

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>V I P MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>		
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F 309	Continued From page 23	F 309			
F9999	<p>4. RM reviewed all resident's clinical records for code status and care planned accordingly. Completed 2/13/13.</p> <p>5. Quality Assessment Committee reviewed systems, and policies and procedures. No changes were necessary. Completed 2/14/13.</p> <p><b>FINAL OBSERVATIONS</b></p> <p><b>LICENSURE VIOLATIONS</b></p> <p>300.610a) 300.610c)2) 300.1030a)1)2) 300.1210b) 300.1210d)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>c) These written policies shall include, at a minimum the following provisions:</p>	F9999			

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F9999	Continued From page 24  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).  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.	F9999			

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F9999	Continued From page 25  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.  Section 300.3240 Abuse and Neglect  a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)  These requirements were not met as evidenced by:  Based on interview and record review, the Facility failed to monitor and treat a resident in respiratory failure, and failed to immediately call for an ambulance as ordered by the physician for 1 of 4 resident's (R1) reviewed for changes in condition in the sample of 4. This failure resulted in R1 expiring upon arrival at the hospital emergency room.  Findings include:  R1 was originally admitted to the Facility on	F9999			

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F9999	<p>Continued From page 26</p> <p>9/22/09, with diagnoses, in part, of Congestive Heart Failure, Alzheimer's Dementia and Depression. R1's Minimum Data Set (MDS), dated 1/15/13, documents that she is cognitively impaired and requires extensive staff assistance with all activities of daily living. R1's plan of care, dated 1/22/13 with an original date of 3/31/11, documents "resident has the following Advanced Directives on record: Health Care Surrogate; DNR of 3/31/11. Resident is not capable of making informed consent regarding their health care decisions".</p> <p>R1's computerized vital signs record documents that at 9:32 AM on 1/28/13 her vital signs were as follows: Blood Pressure-166/86; Temperature-97.4; Pulse-89, Respirations-24. There are no further vital signs documented for R1 on 1/28/13.</p> <p>R1's nurses notes dated 1/28/13 document the following:</p> <p>"9:33 AM, Resident continues on antibiotic follow-up day 2 for upper respiratory infection with no adverse reaction noted. No respiratory distress noted. Noted non-productive cough still at this time.</p> <p>12:08 PM, At approximately 11:45 AM, this nurse was called to resident room, resident was gurgling and unresponsive. This nurse checked resident oxygen saturation levels (O2 Sat) and it was 80%, this nurse put oxygen (O2) at 2 liters per nasal cannula per nursing judgement, raised the head of her bed. Z1, R1's physician was here and assessed R1. Called family to see if they wanted to send her to the ER. Family wanted her</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>sent to ER. This nurse gathered paperwork, called ambulance and gave report to the ER.</p> <p>1:15 PM, ambulance here to transport resident to ER. Resident not doing well. This nurse called family and informed the family that they need to get to the hospital as soon as possible."</p> <p>Emergency Medical System (EMS) Patient Care Report for R1 documents that at 12:15 PM on 1/28/13, the ambulance company was contacted to transfer R1 to the hospital emergency room. The Report documents that the ambulance arrived at the Facility at 12:34 PM and was at R1's bedside at 12:38 PM. The Narrative on the Report documents the following:</p> <p>"Requested to respond non-emergent to Facility for a patient with cardiac problems. Upon arrival at Facility, looked around for a nurse to obtain paperwork and report. After a couple of minutes a staff member came up to the nurses station and gave me paperwork. I asked her what is going on with the patient and she told me that patient just finished a Z-pack antibiotics for an upper respiratory infection but her lungs still sound bad. She stated the doctor was here and wants her sent to the Emergency Room (ER) because he believed that patient is going into Congestive Heart Failure (CHF). I asked how long had it been since the doctor saw the patient and I was told today, but she couldn't give me a time because she wasn't the nurse for that hall, that nurse was at lunch. Staff member then showed EMS where patients room was. Once at patients side noted patient was on 2 liters of oxygen via nasal cannula, patient is dark blue in face. Assessed Loss of Consciousness (LOC) and patient is unresponsive to painful stimuli, with</p>	F9999			

