STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. BUILDING ______ B. WING ______	C 06/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVIN JOHNSON CARE CENTER	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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 000	INITIAL COMMENTS Complaint investigation #0742167/ IL28862 A partial extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to ensure that 1 resident on the sample, R3, was assessed and monitored after a fall; failed to take corrective action on previous falls; and failed to initiate CPR when he was found on the the floor, non-responsive. This failure resulted in the neglect of R3, experiencing five falls in the Facility, from 1/19/07 until 3/1/07. On 3/1/07, R3 was found lying on the floor of his bathroom without vital signs. R3 had a physicians order and an advanced directive for a Full Code. The Facility failed to initiate Cardio Pulmonary Resuscitation (CPR). R3 was resuscitated by emergency room personnel and sent to the Intensive Care Unit (ICU). R3 was pronounced dead on 3/2/07 at 6:55 AM. R3's cause of death was a Subdural Hematoma. This failure resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 6/7/07, the Facility remained out of compliance at a severity level two as the Facility continues to educate staff concerning monitoring	F 224		6/27/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1	F 224		

residents on anticoagulant therapy, assessing for falls, performing CPR, performing neurological checks for residents with head injuries, laboratory protocol and answering call lights during meals.

Findings include:

1. R3's Facility nurses notes show that on 3/1/07, "6:30 PM, (R3) was found in the bathroom slumped over, had large food content emesis with large amount of blood. Was completely unresponsive. Taken to bed after being unable to obtain any vital signs. Call placed to 911 and stated code in progress. Call to inhalation therapist, arrived stat, ambulance arrived and continued code with successful intubation."

The report from the paramedics who arrived at the Facility in response to the 911 call for R3 reflects the following: "Call received from nursing home - 1912 (7:12 PM). Dispatched - 1914 (7:14 PM). Arrived at scene - 1917 (7:17 PM). Arrived at scene patient lying in bed being cleaned by nursing home staff. Per nurse, no CPR had been done prior to our arrival. Patient had fallen in the bathroom but was moved to bed by staff. Per nurse "I tried to take his vital signs but couldn't get any".

On 6/4/07, Z4, paramedic, was interviewed. Z4 stated that he was the lead paramedic on the team that picked up R3 on 3/1/07. Z4 stated that when the team arrived at the Facility there was only 1 Facility staff member in the room with R3 and she was cleaning fecal matter off of R3's lower body. She was identified as E4, Inhalation Therapist. Z4 asked E4 what had happened. E4 stated that R3 had been found lying on the bathroom floor. She further stated that they had tried to obtain vital signs but, could not get any. Z4 asked what the Facility had done so far. E4

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F 224	Continued From page 2 said "nothing". The paramedics placed R3 on a backboard and onto the stretcher. Z4 stated he told E4 to begin chest compressions on R3 while Z4 put monitor leads on R3 and his partner began to "bag" R3. Z4 then successfully intubated R3. The paramedics then began to push the stretcher to the ambulance while E4 continued chest compression. The paramedics took over once they arrived at the ambulance and transferred R3 to the local emergency room. Z4 said that he was rather "short" with the nurse at the desk, E3, because "they were not doing what they are supposed to do - there was no oxygen, no CPR and there was only 1 person in the room cleaning the feces and urine off of him". Z4 stated that when the staff found R3 lying in the bathroom, R3 should not have been moved. Facility staff should have been doing compressions as it is more important to "pump" on someone's chest in the first few minutes of a cardiac arrest. He stated that they "shouldn't have worried about getting paper work done and taken care of the patient". Z4 stated that another way that he could tell that the Facility had not done any CPR was because R3's ribs "popped" when chest compressions were initiated after the paramedics arrived on the scene. Z4 said that the cartilage in a persons ribs will make a "popping" sound when chest compressions are initiated. Z4 stated that it occurs because the cartilage in the bone is pushed against its normal range. Z4 also stated that if the Facility ever started CPR they should not have stopped it until the paramedics arrived on the scene. Z4 said that starting CPR immediately increases a patients chance of recovery. On 6/4/07, Z1, R3's son and roommate at the Facility, was interviewed. Z1 stated that on 3/1/07, R3 went in to use the bathroom in their	F 224		

