

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2014
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NAME OF PROVIDER OR SUPPLIER HAVANA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HARPHAM STREET HAVANA, IL 62644
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1035a)2) 300.1210a) 300.1210c) 300.3220f) 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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1035 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>2) the implementation of physician orders limiting resuscitation such as those commonly referred to</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility.</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>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.</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. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to follow operational policies and procedures regarding Advance Directives and failed to ensure resident requested Advance Directives regarding Cardiopulmonary Resuscitation (CPR) were honored, for one of three residents (R1) reviewed for Advance Directives, in a sample of three. These failures resulted in R1 receiving CPR after cardiac activity had ceased and the prolonging of R1's death.</p> <p>Findings include:</p> <p>An Admissions Summary (no date) documents R1 was admitted to the facility on 6/29/09 with the diagnosis of Multiple Sclerosis. A Power of Attorney for Health Care, dated 7/01/09 and signed by R1, appoints Z1 (Power of Attorney) as designated Agent for Power of Attorney for Health</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>Care. A Uniform Do-Not-Resuscitate (DNR) Advanced Directive, dated 5/17/12 and signed by Z1 and E3 (Medical Director), indicates in an event of "Full Cardiopulmonary Arrest (When both breathing and heartbeat stop): Do Not Attempt Cardiopulmonary Resuscitation" or in a "Pre-Arrest Emergency (When breathing is labored or stopped and heart is still beating): Do Not Attempt Cardiopulmonary Resuscitation." A Physician's Order Sheet, dated 4/01/14, documents R1 as a DNR. A Plan of Care, dated 6/30/13, documents "(R1) has chosen Advance Directives" and "(R1) has chosen DNR, do not proceed with CPR if resident is found unresponsive without pulse AND/OR respiration." A Minimum Data Set, dated 3/16/14, documents R1 as cognitively intact. A Quarterly Social Service Progress note, dated 3/21/14, documents R1 as having a continued "code status DNR."</p> <p>Nursing Notes, dated 4/06/14 at 11:35 a.m., document "(R1's) eyes fixed, skin pale, cold, dry. Respirations shallow with periods of apnea (temporary cessation of breathing). (R1) unresponsive to name. Unable to voice anything. (R1) wheeled to room and (lifted) onto bed. Unable to get (blood pressure) reading....(R1) continued to have periods of apnea. (Hospital) called and ambulance on its way..."</p> <p>A Ambulance Service Patient Care Report, dated 4/06/14, documents "Called by nursing home on Hospital line for (person) that was having periods of apnea and not responding. Immediately on arrival at scene we were advised that the patient was a Full Code. On entering the scene presented with 60 year old (person) laying in bed, agonal respirations. Patient pulseless. BMV (Bag Valve Mask) ventilations initiated. Poor chest rise secondary to patient's position on bed.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Cardiac monitor applied and patient presenting with PEA (Pulseless Electrical Activity) at approximately 10 beats per minute, NO PULSE associated with beats. Ambulance crew again advised that the patient was a FULL CODE. IV (Intravenous) attempted (once) with no success. Patient moved to cot, ventilation continued with chest rise, compressions initiated.....CPR for duration of transport. No change in status on arrival...." The Ambulance Service Report documents the Ambulance Team was at the facility at 11:46 a.m. and departed the facility at 11:54 a.m.</p> <p>Hospital Nursing Notes, dated 4/06/14 at 11:55 a.m., document "Appears (R1) in cardiac arrest. Behavior is unresponsive....Level of consciousness is unresponsive. Cardiovascular: Rhythm is asystole. Respiratory: Respiratory effort is none." At 12:01 p.m., Hospital Nursing Notes document, "(E2 - Director of Nursing) called and speaking (with) this nurse on trauma room phone, informs this nurse that patient is a DNR. (Z5 - Emergency Room Physician) immediately informed and per (Z5) CPR stopped at this time." At 12:05 p.m., Hospital Nursing Notes document, "After declaring stopped resuscitation efforts, (Z5) noted spontaneous return of circulation, sinus rhythm noted on monitor, patient appears to be attempting spontaneous breaths...."</p> <p>Hospital Physician's Notes, dated 4/06/14 at 12:32 p.m., document "Patient's Daughter (POA - Power of Attorney), Sister and Brother in Law, state that (R1) would not want to be on a ventilator and ask for the ET (Endotracheal) tube to be removed per patient's wishes. I advised them of the risks with removing the tube, including loss of airway, resulting in respiratory</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>and cardiac arrest. They state they are aware of the risks, but want to respect the patient's wishes. They would like to have the ET tube pulled and place the patient on comfort measures only."</p> <p>A Hospital History and Physical, dated 4/06/14 at 7:18 p.m., document R1 as experiencing "Cardiac Arrest" and as having a "history of advancing Multiple Sclerosis and seizure disorder, who was found unresponsive in the Nursing Home. At that time, there was some confusion on (R1's) code status. The Nursing Home immediately thought (R1) was a full code. EMS (Emergency Medical Support) was called and resuscitation was started." The 4/06/14 History and Physical further documents, "Resuscitation and intubation was undertaken and was able to get back spontaneous respirations and spontaneous pulse, but again, the patient was a DNR and there was a mix-up through the Nursing Home. Spoke with the Nursing Home and it seems that the nurse on the Wing is a PRN (part-time) nurse and a CNA (Certified Nursing Assistant) was also there, and they thought that the patient was a full code at the time. Once the patient was taken to the Emergency Department, they did find in the chart that (R1) was a DNR and immediately called the Emergency Department to let them know.....We will order Morphine 4 mg (milligrams) (every one) hour for any respiratory distress or air hunger." A Hospital Death Summary, dated 4/07/14 at 8:10 a.m., documents R1 expired.