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F9999	Continued From page 28 a respiratory rate of 4 showing agonal respirations, deep, gurgling breaths. Moved patient to stretcher, started high flow oxygen with Bag-Valve-Mask ventilation (BVM), placed on cardiac monitor showing an idioventricular rate of 44. Unable to feel radial pulses or palpate a carotid pulse. Obtained an automatic blood pressure via cardiac monitor showing 93/72. I asked the staff member that gave me the paperwork if patient was a full code or not, she went and grabbed patients code status advising that she is a Do Not Resuscitate (DNR). I asked to see the DNR and the DNR stated that if patient is still breathing or has a pulse to initiate Cardio Pulmonary Resuscitation (CPR). At that time I told the nurse to give us a few minutes and call the family and let them know that this has turned into an emergency and they may want to get to the hospital. We took patient to unit, placed combo pads on patient, and started CPR. Attempted assessment for possible intubation and found clumps of food in patients mouth, in turn I suctioned a large amount of yellowish/orange thickened liquid and clumps from oral Pharynx and out of airway. Continued to ventilate patient via BVM and CPR, glucose assessed, 18 gauge intravenous line (IV) location established in patients left elbow joint and flushed. 5 ampules of epinephrine given throughout transport. My partner called in report while I continued with CPR. On arrival at hospital advised to take patient to ER 4 with staff entering room with EMS. Patient moved to ER bed. Patient asystolic without CPR. Showed ER doctor the DNR form and the specific comments about initiating CPR. Shortly after ER Doctor pronounced the patient at 1314 as deceased".	F9999			

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F9999	<p>Continued From page 29</p> <p>Z2, Emergency Medical Technician, stated in a telephone interview on 2/14/13, at 10:30 AM that the Facility did not seem to be aware of R1's medical status or "know that she was really blue" when they entered R1's room to transport her on 1/28/13. Z2 said that she asked R1's DNR status and no one from the Facility knew what it was. Z2 said that they brought her the DNR form after she started "bagging" R1. Z2 said that the nurse said R1 was a DNR. Z2 asked to look at the form and noted that it said to initiate CPR if R1 had a pulse or blood pressure. Z2 told the staff that R1 is not a DNR. Z2 said "I had initiated breathing for the patient prior to looking at the DNR form. Meanwhile, I was looking for a pulse. After looking at the DNR form and saw her code status I began CPR". The Facility called for a "transfer only, which means no lights or sirens. Thank goodness we were close by".</p> <p>E4, Licensed Practical Nurse (LPN), was interviewed on 2/7/13 at 11:38 AM. E4 said that she was R1's nurse on 1/28/13 when R1 was sent out to the hospital. E4 said that R1 seemed fine in the morning and had a non-productive cough. E4 stated "the Certified Nurses Aides (CNA's) were getting R1 up for lunch and they came and got me as she wasn't sounding good. I did her vitals and O2 Sat was 80% so I put O2 on her. I met Z1, R1's physician, at the door as he was coming into the Facility and I said "come with me now". Z1 went and assessed R1 and asked if I had called her family. I called her family member and she said definitely send her out to the ER. I called the ambulance and the hospital and got the paperwork ready. I did not call 911 - I just called for a transport. I didn't think she was that bad, that quick. I put the head of her bed up</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>and put O2 on her. By the time Z1 came down to see her, she wasn't coughing anymore. I didn't think she was that bad off - I had no clue it was that bad. Z1 didn't tell me to send her out STAT - he told me to see what the family wanted to do". E4 went on to say that she did not remember if she took R1's vital signs. E4 said that she checked on R1 before she went to lunch "but, I don't remember when". E4 confirmed that no vital signs had been documented for R1 after 9:32 AM on 1/28/13.</p> <p>Z1's Physician's Progress Note, dated 1/28/13, and signed by Z1 documents "I was asked to see patient in acute respiratory distress of sudden onset". R1's "general appearance" is documented as "severe respiratory distress-saturation 80%, respirations 24". Z1 documented in the area on the bottom of the form entitled "Assessment/Plan: Severe Respiratory Distress, pending respiratory failure, acute pulmonary edema, send to ER STAT." (Stedman's Illustrated Medical Dictionary, 24 th Edition, documents that the word stat or statim is defined as "at once, immediately".)</p> <p>Z1 was interviewed by telephone on 2/7/13 at 1:45 PM. Z1 said that E4 met him at the door as he was coming into the Facility on 1/28/13 and asked him to look at R1. Z1 said that he told E4 to call R1's family to see if they were in agreement to send her out to the ER - "that means it's out of my hands". Z1 said that it sounded like R1 was in Congestive Heart Failure (CHF) or had pneumonia. "I said send her out As soon As Possible (ASAP). Z1 said that "STAT" means to send out ASAP. Z1 said that he would have expected R1 to get to the ER within a</p>	F9999			

