

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F 309 | Continued From page 8 have an on-call Supervisor Nurse available 24 hours a day for an emergency. 6. Facility has 2 employees per shift that are certified in CPR. 7. Quality Assurance Monitoring (Q.A. Tool) ADNS or designee will review the staff roster to ensure all licensed staff have been in-serviced on the Cardio-Pulmonary Resuscitation policy and procedure. Will audit new admission charts to insure DNR status has been established. Above information will be brought to QAA committee for analysis and further direction as needed to ensure that system will remain in place . | F 309 | | | |
| F9999 | FINAL OBSERVATIONS STATE LICENSURE VIOLATION: 300.1030a)1) 300.1030a)2) 300.1030d) 300.1035a)3) 300.1035a)4) 300.1035a)5) 300.1035d) 300.1210a) Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 9</p> <p>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:</p> <p>1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).</p> <p>2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).</p> <p>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.</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>3) procedures for providing life-sustaining treatments available to residents at the facility;</p> <p>4) procedures detailing staff's responsibility</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 10</p> <p>with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;</p> <p>5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.</p> <p>d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record.</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 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>These REGULATIONS are not met as evidenced by:</p> <p>Based on record review, review of the facility's "General Directives To Be Followed In Emergencies" and Cardiopulmonary</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 11</p> <p>Resuscitation [CPR] policies, and staff interviews, the facility failed to provide care/treatment for 35 minutes for a resident who was found unresponsive, cold, and presumed dead by the facility staff. The facility failed to perform CPR and failed to call 911 from 2:45AM to 3:20AM for 1 of 1 sampled residents (R4).</p> <p>Findings include:</p> <p>Overview: E6 (RN) did not know the facility's medical emergency procedures related to CPR/medical emergencies.</p> <p>On 09/08/05 at 3:20AM, E6 (RN) called paramedics to provide treatment to R4. When the paramedics arrived, E9 (LPN, from another unit) was performing CPR on the resident. According to E9, R4 was not breathing, had no pulse, was cold, mottled/gray in color, and stiff when she arrived on the unit. R4, who is not a DNR-(Do Not Resuscitate), did not receive treatment (CPR and 911 were not called) for 20 to 35 minutes.</p> <p>R4 was a 93 year old with diagnoses including Hypertension and Head Injury, Unspecified. According to a review of the clinical record, R4 was to be resuscitated, and the DNR form/advance directive remained un-signed by R4 or a legal representative.</p> <p>Nurse's note: According to interdisciplinary progress notes 09/08/05 beginning 3:00AM, E6 (RN) was informed by E7 (CNA/certified nurse assistant) that R4 had expired. CPR initiated by nurse, vital signs were</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 12</p> <p>taken. (However, CPR was not started at the time this entry was made). 3:30AM, paramedics were called; arrived 3 minutes later. 3:45AM, resident transported to Z6 (hospital) by paramedics.</p> <p>EMS report: A review of the paramedic report of 09/08/05 indicated at 3:21AM the call was received. 3:21AM, crew dispatched. 3:25AM, crew arrived to facility. 3:26AM, resident contact. 3:51AM, paramedics left Z7 (facility). 3:52AM, arrived at Z6 (hospital). The report goes on to say, the crew was dispatched to Z7 (facility) to a full arrest, and they found the resident with obvious rigor mortis and lividity. The Z7 (facility) staff stated last time R4 was seen was approximately 3 hours ago. Z6 (hospital) contacted to confirm triple zero (no pulse, no blood pressure, and no respirations), and the patient was transported without incident.</p> <p>E7 (CNA) notified E6 (RN), at 2:45AM on 09/08/05 about R4's change of condition. 911 was called at 3:20AM. CPR was not initiated until 3:25 AM. The paramedics arrived to Z7 (facility) at 3:25AM. There was no care/treatment provided for R4 for at least 20 to 35 minutes.