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F 224	Continued From page 3 room. He did not come out for about 15 minutes so, Z1 got up, transferred to his wheelchair and went and checked on R3. R3 was lying on the bathroom floor, with his face on the floor. Z1 pushed the call light and went out into the hall and started yelling for help. He stated that he hollered for at least 10-15 minutes before anyone came. At approximately 6:30 PM, E3 came and checked on R3. E3 came out of the bathroom and Z1 asked E3 how his father, R3, was doing. E3 said "Do you want me to lie to you?" Z1 stated that he wanted to know the truth. E3 stated "He's dead". Z1 said that none of the staff at the Facility attempted to perform CPR and that all they did was put R3 into bed and clean him up. Z1 stated that paramedics arrived and began CPR. E3 heard Z1 crying and told Z1 not to cry because his father "was in a better place". Z1 said that R3 lived for 10 hours at the local hospital Intensive Care Unit (ICU), after being resuscitated at the emergency room. On 5/30/07, E3 was interviewed by telephone regarding the incident concerning R3 on 3/1/07. E3 stated that she found R3 in the bathroom slumped over and she grabbed him as he slipped to the floor. She called for help. A Certified Nurses Aide (CNA) came in, put R3 in bed and E3 tried to take R3's vital signs. E3 said that when she could not get any vital signs, she left the room, went to the nurses station and called 911 then, stayed on the phone and paged inhalation therapy. E3 said that she never started CPR. E3 said that the ambulance driver "hollered" at her when he got there because "they said we should have started CPR and done it immediately by laying him on the bathroom floor". On 5/31/07, both E5 and E6, CNA's, who helped E3 lay R3 in his bed were interviewed. Both stated that they do not remember anyone at	F 224		

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the Facility initiating CPR however, E5 does remember E4 helping the paramedics do CPR after they arrived at the Facility.

R3 was originally admitted to the Facility on 12/29/06. R3 shared a room in the Facility with his son, Z1. R3's diagnoses included, in part, Diabetes Mellitus, Atrial Fibrillation and a history of prostate cancer. R3's medication regime included Warfarin Sodium, 4 milligrams once daily and Aspirin, 81 milligrams once daily. R3's Minimum Data Set (MDS), dated 1/3/07, shows that he had no short or long term memory problems, was independent in cognitive skills for daily decision making and required the limited assistance of one person for ambulation and transfers to and from his wheelchair. R3's Resident Assessment Protocols (RAP's), do not address falls.

R3's Facility plan of care, dated 1/17/07, shows a "Problem" of "Resident has a potential for falls". The short term goal for this is "resident will have no falls". The "Approaches" are all dated 1/17/07, with no revisions or additions to the "approaches". There is no assessment of R3's physical capabilities or fall risk present in the Facility clinical record. During an interview on 6/4/07, Z1 said that R3 kept falling out of his wheelchair and no one at the Facility did anything about it.

The Facility failed to assess and care plan for the potential dangers related to the use of Warfarin, a blood thinner. During an interview with E2, Director of Nursing, he stated that the Facility does not have a policy regarding reporting of abnormal laboratory values to the physician. The Facility does not have a policy concerning observation of residents who are taking anticoagulant medication.

During a review of R3's Facility incident

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F 224	Continued From page 5 reporting forms, it was noted that R3 experienced falls in the Facility on 1/19/07, 1/28/07, 2/5/07, 2/27/07 and 3/1/07. On 1/19/07, at 4:30 AM, Facility nurses notes show and E2 confirmed that R3 was found sitting on the floor. Small abrasions were noted to his right and left shins. R3 stated "I guess I can't walk alone anymore". The corrective action for this fall was "(R3) agreed not to try to walk alone anymore". During a review of R3's clinical record, a physicians telephone order dated 1/20/07 was noted. This telephone order states "1/20/07, 1:50 AM, Sent out to (local) emergency room for evaluation". There is nothing else in R3's clinical record that states why R3 was sent to the emergency room on 1/20/07. On 6/5/07 E8, Licensed Practical Nurse, was interviewed. E8 stated that "if she remembers correctly" R3 was sent to the emergency room due to his fall on 1/19/07. No new orders or progress notes related to the 1/20/07 emergency room visit is present in the Facility clinical records. On 1/28/07 at 2:30 AM, Facility nurses notes show and E2 confirmed that "R3 was found sitting on floor in front of (his) wheelchair. States "I just slid out of the wheelchair when I was asleep. Resident complained of his tail bone hurting". There is no causative factors or corrective action for this fall. On 2/5/07 at 7:00 PM, Facility nurses notes show and E2 confirmed that "R3 was found in sitting position in front of his toilet. Resident states I was sliding off the toilet and I could not pull my self back up so I eased myself down to the floor". There are no causative factors given for this fall. The corrective action for this fall is "Encourage resident to use call light system in bathroom if unable to transfer self safely". On 2/27/07 at 7:10 AM, Facility investigation	F 224		