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F9999	<p>Continued From page 31</p> <p>half-hour - "I can judge that". Z1 said "I would have moved faster if it had totally been in my hands".</p> <p>E9, CNA, was assigned to work with R1 on 1/28/13. E9 was interviewed on 2/7/13 at 2:10 PM. E9 said that R1's hall is her "permanent" hall and she was very familiar with R1. E9 said that R1 was "O.K." in the morning, just a little bit congested. R1 "ate fine" at breakfast. "After breakfast, after laying her down, I looked in on her and she was having a hard time breathing. I got the nurse and she hooked her up to the oxygen machine and took her vitals. R1 wouldn't eat lunch, she was awake but having a hard time breathing - her chest was rattling". E9 said that she stayed on the 100 hall while the resident's were served lunch in the dining room. E9 said that she did not stay with R1 nor did she see E4 go into R1's room between 11:45 and 12:38, when EMS arrived. E9 said that she would look in at R1 when she passed R1's room and her condition appeared to be "the same". E4 said "They (EMS) were trying keep her alive with the Ambu bag. The ambulance people said that her blood pressure was extremely low".</p> <p>E10, CNA, was interviewed on the telephone on 2/12/13 at 9:00 AM. E10 said that she was working on a "different" hallway on 1/28/13 but, went to help transfer R1 when the paramedics showed up. E10 said that R1 was still breathing when she entered R1's room. E10 said "after I helped transfer her to the stretcher, it looked like her soul left her. She became unresponsive. They gave her oxygen, hooked up the heart rate monitor and then started bagging her".</p>	F9999			

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F9999	<p>Continued From page 32</p> <p>E5, Care Plan Coordinator, stated in an interview on 2/7/13 at 12:10 PM, that she was working at the Facility on 1/28/13 but, not on R1's hallway. E5 said that E4 told her that R1 was going out to the hospital and had been seen by Z1 - "that was it". E5 had been gone to lunch about 5 minutes when the EMT's arrived. "We went down to R1's room, put her on the stretcher and they started working on her". E5 said that the EMT's started R1 on a heart rate monitor, did a oxygen saturation reading and listened to her lungs. E5 said that the EMT said "she's not doing well" and began "bagging" her. As the EMT's were leaving they said to call R1's family. "Her heart rate was maybe in the 40's". E5 said that she had not seen R1 on 1/28/13 prior to assisting in her transfer.</p> <p>E2, Director of Nursing (DON) and E3, Assistant Director of Nursing (ADON) were interviewed on 2/7/13 at 1:25 PM, concerning R1's transfer on 1/28/13. Both E2 and E3 confirmed that 30 minutes had elapsed between R1's onset of symptoms and when the telephone call was placed for R1's non-emergent transfer to the hospital. Both also confirmed that there is no documentation showing that anyone in the Facility checked on R1 while she was waiting to be transported to the hospital. Both E2 and E3 stated that the Facility does not have a policy defining a medical emergency. E2 said that nurses should use "good nursing judgement" in a situation such as occurred with R1.</p> <p>The Facility's policy entitled "Investigating Allegations of Neglect" documents that "All reported incident's of neglect will be promptly and</p>	F9999			

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F9999	Continued From page 33 thoroughly investigated. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness or the deterioration of a Resident's physical or mental condition. Neglect is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death".  <p style="text-align: right;">(AA)</p>	F9999			