</p> <p>On 4/14/14 at 12:10 p.m., E8 (Certified Nursing Assistant) stated R1 was sitting near the Nurses Station after lunch on 4/06/14. E8 indicated, when wiping R1's nose, R1 was unresponsive, eyes were open, pupils fixed, and breathing small short breaths. E8 stated E10 (Licensed Practical Nurse) was assigned to R1, but E10 had been</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>out of the building on lunch for approximately 30 minutes. E8 indicated that someone summoned E4 (Licensed Practical Nurse) from the other Wing. E8 stated E4 (Licensed Practical Nurse) "looked at (R1)" and called 911.</p> <p>On 4/14/14 at 12:00 p.m., E9 (Certified Nursing Assistant) stated (on 4/06/14) R1 was sitting near the Nurses Station and (E9) and E8 noticed R1's nose needed wiped. E9 stated, when E8 wiped R1's nose, R1 was unresponsive and breathing abnormal with periods of apnea. E9 called for E4, who was at the other end of the building, because R1's assigned nurse (E10) was out of the building for lunch.</p> <p>On 4/15/14 at 4:55 p.m., E4 (Licensed Practical Nurse) indicated R1 had not been assigned as (E4's) patient on 4/06/14, but E4 was working the facility's other wing. E4 stated, shortly after E10 had left the building for lunch, CNA's (Certified Nursing Assistant's) found R1 unresponsive while sitting in the wheelchair. E4 immediately assessed R1 and R1 was having periods of apnea, no blood pressure and a "very low pulse." E4 stated (E4) immediately phoned E2 (Director of Nursing) to see what needed to be done and was instructed to call for an ambulance. E4 indicated (E4) had R1's medical record, but "I couldn't find a DNR in the chart. I probably passed right by it." E4 stated, "EMS (Emergency Medical Services) arrived and asked if (R1) was a full code and I told them I didn't know." E4 stated several staff were in R1's room at that time and were all yelling, "(R1's) a full code." E4 stated Z2 (Paramedic) indicated R1 may have been a full code, based on knowledge of R1 from previous Emergency Room visits. E4 stated EMS initiated CPR on R1 and R1 was transported to the Emergency Room. E4 indicated, (E4) has only</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>been employed at the facility for a few months and works every other weekend. E4 stated, "I didn't get much orientation" and could not recall receiving orientation regarding Advance Directives or how to determine a resident's code status.</p> <p>On 4/15/14 at 10:40 a.m., E11 (Certified Nursing Assistant) stated (E11) had gone up to the Nurses Station during the lunch service of 4/06/14 and noticed staff rushing R1 into R1's room. E11 stated that (E11) "thought (R1) was a full code" and met the EMS Team at the front door, opening it for them. E11 stated (E11) told Z2 (Paramedic) that R1 was a full code. E11 indicated that R1's code status had been discussed the day before, and it was believed, because of R1's age of 60, R1 was a full code. E11 stated that the Certified Nursing Assistants had not received training as to the importance of Advance Directives or where to locate Advance Directives in the chart, until this incident and all staff were given an inservice on 4/10/14.</p> <p>On 4/14/14 at 1:02 p.m., Z2 (Paramedic) stated they were called to the facility on 4/06/14 for a resident who was unresponsive with periods of apnea. Z2 stated a staff person met (Z2) at the door of the Nursing Home and stated R1 was a full code and in distress. Z2 stated R1 was found in R1's room, with no pulse and agonal (gasping breathing often present during cardiac arrest) respirations. Z2 stated the "nurse in the room" told Z2 two more times that R1 was a full code. Z2 stated R1 was given CPR in route to the Hospital and in the Emergency Room, up until E2 called indicating R1 was actually a DNR. Z2 stated the facility did not provide Z2 or the other Emergency Responders with any documentation regarding R1's code status. Z2 stated the first</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>responders "depend on the Nursing Home" to be knowledgeable of a resident's code status.</p> <p>On 4/14/14 at 1:20 p.m., Z4 (Paramedic Student) stated (Z4) accompanied the EMS Team that responded to R1's respiratory distress, on 4/06/14. Z4 stated "staff" told the first responders two to three times that R1 was a full code.</p> <p>On 4/14/14 at 2:20 p.m., Z3 (Emergency Medical Technician) stated on 4/06/14, they arrived at the nursing home and staff met them at the door to the facility. Z3 stated one staff member indicated R1 was in "distress" and that R1 was a full code. Z3 stated that Z2 confirmed with the nurse in the resident's room what R1's code status was. Z2 was told by nursing home staff, R1 was a full code. Z3 stated CPR was initiated at that point, as R1 had no pulse and agonal breathing.</p> <p>On 4/15/14 at 9:55 a.m., E2 (Director of Nursing) stated E4 phoned on 4/06/14, indicating R10 had left the building for lunch and R10 had been called to the other side of the facility because R1 was unresponsive. E2 instructed E4 to call an ambulance and verify R1's code status. E2 immediately came to the facility. Upon arrival, the first responders were wheeling R1 out on a stretcher. E2 obtained R1's medical record and was the first responders had initiated CPR on R1. E2 immediately called the Emergency Room and instructed the nurse that R1 had a valid DNR in effect.</p> <p>On 4/15/14 at 1:08 p.m., E10 (Licensed Practical Nurse) stated R1 was assigned to (E10) as a patient on the day shift of 4/06/14. E10 stated that (E10) left the building for lunch. Upon return, E10 found out R1 became unresponsive and went to the Emergency Room. E10 indicated,</p>	S9999		

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