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	146035	A. BUILDING _____ B. WING _____	06/15/2006

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NORTH ADAMS HOME	2259 EAST 1100TH STREET MENDON, IL 62351

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F 324	Continued From page 28 developed to help prevent further falls for R1. During interview on 6-9-05 at 1:45 p.m., E2, Director of Nursing verified that no new interventions had been implemented to prevent further falls since with new intervention added 12-22-05. 2. According to R 12's current Minimum Data Set dated 3/30/06, R12 is moderately impaired for decision making and requires the assistance of 1 staff for transfers. Accident / Incident reports note that R12 fell on 12/7/05, 1/23/06, and 4/9/06. All three falls were during transfers by 1 staff person. Two of the three falls note R12 to have thrown herself backwards during the transfers. During interview with E2 (Director of Nursing) on 6/08/06 at 11:15 A.M., E2 stated that these were behaviors when R12 would throw herself backwards. E2 verified that no new interventions were tried to prevent further falls after any of the three falls.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030 a)1) 300.1030 a)2) 300.1030 a)3) 300.1030 a)4) 300.1030 a)5) 300.1030 c) 300.1030 d) 300.1210 a)	F9999		

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F9999	Continued From page 29 300.3240 a) 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. 2) Cardiac emergencies. 3) Traumatic injuries. 4) Toxicologic emergencies. 5) Other medical emergencies. c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies listed in subsection (a) of this Section. This staff person may also be counted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. 300.1210 General Requirements for Nursing and	F9999		

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F9999	Continued From page 30 Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with 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. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by : Based on observation, record review and interview the facility: 1. Failed to provide CPR (Cardio-Pulmonary Resuscitation) to R23. R23 had an Advanced Directive which indicated that all services necessary to sustain life be performed. 2. Failed to have a system in place to identify which staff were currently CPR certified and neglected to ensure that the necessary staff were trained in CPR. 3. Failed to inform other staff as to who was CPR certified. 4. Failed to follow the facility policy on identifying	F9999		

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residents who have been designated to be provided CPR.

5. Failed to follow the facility policy on when and how to initiate CPR.

6. Failed to call 911 as specified by the facility policy.

This is for R23, 1 of 16 residents who were designated to be full code (indicating that all efforts be made to prolong their lives). When R 23 was witnessed to be in arrest, CPR was not initiated by staff and 911 was not called. R23 then expired at the facility.

Findings include:

R23's admission face sheet dated 4/14/06 documents that she was 74 years of age with diagnoses including: Hypertension, Atrial Fibrillation, Insulin Dependent Diabetes, Low Back Pain and Anxiety. Review of R23's MDS (Minimum Data Set for Resident Assessment), dated 4/20/06, indicates that she was cognitively independent and independent for all Activities of Daily Living.

Review of R23's nurses notes for 5/20/06 at 6:30 A.M. by E5 LPN, (Licensed Practical Nurse) documents: "At 5:25 A.M. went into (R23's) room to change pain patches and give medications. This nurse tapped on resident's arm to wake her and resident opened her eyes. This nurse asked resident if she was awake and resident responded with a 'Yes.' This nurse informed resident of patch changes. Resident sat up in chair then fell back in chair, took about 4 deep

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breaths then had periods of not breathing with about 2 longer deep breaths then all breathing ceased. (E6), LPN charge nurse, was called to resident's room. Time of death was called at 5:40 A.M., at 5:45 A.M. (R23) was transferred via full body lift to her bed."

An Advance Directive Selection Record for R23 and signed by R23 and dated 4/14/06 was reviewed. The box is checked which stated, "I want all efforts made to prolong my life, including CPR, calling 911, emergency IV's and medication ." The POS (Physician Order Sheet) dated 4/14/06 includes a physician order that reads: Do CPR.

During interview with E2 D.O.N. (Director of Nursing), on 6/7/06 at 2:00 P.M., E2 stated, "CPR was not done. I did an investigation. I interviewed (E5). (E5) is a new nurse. I asked her why she didn't do CPR and (E5) told me that she was nervous and didn't think about doing CPR." When asked about E6 (charge nurse) doing CPR, E2 stated, "No. He did not do it either."

