STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. BUILDING _____ B. WING _____	04/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE, THE	**150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069**

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F 333	Continued From page 14 another order for Seroquel 50 mg at 1 pm. When E20 was questioned about the error, E20 said there was not a 25 mg Seroquel tablet available. No further explanation was offered. The clinical record of R6 was later checked to see what action E20 had taken to notify the physician of the error, document the condition of the resident after receiving the wrong dose, and if E20 had reported the error to the director of nursing (E2) so that a medication error report could have been filed out. E20 did not do any of this.	F 333		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATION: 300.1035a)2)3)4)5) 300.1035d) 300.1035e) 300.1035f) 300.1035g) 300.1210a) Section 300.1035 Life-Sustaining Treatments 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: 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of	F9999		

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F9999	Continued From page 15 documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. (Section 2-104.2 of the Act); 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility 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; 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. 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. e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70]	F9999		

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F9999	Continued From page 16 f) The resident, agent, or surrogate may change his or her decision regarding life-sustaining treatment by notifying the treating facility of this decision change orally or in writing in accordance with State law. g) The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act. Section 300.1210 General Requirements for Nursing and Personal Care 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. These REGULATIONS are not met as evidenced by: Based on record review and interview, the facility failed to initiate Cardiopulmonary Resuscitation on a resident with Physician orders for a full code . This was for one resident (R1) out of three records reviewed for residents who expired in the facility. This failure resulted in the resident being found in Cardiopulmonary Arrest upon arrival of an ambulance crew on 3/29/06. The facility failed to have current Physician DNR orders for three	F9999		

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F9999	Continued From page 17 additional residents who had signed Advanced Directives. This included R3, R7, and R6. The findings include: 1. A review of R1's Physician Order Sheet (POS) dated 3/1/06 through 3/31/06 documents an Advance Directive of Full Code. A review of nurses notes documents the following: 3/29/06--8:00pm Ambulance notified with an Estimated Time of Arrival (ETA) within 30 minutes. 8:05pm Evening care done. Saturation of 90% with 5 liters oxygen per nasal cannula. BP still 80 /60. 8:30pm Ambulance came. Patient has stopped breathing. Ambulance personnel started Cardiopulmonary Resuscitation (CPR). Called Director of Nurses and called 911. E11 (CNA) was interviewed on 4/3/06 at 3:21pm. E11 worked 3-11pm on 3/29/06. E11 said R1 was in a deep sleep that night and the nurse said to not give any fluids. E11 said R1's vitals were low, oxygen was given, and that staff was busy that night. E11 said when checking R1's pulse oxygen level, there was no reading. E11 said that she then checked to see if R1 was breathing. R1 was not breathing and had no pulse. E11 said she called the nurse. E11 did not start CPR because she thought that maybe she had missed the pulse. E11 said that when the ambulance people came, they all went in, the ambulance people checked the pulse, started CPR, and 911 was called. E10 (RN) was interviewed on 4/3/06 at 7:30pm E 10 said R1 was not well on 3/29/06. E10 said the ambulance was called at 8:00pm with an ETA of	F9999		

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F9999	Continued From page 18 30 minutes. E10 said she was at the desk copying papers for the hospital when the CNA (E 11) came and said she could not get a pulse. E 10 said that at this time, two ambulance guys walked into the unit, and we all walked into the room. E10 said we need to call a code. The ambulance guys said you should have done that before you called us. We called a code. The ambulance guys intubated him. The ambulance guys said he was dead. Z1 (Paramedic) was interviewed on 4/4/06. Z1 said they arrived on the unit at 8:28pm. Z1 said E10 was on the phone and ignored them. A patient care technician came up to them, asked if they were there for R1 and said "I think he is dead." Z1 said that as soon as E10 heard that she hung up the phone and said "I saw him at 8 pm when he had an oxygen level of 81%." Z1 said we all walked into R1's room and he (R1) was gone. R1 had no pulse, no respirations, the extremities were cold, and the trunk was warm. Z1 said they initiated CPR but R1 was gone. Z2 (Physician) was interviewed on 4/18/06 at 1: 20pm. Z2 said R1 was a full code and the facility should have started Cardiopulmonary resuscitation when found unresponsive. 2. R3's POS dated 2/1/06 through 2/28/06 documents Advance Directives of Full Code. Nurses notes dated 2/28/06 document the following: 1:10pm Daughter arrived and breathing stopped, no pulse felt, no heartbeat heard on auscultation. Resident expired at 1:25 pm. R3's medical record contained a DNR order which was signed and dated on 8/20/04.	F9999		

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F9999	Continued From page 19 E3 (RN) was interviewed on 4/3/06 at 11:35pm. E3 said when a person has an order for a full code, we have the right to do CPR, call 911, send them to the hospital and notify the physician. When R3's medical record was reviewed with E3, E3 saw R3 had physician orders to be a full code yet did not receive CPR on 2/28/06. E3 responded they would not follow the physician orders dated 2/1/06-2/28/06 and would honor the DNR which was signed on 8/20/04. E3 did not know whose job it was to be certain that physician orders were current for DNR/Full Code status. 3. R7's POS dated 2/7/06 documents R7 as a new admission. R7's medical record contains a uniform DNR order form signed and dated 2/21/06. A review of R7's current POS dated 3/1/06 through 3/31/06 do not include a DNR order. E12 (LPN) was interviewed on 4/5/06 at 9:20am. R7's medical record was reviewed with E12. E12 said "you are right--there is no physician order for a DNR." E12 said even though R7 had a signed DNR order form, if R7 were to become unresponsive, CPR would have to be performed because of the lack of a signed physician order for a DNR. 4. R6's POS of 3/1/06 through 3/31/06 documents a re-admission on 3/9/06. R6's medical record contains a uniform DNR order form signed and dated 8/9/05. A POS dated 3/30/06 documents a DNR order. E12 was interviewed on 4/5/06 at 9:20am. E12 said that if R6 had become unresponsive prior to the physician order for a DNR, CPR would have	F9999		

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F9999	Continued From page 20 to have been performed. 5. Other examples include: R8 admitted on 2/1/ 06 with a Uniform DNR order form signed and dated 3/11/06. A physician order for a DNR was not obtained until 3/30/06. A review of the facility's Policy for Valid DNR orders dated 7/23/05 documents the following... Physician must write a DNR order in his/her own handwriting on the Physician Order Sheet. When this order is written Medical Records will stamp " Do Not Remove from Chart" and this POS should remain on the resident's active record. An exception to this will be if the resident and /or family or POA for Health Care has completed the form and the physician has given a phone order for DNR this will be accepted until the physician's next visit at which time the DNR order and the Request for DNR form must both be signed. (A)	F9999		