

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2005
NAME OF PROVIDER OR SUPPLIER ANCHORAGE OF BENSENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 111 EAST WASHINGTON BENSENVILLE, IL 60106		
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F 309	Continued From page 7 3. Crash carts with basic emergency equipment of Ambu bags, suction machines, blood pressure cuff, oxygen tubing, stethoscope and SPO2 machine were set up for each unit. This was completed on 9/12/05. 4. On 9/12/05, CPR certification was verified as current for all licensed nursing staff and at least two-thirds of the CNA staff. All new hires are required to be certified in CPR and if not already certified, will be trained and certified by DON when hired. The facility CQI meeting of 9/21/05 reviewed the above actions taken to resolve the Immediate Jeopardy. The DON will monitor staff CPR certification and conduct classes a minimum of two times a year to ensure they are current and quarterly audits of physician order sheets will be done to ensure accuracy of DNR orders.	F 309			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: Section 300.610 Resident Care Policies 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	F9999			

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F9999	<p>Continued From page 8</p> <p>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. (B)</p> <p>c) These written policies shall include, at a minimum the following provisions:</p> <p>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).</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 any life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:</p> <p>3) procedures for providing life-sustaining treatments available to residents at the facility;</p> <p>4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept or reject available life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) The facility must 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</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>each resident's comprehensive assessment and plan of care. 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.</p> <p>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:</p> <p>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.</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.</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to:</p> <p>1) ensure that an emergency protocol for life threatening situations was in place, and that emergency equipment is readily available on all units for life threatening emergencies;</p> <p>2) that physician order sheets and indicators of code status [stickers on charts, Do Not Resuscitate (DNR) sheets] agree with the residents current code status, and that staff is familiar with identifying the code status of a resident; and</p>	F9999			

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F9999	Continued From page 10 3) ensure that staff follow physician orders and initiate emergency measures such as placement of oxygen, monitoring pulse and respirations closely, staying with the resident until the ambulance arrives and initiate cardio pulmonary resuscitation (CPR) when a resident (R1) was found unresponsive, not breathing, and without a pulse on 9/5/05. These failures resulted in the death of a resident (R1). This is for 1 of 27 residents who have full code / heroic efforts status that did not receive CPR (R1). The examples include: Review of R1's clinical record on 9/9/05, showed that resident (R1) was an 83 year old with a history of hypertension, coronary artery disease, and chronic ischemic heart disease, with "Full Code" status. Review of the nurse's notes, dated 9/5/05, documents that R1 was showing signs of possible myocardial infarction (MI); nausea, dizziness, respiratory distress. Based on this nurse's notes and interview of E2 (unit nurse), she (E2) failed to act on these symptoms in a timely manner, and apply the procedures of the facility policy for possible MI including administering oxygen, reassuring the resident and relieving his anxiety, staying with him until the ambulance arrives, monitoring blood pressure and pulse and respirations closely and initiating Cardio Pulmonary Resuscitation when he	F9999			

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F9999	<p>Continued From page 11 became unresponsive.</p> <p>Ultimately, R1 arrested and attempts to resuscitate him were made by paramedics upon their arrival. R1 was transported to the hospital where he expired.</p> <p>E2 was interviewed by phone on 9/9/05 at 1:15 pm, and was asked how she alerted anyone to the fact that R1 was in need of help. E2 stated that there was no way to page overhead or "call a code". E2 stated she called the receptionist, who physically went to the main dining room, and sought out (E7) the PM supervisor and told her that E2 was calling for assistance. E6, E7, confirmed what E2 had stated, saying " there is no code system here."</p> <p>When E1(DON) was interviewed at about 3:00pm on 9/9/05, she confirmed that there was no protocol or system in place to call a code or page anyone overhead, unless in the medicare unit. E 1 stated that she would look at it for other units now that it had been brought to her attention.</p> <p>At time of survey, the facility was asked to provide the current in-house listing of the advance directives for all the residents. Review of the facility Do Not Resuscitate (DNR) policy, dated 6/01, documents, that once a DNR form is signed by a resident or his representative, the physician (MD) must sign and date the form. The MD must then write a DNR order on the physician order sheet (POS) and an orange DNR sticker is to be placed on the resident's chart to identify that the resident has a DNR.</p> <p>Random charts were then selected to check to</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>see if the facility policy and procedure for Do Not Resuscitate (DNR) orders were followed. Among those reviewed the following was found:</p> <p>-R8's medical record reviewed showed a sticker for DNR inside the chart dated 12/19/03, although the current MD order ((9/05) documents " Full Code".</p> <p>R5 admitted 8/18/05 had no stickers on the chart and when the record was reviewed the Advance Directive form was empty--no decision given--no orders listed on POS.</p> <p>R6 had a DNR sticker on the chart, however the Advance Directive letter of 9/6/05 indicated no decision and there was no DNR order.</p> <p>R7 admitted 7/28/05 has no sticker on the record. Living will dated 4/12/00 indicates no resuscitative measures desired. The Admission check list is marked off as completed, but there is no DNR sheet and no order is on the POS.</p> <p>R3 has a DNR sticker on the chart, a DNR is signed dated 9/2/05, but there is no MD order for DNR on the POS.</p> <p>The code status for R1 dated 7/26/04, indicates heroic efforts shall be undertaken if the situation arises. The physician order sheet indicates "full code."</p> <p>The nurses notes dated 9/5/05 documents the following: = 5:30pm; (E2) found the resident in his room complaining of not feeling well and vomited moderate amount of undigested food.</p>	F9999			