</p> <p>Z7 (facility), per surveyor request, provided a copy of E6's (RN) written statement about the incident, dated 09/09/05. It states, as written in part, "...E7 (CNA) came to get me. She (E7-CNA) stated, "I hate to tell you this, but the patient in room 211A has expired. I (E6-RN) went immediately to the room, took radial pulse (no</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 13</p> <p>pulse), and arm very cold. I immediately went to the phone in the nurses station and called E9 (LPN). Approximately 3:20AM, a few minutes later she (E9-LPN) came up and checked the chart for DNR and stated we have to do CPR on her (R4). E9 (LPN) started CPR, and told me to call 911. I called them and she (E9-LPN) was still in the room doing CPR. I called E9 (LPN) to help me fill out paper work as I thought the resident was deceased."</p> <p>Surveyor interviewed E6 (RN) via telephone on 11/29/05 at 1:30PM, about what happened with R 4 the night of 09/08/05. E6 (RN) stated, as reported in part, "...I was the only nurse on that floor with all those residents, around 50 something. I had only been there 3 weeks. They left me alone with all those residents. I was at the nurses' station, and E7 (CNA) came and told me, I think the resident had expired. I went in there. She (R4) had expired. She (R4) was laying there still like someone who was sleeping. She felt cold because I tried to get a pulse, there wasn't any. She (R4) didn't have no vital signs at all. I think E 9 (LPN) started CPR after she came up. She (E9-LPN) told me (E6-RN) to call 911. E9 was doing CPR."</p> <p>On 11/29/05 at 2:05PM, surveyor interviewed E9 (LPN) about R4. E9 (LPN) stated, "I was called to the unit by E6 (RN). I arrived at 3:25AM approximately. E6 (RN) said she (E6-RN) had someone who died and needed to be sent out. She (R4) was not breathing, there was no pulse, she was basically like a mottled color (gray color). She (R4) was cold. I could bend her arm, but, yeah, she was pretty stiff. I said how long has she been like that? E7 (CNA) said that she told E</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 14</p> <p>6 (RN) at about 2:50AM. I told her that she didn't look good, could she (E6-RN) come and take a look at the resident. So I just said O.K., lets go, we've got to start CPR on her (R4)."</p> <p>E7 (CNA) was interviewed about R4 on 11/29/05 at 2:20PM. E7 (CNA) stated "around a quarter to three roughly, I noticed that she (R4) wasn't looking right. I told E6 (RN) to come look at her, that she (R4) wasn't looking right. She (E6-RN) stopped everything she was doing and went looked at her (R4). E6 (RN) said she (R4) wasn't breathing at that time. I didn't touch her (R4). I can't remember whether she was stiff or cold."</p> <p>Again, on 12/01/05 at 3:25PM, E6 (RN) was interviewed. First, E6 (RN) was asked why no CPR was done on R4? E6 (RN) stated, "the woman (R4) was cold. She had expired. That's why I did not do CPR. If I remember correctly, nothing, there was no CPR done until E9 (LPN) came up. We took the vitals; they were taken. I guess, I should have started CPR right away. I had no training for CPR. I have not had any training for medical emergencies at Z7 (facility)."</p> <p>Then E6 (RN) was asked, what took so long to call 911? E6 (RN) stated, "I did not know the procedures that I had to call 911. I told E9 (LPN) to come up because I didn't know the procedures /paperwork. I wasn't expecting nothing like that. E 9 (LPN) told me I had to call 911."</p> <p>During the daily status telephone conference on 12/01/05 at 4:05PM, E1 (administrator) stated, "I believe this might have been her (E6-RN) first code here."</p> | F9999 | | | |

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/14/2005 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463 | | |
| (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 | |
| F9999 | <p>Continued From page 15</p> <p>The facility failed to follow their (General Directives To Be Followed In Emergencies) policy for acute medical emergencies to:</p> <ol style="list-style-type: none"> 1) Call paramedics for assistance and transport. 2) To maintain a patent airway, employing resuscitation measures if necessary (begin CPR). <p>They also failed to follow their (Cardiopulmonary Resuscitation-CPR) policy which has been in place since October of 1992 that indicates CPR will not be administered to any resident who exhibits all of the following signs and symptoms:</p> <ol style="list-style-type: none"> 1) An unwitnessed cardiac arrest. 2) Unresponsive. 3) Pupils are fixed and dilated. 4) General body temperature is cool/cold indicating hypothermia. 5) No pulse. 6) No blood pressure. 7) Dusky color. 8) Presence of line of lividity (an irregular, reddish skin discoloration) indicating that gravity has caused the blood to sink and pool in dependent body parts. | F9999 | | | |