STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G190	A. BUILDING _____ B. WING _____	C 04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLFVIEW DEVELOPMENTAL CENTER	**9555 WEST GOLF ROAD DES PLAINES, IL 60016**

(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 000	INITIAL COMMENTS COMPLAINT INVESTIGATION Complaint # 1691802 / IL 84545 W154, W189, W331	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a serious incident that resulted in death within 1 day of hospitalization was thoroughly investigated to determine whether facility intervened in a timely manner. This affected 1 of 1 individual in the sample for whom the immediate cause of death was determined to be sepsis and pneumonia (R3). Findings include: Facility policy titled, "Prompt Reporting to [DPH] (Department of Public Health) for Incidents and Accidents" reads the following for objective of the policy, "'Serious' means any incident or accident that causes physical harm or injury to a resident." Facility policy on "Incidents: Documentation, Investigation, and Reporting of Incidents and Accidents, and Documentation of Behavior Incidents" reads the following, "It is the policy of [the facility] that each incident or accident affecting clients... be thoroughly documented, investigated, and reported... an "incident" shall mean an occurrence (including an accident)	W 154		5/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/02/2016

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W 154	Continued From page 1 which has, or is likely to have, a significant effect on, the health, safety, or welfare of one of more residents." The 6/4/15 Medical Certificate of Death documents, "Age at Last Birthday - 46 years. Date of death - 6/3/15. Immediate Cause [of death] - Part I. a. Sepsis (1 day), b. Pneumonia. Part II. significant conditions contributing to death - congenital heart disease." The 6/4/15 [DPH] Notification Form documents, "R3 sent to ER (Emergency Room) on 6/2/15 due to altered mental status and abnormal vitals. While in hospital, her O2 (Oxygen) level dropped and she was placed on a ventilator upon removal from the ventilator, she died." The 6/4/15 Discharge Summary documents, "date of discharge: 6/3/15, disposition of discharge: death... QIDP (Qualified Intellectual Disabilities Professional) notes: 6/2/15 - R3's gait was very unsteady and she fell in her room. Nurse took R3's vitals and her blood pressure and body temperature were very low and blood sugar was very high. R3 was sent out to ER 6/2/15 and admitted to Intensive Care Unit (ICU). R3 had been refusing meals since 5/30/15. QIDP visited R3 6/3/15. R3 was not conscious or responsive. She died during the night." The 6/2/15, 9 a.m. Nursing Notes document, "R3 refused breakfast. Per staff she put her self down in the elevator. VS (Vital signs): BP (blood pressure) 110/60, P[ulse] 71, R[espiration] - 16, T[emperature] - 96, O2 92%, B[lood] G[lucose] 202. No injuries noted... [Except for] old discoloration [left] elbow [left] knee from... fall on 5/30/15."	W 154		

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W 154	Continued From page 2 The 6/2/15 General Incident Report completed by E4, Assistant Director of Nursing (ADON) documents the following: "Time of incident: 10:30 a.m., Briefly describe what happened: resident found on floor. Describe why it happened: unknown. [Nurse notified]: E4 Time Nurse Notified: 10:30 [Vitals]: Temp - 86.4, Pulse 62, Resp. 18, B.P. 65/40 lethargic Level of Consciousness: responsive when shaken. (A) Physician's Orders Received: Per CNP (Certified Nurse Practitioner) send to hospital ER for eval[uation] (B) Care Rendered: Assessment Resident very Lethargic Was Physician Notified - Yes was checked. Time of Notification: 10:55 a.m. Time Responded: 10:55 a.m." The 6/2/15 Patient Transfer Form documents, "Physician Orders on Transfer: send to hospital for eval[uation] due to mental status change. Nursing Assessment and Recommendations: 68/40 62 18 87.7 at 10: 45 a.m., 90/58 11:19 a.m." The 6/2/15 Nursing Notes at 12 p.m. documents, "R3 sent to [hospital] - ER per Physician's order, D[iagnosis] - mental status change, lethargic, weak. VS: BP - 90/58, P - 58, T - 87.6, R - 18, BG - 241, O2 - 90%. Guardian notified." On 4/19/16, at 1:35 p.m., E4 was interviewed about the time when R3 was sent to the hospital. E4 said, "According to Building Security Log, the Ambulance came to pick up R3 at 11:48 a.m., at 12:01 p.m. the Ambulance exited the building."	W 154		