E5, LPN was interviewed on 6/8/06 at 8:55 A.M.. E5 stated, "It was around 5:30 A.M. when I took her meds in. I tapped her arm and she looked at me and said 'Yes.' Then I remember her looking at the medicines in the cup. I sat it on the table. I said to her, 'The patches go on your back.' She leaned forward, I put it on and she fell back. I started to get out the second pain patch, but then I couldn't get a response from her. I went to get the blood pressure monitor and I called the charge nurse (E6) to come to (R23's) room. I hollered at her again, tried her blood pressure and couldn't get it so I went back into the hall. (E

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6) was not coming so then I went back to the Nurses' station and this time (E6) was coming. (E 8), the CNA (Certified Nurse Aide) assigned to my halls that night, was inside the special care unit with a resident during this time. She came later and helped us transfer her. There were no other staff around." E5 was asked if CPR was initiated and if 911 was called. E5 replied, "No." E5 was asked if it was supposed to be? E5 stated, "Yes it was, but I didn't realize that until it was all over." When asked how long E5 had been a nurse, E5 replied, "I worked here as a CNA (Certified Nurse Aide) for about three years before getting my LPN the first of the year."

E5 did not identify that R23 was a full code, did not call 911, did not initiate CPR, and did not call for immediate assistance even though she had three opportunities from the moment R23 went into an irregular breathing pattern.

At 1:45 P.M. on 6/8/06 E6 LPN was interviewed. E6 stated, "That morning (E5) called me on the speaker phone at the nurses' station where I was working. There was no sense of urgency in her voice when she asked me to come down. (E5) asked me if when I got a chance could I come down. So I finished up what I was doing, maybe around 10 minutes or so, and then went down. When I got there I found that (E5) had called for a second opinion because when I got there she said, 'I think (R23) died.' I found (R23) leaning back in the recliner with her mouth agape and she had that expired color. A rather laid back look ." When E6 was asked about calling 911 and if CPR was started, E6 stated, "Not to my knowledge. We did not discuss her code status. I was unaware that (R23) was a full code. In the

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military when a person has been passed on for 10 to 15 minutes, we didn't bother." E6 was asked if the facility had a policy on when to initiate CPR, E6 stated, "With me working nights, well not to my knowledge." E6 was asked if he attended the March 2006 inservice on Medical Emergency including when to do CPR and how to identify codes. E6 replied, "I did watch the video of that inservice. I signed the sheet when I watched it." When asked if E6 was currently CPR certified, E6 stated "No."

E6 did not identify R23's code status, did not call 911 and did not initiate CPR for R23.

Review of the facility investigation dated 5/22/06 documents that E5 and E6 did not call 911 and did not provide CPR to R23 after E5 witnessed R 23 having difficulty breathing.

E5's personnel record was reviewed and contained a counseling form for not calling 911 and for not providing CPR for R23. This form was dated 5/22/06. E6's personnel record was reviewed and contained a counseling form for not calling 911 and for not providing CPR for R23. This form was dated 5/23/06.

Z1, R23's Attending Medical Doctor was interviewed on 6/12/06 at 8:45 AM regarding R23 not being resuscitated when found to be in arrest. Z1 stated, "If it was a witnessed arrest then yes she should have been resuscitated. She had a fairly good quality of life. She dealt with some pain but she was ambulatory and only needed a protective environment. I was not given the information that this was a witnessed arrest."

