular and Senile Dementia. R2 has comprehensive assessment of being cognitively impaired related to Dementia. These clinical records of R2 also indicated that she has POA (Power of Attorney) for health care. Facility staff interview (E1-Administrator and E7-Regional Comptroller) on 6/26/12 and 6/27/12, both confirmed during these interview that the POA of R2 was not notified when the facility had given her (R2) personal informations to an outside agency (AARP) to file R2's taxes electronically.	F 157		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1210a) 300.1210d)3)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

(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 2 300.3240a) General Requirements for Nursing and Personal Care 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) 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.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

(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 3	F9999		

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 regulations were not met as evidenced by the following:

Based on interviews and record reviews the facility failed to document changes in condition, update the care plan and failed to assess and document a rapid decline in condition for 1 resident (R5) in a sample of 3 reviewed for tube feedings. This failure resulted in a delay of emergency care. R5 was admitted to the hospital and expired.
Findings include:

R5 was admitted to the nursing facility on March 28, 2011 and readmitted on May 5, 2011 from the hospital. This resident was being treated for the following diagnosis: Atrial Fibrillation, Peripheral Vascular Disease, Dysphasia, and Post Surgical Aortocoronary Bypass. During R4's stay at the facility he was fed his nutrition via g-tube. On June 8, 2011 the resident's feeding was changed per the physician order sheet of June 8, 2011 to, " Decrease tf [tube feeding] to: Glucerna 1.2 90cc/ hour [90cc per hour] x [times] 8 hours (10p-6a). " " Bolus Glucerna 1.2 1 can QID [four times per day] (8a, 12p, 4p, 8p) " "If res [resident] tolerates bolus feeding tomorrow, d/c [discontinue] nocturnal feedings and increase bolus to 2 cans QID. " On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

(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 4	F9999		

June 9, 2011 the nursing notes for 10:00am state: " Resident tolerating bolus feeding. Blood glucose monitored. No s/s [signs and symptoms] of distress noted. " No other nursing note related to the resident's tolerance to the feeding change was noted on the nursing notes. On June 10, 2011 a short note regarding the tolerance to the feeding while on June 11, 2011 the nursing notes state, " 10:00am resident up in his chair, tolerates bolus feedings, no emesis noted." On June 12, 2011 at 5:30am, the resident was noted with a nose bleed and nursing notes indicated that this was endorsed to the next shift. At 9:00am the resident was given 1 can of glucerna but stated, " ' I feel full ' " and according to the nursing notes, " 1 can Glucerna held, BP [Blood Pressure] 124/74, T [Temperature] 97.3, P [Pulse] 113, R [Respirations] 20 " . At 10:30am the resident was given the second can of Glucerna 1.2 and 10 minutes later the resident vomited and complained of nausea. Furthermore according to the nursing notes crackles were noted to the right base of the lung. At 1:45pm, 60cc of water was given per the g- tube. There was no assessment of the tolerance or residual feeding or ability of the resident to tolerate the water. At 2:00pm the resident was noted with a temperature of 99.0 and at 3:40pm the temperature was noted to be 100.2F. New orders were faxed and carried out and at 4:30pm the physician was notified of the decline in R5 ' s condition and vomiting of fluid and blood. R5 left the facility via 911 at 4:45pm and expired on June 18, 2011 and per the Death Certificate the cause of death was, " Aspiration Pneumonia. "

A review of the hospital record dated June 12, 2011 states the following: " He had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

(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 5	F9999		

vomiting for a while when EMS was called. Vitals on EMS arrival Blood Pressure 106/56, Pulse 96, Respirations of 22, Saturating at 54% on room air and 90% on high Fi02 [Oxygen level]. " The hospital record also indicates that Pneumonia is secondary to vomiting and aspiration.

The local EMS (Emergency Management System) documents the ambulance arrival time at 16:46 (4:46pm) and departure time as 17:06 (5:06pm). The EMS applied the Oxygen via Non-rebreather mask at 15 Liters per minute and started the intravenous fluids. The EMS documents the reason for call as, " Vomiting blood for 1 hour. "

Z8 (family member of R5) was interviewed by phone October 4, 2012 at 2:00pm and stated that staff was not in the room while R5 was throwing up and that they had to beg the facility to send R5 out to the hospital. Z8 stated that the physician never called back and that if the family had not insisted the resident would not have gone out 911.

On September 27, 2012 at 1:40pm and again on October 1, 2012 at 10:50am during interviews with E2 (Director of Nursing) and E3 (Assistant Director of Nursing) in the conference room, E2 stated that the facility charts by exception when the resident's condition changes. Neither E2 nor E3 could provide nursing assessments or documentation related to a change in the resident's condition. E2 stated that R4's nosebleeds were common, yet only one other nosebleed was noted in the resident's clinical condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	C 10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

(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 6	F9999		

Z2(Physician) was interviewed by phone on June 28, 2012 and stated that the bolus feedings were started to allow the resident more time to be free from the feeding. Z2 stated that R5 ' s decline was a surprise since the resident was getting better.

R5 ' s care plan dated April 4, 2011 states for interventions, " check stomach for residual as ordered and PRN [as needed]. " " Assess/record sign or complaints of abdominal pain, distention, constipation, nausea, vomiting, and diarrhea. " And " Observe for fluid volume deficit risk factors. " A review of R5 ' s plan of care of 4-4-11 indicates that R5 ' s plan of care had not been updated or revised to reflect the change in tube feeding regimen. The interventions and goals had not been adjusted after the 6-8-11 change from continuous feedings.

The facility failed to follow the care plan and assess the resident ' s change in tolerance to the feeding. The facility failed to assess the residual or bowel sounds prior to giving the resident a second bolus feeding and the facility failed to promptly act on changing vital signs and increasing temperature.

B