STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. BUILDING _____ B. WING _____	C 01/14/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE AT HILLSIDE	**4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	FINAL OBSERVATIONS Licensure Violations	F9999		

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F9999	Continued From page 6 300.1030a)2) 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: Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 300.1210b)3) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. 300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) Based on record review and interviews the facility failed to monitor 1 resident (R4) assessed to be in respiratory distress, and failed to perform CPR for 1 resident (R4) after the resident was assessed to be unresponsive with fixed and dilated pupils. Findings include: R4 was a 74 year old admitted 01-18-2002 with diagnoses that include Dementia, Gastritis, Degenerative joint disease and Anxiety. R4 did not have a DNR (Do Not Resuscitate) order in	F9999		

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place. Social service notes dated 5-17-04 reflects {Patient and son made aware that writer will proceed with discharge planning process.....}. Per interview on 6-11-04 E2 (LPN) stated that R4 had not shown any signs of illness prior to 6-5-04 .

Review of nurses notes dated 6-05-04 8:20 a.m. denotes that R4 was noted by staff E4 (LPN) to be cool to the touch, unresponsive to tactile stimuli ,verbally unresponsive and to be having labored breathing. R4's blood pressure was noted to be 100/66, pulse 58 and temp 94.7. Per documentation oxygen was placed on R4 and the physician was called. Further documentation denotes that at 8:30 a.m. R4's respirations continued to be labored and that R4's pupils had become fixed and dilated and that 911 was called . Further documentation at 8:40 a.m. denotes that R4 was taken to the hospital emergency room for evaluation. This statement contradicts the EMS (Emergency Medical Systems) report and paramedics statements, which denotes that the 911 call was received at 9:05 a.m., that the paramedics arrived at the facility at 9:06 a.m., CPR was initiated at 9:08 a.m. and they departed the scene a 9:34 a.m.

Per interview on 6-11-04 and 11-4-04, E4 (LPN) stated that on 6-5-04, when she arrived on the unit at 7:00 a.m. R4 was alert, verbally responsive and showed no sign of distress. E4 stated that at 8:20 a.m. she was informed by E3 (CNA) that something was wrong with R4. E4 stated that she went into R4's room and noted that" R4 was blowing". E4 stated that she called R4's physician and went back into the room to take R4's vital signs and to place oxygen on. E4

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stated that she went back into R4's room around 8:30 a.m. and noted that her pupils were fixed and dilated and that R4 was having "Cheyne-stokes" breathing. E4 stated that she left the room to call 911. E4 further stated that CPR was not initiated because R4 had not stopped breathing. E4 stated that she does not recall taking any vital signs at that time. E4 stated that E3 was still in the room with R4 when she left, and that E3 did not leave the room until the paramedics arrived. E4 stated that she was at the front desk writing out the transfer form when the paramedics arrived on the unit and that E3 was standing in the doorway of R4's room. E4 stated that it was approximately 15-20 minutes from the time that she initially assessed R4 and the time the paramedics arrived. E4 further stated that within minutes after she and the paramedics arrived into R4's room CPR was initiated by the paramedics.

Per interview on 6-11-04 and 11-04-04 E3 (CNA) stated that she walked into R4's room on 6-5-04 and noted that R4 was not breathing right. E3 stated that she ran out of the room to get E4. E3 stated that E4 came into the room and assessed R4, put oxygen on and left to call 911. E3 stated that she stayed with R4 until she heard the paramedics approaching R4's room. E3 stated that CPR was not done on R4 prior to the paramedics arrival.

Per Interview via phone on 6-29-04 E1 (DON) stated that she was informed by staff that R4's pupils were fixed and dilated, but CPR was not initiated because R4 was still breathing.

Review of the Emergency medical systems report

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dated 6-5-04 denotes that upon arrival to the facility at 9:06 a.m.. R4 was assessed by the paramedics to be unresponsive, with no blood pressure or pulse, and with agonal respirations at 2 per minute. R4's skin was noted to be cool and dry and the pupils were noted to be dilated. Further documentation denotes that CPR was initiated by the paramedics and continued until R 4 was transferred to the emergency room.

Review of the faxed statement from Z2 (paramedic) denotes that upon entering into R4's room on 6-5-04 the patient was found in a supine position in bed. Further documentation denotes that no staff were in the immediate area. R4 was assessed by the crew and CPR was immediately initiated.

Review of the faxed statement from Z3 (paramedic) denotes that R4 was found lying in bed, and that the nursing home staff had to be summoned to the room.

Review of the faxed statement from Z4 denotes that Z4, Z2 and Z3 all responded to a 911 call at the facility at 9:05 a.m. for a unresponsive female. Further documentation denotes that upon arrival, they were directed to the room by staff members who were standing around the nurses station. Documentation denotes that Z4 was informed by staff that R4 was still breathing and had a blood pressure. Further documentation denotes that once inside of the room R4 was found to be unresponsive, with agonal respirations of 2 per minute and no pulse. Documentation denotes that CPR was initiated and that R4 was treated per PEA (Pulseless electrical activity) protocol. R4 was transferred to

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F9999	Continued From page 10 the hospital were she was pronounced dead. Review of the faxed statement from Z5 denotes that upon arrival into the room R4 was found in bed foaming at the mouth with agonal breathing. Further documentation denotes that there were no staff member in or around the patients room. Z5's statement denotes {I am concern that we received a 911 call for an unresponsive pt. no nursing home staff was present in the room with the pt. There was no CPR started, breathing assisted etc. prior to our arrival}. Review of the faxed police report from Z6 (police officer) denotes that upon arrival to the facility on 6-5-04, he was directed by Z4 (who was already at the scene) to locate a nurse for assistance. further documentation denotes that Z6 was unable to locate a nurse in the area. Documentation denotes that Z6 then walked to the nurses station where he found E4 and they both returned to R4's room. The facility Emergency Management Policy states: Monitor and treat as much as possible the following areas: a. Maintain a patent airway and circulation, began resuscitative measures if necessary. b. Take vital signs c. Have someone stay with the resident at all times.	F9999		