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F9999	Continued From page 35 E2, D.O.N., was interviewed on 6/7/06 at 9:00 A. M. regarding a list of CPR certified staff. E2 stated, "I don't know. I will have to go through their files." E2 returned at 1:10 P.M. and stated that 14 of the 28 Licensed staff are currently CPR Certified. E2 was asked which non licensed staff were currently CPR certified. E2 replied, "We don't train the non licensed staff. I don't have a copy of CPR cards for all the nurses who are trained, but I will get them." On 6/8/06 at 2:30 PM E2 was asked if the facility provided at least 2 staff per shift that were CPR certified and how would they do 2 man resuscitation if not. E2 did not have an answer. The facility failed to provide a policy on how the staff on duty knew which staff on duty were CPR certified or how the facility scheduled staff to ensure there were at least 2 CPR certified staff on each shift. E2, D.O.N. was asked for the facility policy and procedure titled Procedure of Initiation of CPR in effect at the time of R23's death. E2 provided the policy which was not dated. E2 stated, "This is the policy. It is not dated and there are no others ." The policy was reviewed. It documents that CPR is initiated on all residents who are designated full code and found to be unresponsive or witnessed collapse, ineffective pulse rate and ineffective respiration. It instructs the following: License nursing will check for responsiveness. If not responsive... shout for help, if no help available activate the emergency response system by calling 911 and return to resident and provide CPR continuing until help arrives, too exhausted, or pulse and respiration have returned. During interview with E1, Administrator, on 6/8/06	F9999		

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at 9:10 AM, E1 was asked if E2 had discussed the requirement about staffing CPR certified staff. E1 stated, "No, but we'll have to work on that."

On 6/8/06 at 9:18 AM, E8, CNA (Certified Nurse Aide) was interviewed regarding CPR being performed on R23. E8 stated, "I wasn't on that hall because I was inside the special care unit with a resident. (E5) came to tell me that (R23) had passed. (E6) was with her. When I saw (R23) she was gone. I helped get her from the chair back into bed. I remember asking (E5) afterwards if (R23) was a code. (E5) said that she was. We have stickers on the door and charts to tell who they are." When asked if E8 was CPR certified, E 8 stated, "No."

At 9:25 AM., 6/8/06, E7 LPN, reported, "I was working on the South Hall. (E5 & E6) came up looking for something in the supply room. They told me that (R23) had passed so I made the phone calls to the Doctor, family, and Coroner. I did not see (R23) at all. To my knowledge CPR was not discussed. We were in-serviced on codes and stickers earlier this year."

E13 and E14, both CNA's were interviewed between 9:40 A.M. and 9:50 AM on 6/8/06. Both stated that they were working on other wings when (R23) passed. Both said that they had seen the inservice on CPR this spring.

E15, CNA was interviewed on 6/8/06 at 1:20 P.M. E15 stated that she was working the middle section and was not on that hall where (R23) was and did not see (R23). E15 stated, "I do know that (E5) called (E6) to come down there. I did see the inservice on CPR. February or March I'm

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F9999	Continued From page 37 not sure which." During interview with E5 on 6/8/06 at 8:45 AM, E 5 was asked if she had attended an inservice at the facility in March of this year regarding Medical Emergencies including the colored dot identifications and doing CPR. E5 stated, "Yes, I did." Review of the facility inservice dated 3/9/06 indicates that the facility provided a Medical Emergencies inservice. It included resuscitation and identification of code status by colored stickers. Review of the attendance sheet for this inservice/video does include signatures of E5, E 6, E8, E13, E14 and E15. The facility policy dated 3/2006 and titled Colored Dot Policy for Labeling Charts was reviewed. It states: "To aid our staff during an emergency the code status of each resident according to the wishes of the resident or power of healthcare wishes for such resident. Upon receipt of signed forms, a colored dot will be placed on the name label of the resident chart and outside the residents room on their name. Red sticker---do not resuscitate. Green---full CPR. Yellow---CPR if breathing labored or stopped and the heart is still beating." E2, D.O.N. was interviewed on 6/8/06 at 11:55 A. M. regarding the green stickers being in place for R23 at the time of her arrest. "Yes. We did check and yes they were in place," replied E2. During this survey, the resident charts and room nameplates were observed to have either a red, green or yellow sticker on them.	F9999		

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F9999	Continued From page 38 E2 D.O.N., was interviewed on 6/9/06 regarding R23's vital signs being taken. E2 replied, "I asked (E5) if she took (R23's) vital signs and (E5) said that she did. I told her it wasn't documented in the nurses notes. We do not have any record of her vital signs." (A)	F9999		