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F9999	<p>Continued From page 13</p> <p>Vital signs: blood pressure 120/70, pulse 90, respirations 40, and temperature 99.7 axillary. = 6:00pm; resident vomited again, physician was paged to call back. = 6:15pm; "Resident seen with difficulty breathing and skin is cold to touch. Put a call to 911. Put resident on O2 per mask call PM Supervisor CPR started." = 6:20pm, "Paramedic arrive and start the rescue."</p> <p>E2 when interviewed by phone on 9/9/05 around 1:15pm indicated that in fact -she did not place oxygen on R1, and did not initiate CPR on R1. E 2 said that she was going to get O2 to place on the resident and that by the time she got back to the room the paramedics were there and they are the one who started the CPR. The EMS (emergency medical services) ambulance report dated 9/05/05 documents that the crew arrived on site within minutes of the call to find that no emergency treatment had been started for R1. The resident (R1) was unresponsive, pupils were unresponsive, lung sounds were absent, skin color was pale and capillary refill was delayed. At 6:20pm the ambulance crew found no vital signs and the rhythm strip showed asystole.</p> <p>Phone interviews of E6 at 1:50pm and E7 at 2:10 pm were done on 9/9/05. E6 said that E2 had called to the nursing office looking for E7 saying that she thought that R1 is dying or she needed help, she couldn't remember what was said. She (E6) came out to get E7 just as she was going to the unit and they went to the room together. When they arrived in the room they noted R1 was slumped down in the bed, with his foot off the bed, and his color was dusky. E7 claimed</p>	F9999			

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F9999	<p>Continued From page 14</p> <p>she heard slight gurgly abdominal respirations. E6 and E7 pulled R1 up in bed. E7 sent E6 to get the pulse oximeter, E7 went to the nurses station. E7 said that she went to check the status of the resident and saw "full code." E7 stated that she:" sent E2 down to be with him (R1) and told her to " do what you need to do."</p> <p>E4 (CNA) was interviewed in person on 9/9/05 and stated the following. "At 5:20pm I tried to get R1 up for dinner, the nurse said she'd go because she had medications for him. E4 said E2 asked her to stay with him while he went to the bathroom. R1 told her "I just feel a little dizzy." R1 went back to bed. E4 and the other CNA took the other residents to the dining room and helped them eat. According to E4 at about 6pm the other CNA asked her to help use the sling to put a resident back in bed. While assisting the other CNA, E4 said she heard E2 call their names. She said that by the time she went outside the room , the paramedics were there. She saw that E2 had oxygen and a mask with her, but she was not doing CPR. E4 said that the paramedics and E2 were in the room , E6 was outside the room and E7 was on the phone.</p> <p>On 9/9/05 the facility was requested to supply policies for respiratory arrest, cardiac arrest, and myocardial infarction. These called for oxygen to be administered and equipment to be available such as an Ambu bag and airway. E7 explained during interview that she had set up a type of crash cart for the medicare unit but that this was the only unit so equipped. She said that when she was over on C Unit that she had called to Unit E (the medicare unit), because they have an emergency cart with suction, an Ambu bag, and</p>	F9999			

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F9999	Continued From page 15 other appropriate equipment. The lack of protocol for calling emergencies, the lack of staff knowledge of how to react in an emergency, and the lack of availability of emergency equipment on each unit resulted in a delay of response to R1's need for oxygen and CPR until the paramedics arrived on the scene, contributing to R1's death.	F9999			