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W 154	Continued From page 3 The 6/2/15 Nursing Notes at 7 p.m. documents, "Resident admitted at hospital d[iagnosis] sepsis." The 2015 Facility Monthly Weights and Blood Pressures records the following as R3's normal Blood Pressures: January 2015 - 106/70, February 2015 - 110/80, April 2015-100/60. The May 2015 Medical Administration Record (MAR) records R3's blood pressure as 100/70. The 6/2/15 incident report documents that on 6/2/15, at 10:30 a.m., R3 was lethargic, not responsive unless shaken, had abnormally low blood pressure and low temperature. R3 was first noted to have abnormally low blood pressure at 10:30 a.m.; however, R3 did not leave the facility until 11:48 a.m. to be transported to the hospital. On 4/20/16, at 11:06 a.m., E4 was interviewed. When asked why there was over 70-minute delay until R3 was finally send to ER, E4 stated she didn't think it was an emergency because R3 sometimes has low blood pressure. When asked for past documentation that notes that R3 has a history of low blood pressure, E4 was unable to provide it. The 6/2/15 Incident Report documents that the CNP was not notified until 10:55 a.m. (25 minutes after the Nurse being notified of the incident). The facility failed to identify that R3 was in a medical crisis and failed to intervene in a timely manner to provide necessary services. The 6/2/15 Case Manager Note documents, "R3 had a fall in her room. The nurse was not available [so] E1 (Administrator) came to check on R3. After she received the okay we assisted her to sit in her chair... even with gait belt she was very unsteady and her arms were very cold. I assisted her into a sweater and we assisted R3 to	W 154		

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W 154	Continued From page 4	W 154		

lie on her bed. I told staff to stay one-on-one with R3 and went to get the nurse."

The 6/4/15 discharge summary by the QIDP documents that R3 has been refusing meals since 5/30/15. Neither the Nursing Notes nor the Incident Report document that the Nurse assessing R3 was aware that R3 had not been eating her meals since 5/30/15.

On 4/19/16, at 1:45 p.m., E4 was interviewed. When asked about the delay of notifying CNP, E4 stated she made the assessment of R3 after being notified at 10:30 a.m. and that's the time she was able to call CNP after assessing her. On 4/20/16, at 11:06 a.m., E4 was interviewed. E4 stated that the Nurse who works at the time of the incident was on break so E4 did the assessment. E4 stated she had to relay what she did after the nurse on duty came back; therefore, there was no nursing note written between 9 a.m. and 12 p.m.

The facility failed to investigate the circumstances leading up to and surrounding R3's medical crisis on 6/2/15 and subsequent death on 6/3/15. Facility documentation did not have information on what time the staff found R3 on the floor, what time E1 assessed R3 and how long it took the staff to find the nurse to be notified to make an assessment of R3. Facility documentation also did not have information on how many staff were involved and whether they were interviewed. These failures prevented the facility from resolving the discrepancies in R3's care, such as, whether there was a delay in providing immediate care during a medical crisis.

On 4/20/16, at 11:15 a.m., E1 (Administrator) was interviewed. E1 stated that they review

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W 154	Continued From page 5 hospitalization and deaths in their daily morning meetings and the short narratives are written in the DPH notification form. On 4/18/16, at 3:15 p.m., E1 was interviewed. E1 (Administrator) confirmed that the facility did not conduct an investigation for R3's death because she died in the hospital and not at the facility; therefore, the facility is unable to determine if R3 received immediate care upon nursing assessment.	W 154		