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F 224	Continued From page 6 shows that "Resident was found lying on right side on the floor. Has hematoma on the the right side of his forehead. Resident got up and tried to walk to the bathroom without wheelchair, lost his balance and fell. Gait is unsteady". There is no corrective action for this fall. There is no record that any ongoing assessment was done after R3's fall, such as neurological checks. Facility nurses notes show that only routine vital signs were taken on 2/28/07 and 3/1/07. Facility nurses notes dated 2/28/07, at 1:00 PM, state "Blood pressure 130/60, Temperature 97.4, Respirations 18 and Pulse 68. Right side of (R3's) forehead remains discolored, bruised, scratches on jaw, eyelid has a small amount of swelling. Area red and slightly purplish". 3/1/07, 1:25 PM nurses notes show that R3's blood pressure was 88/92. On 5/31/07, Z3, R3's physician, was interviewed and asked about the blood pressure. Z3 stated that a blood pressure of 88/92 is "impossible". E2 said that the blood pressure of 88/92 was not accurate however he was unable to produce any documentation to show R3's actual blood pressure. Z3 stated that he would expect the Facility to at least perform neurological checks on R3 after his fall on 2/27/07. E2, Director of Nursing, confirmed that Facility staff did not conduct neurological checks on R3 after his fall with a head injury on 2/27/07. The Facility does not have a policy concerning assessing residents after a fall or head injury. On 5/31/07, during the same interview with Z3, it was stated that if the Facility had told Z3 that R3 was on Coumadin (Warfarin) he would have "done something very different" then leaving R3 at the nursing home for observation. Two different physician's names are written on the reports - not Z3's. Z3 said that since the	F 224		

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F 224	Continued From page 7 physicians that come to the Facility are Resident's in-training, the Facility will call whoever is on duty and that physician may or may not let the patient/residents physician know about abnormal laboratory values. During an interview with E2, it was stated that the Facility does not have a policy regarding reporting abnormal laboratory values to the physician. A review of R3's emergency room and ICU records from the local hospital where R3 was taken on 3/1/07 show that R3 arrived at emergency room at 1938 (7:38 PM), was resuscitated in the emergency room, stabilized and transferred to the Intensive Care Unit (ICU) at 2330 (11:30 PM). At 0640 (6:40 AM), on 3/2/07, R3 experienced heart rhythm changes while in the ICU. The ICU was unable to obtain a blood pressure and "code blue protocol was initiated". ICU notes show that on at 6:55 AM, "Dr. spoke to (R3's) son who is Power of Attorney, who wishes to end resuscitation". R3 was pronounced dead at 6:55 AM on 3/2/07. Autopsy report, dated 5/24/07, shows that R3's cause of death was a Subdural Hematoma. In a letter written by Z5, the physician who performed the autopsy on R3, the following statement is written: "I am attributing the cause of death to the subdural hematoma that (R3) had at the time of autopsy. I believe that the subdural hematoma was the result of the head trauma that he experienced when he fell at the nursing home. I note that he was on Coumadin which would make him more likely to experience a bleeding after the fall". The Pathology report for the autopsy conducted by Z5 states "Brain: reflecting the scalp shows that there is hemorrhage in the scalp on the right side. Removing the skull reveals a large subdural hematoma involving the entire right superior surface of the cortex and	F 224		

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F 224	Continued From page 8 extending inferiorly. The brain is swollen". The Immediate Jeopardy was identified on 6/4/07. The Immediate Jeopardy was determined to have begun on 2/27/07, when the Facility failed to assess and monitor R3 after he fell and had injuries to his head. The Facility also failed to initiate CPR when R3 was found without vital signs, resuscitated by the local hospital emergency room and was later pronounced dead after being transferred to the ICU. E2 was notified of the Immediate Jeopardy at 12:45 PM on 6/4/07. The surveyor confirmed through record review and interview that the Facility took the following actions to correct the immediacy: 1. E3 was immediately terminated and actions were reported to the Illinois Department of Professional Regulation on 6/4/07. 2. Facility policy for neurological checks was written and given to all professional staff either in person or reviewed with them by telephone by 6/7/07. 3. A mandatory meeting was held for all direct care staff on 6/6/07 at 2:00 PM to review neurological checks, CPR, laboratory protocol, notification of fall risk assessments to MD's, monitoring resident on anticoagulant therapy, answering call lights during meals and plans to ensure access to current CPR certification. 4. Quality Assurance Committee met and reviewed Facility CPR protocol, as well as all other issues of concern, on 6/4/07. 5. Facility Medical Director was notified of the incident on 6/4/07.	F 224		
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		6/27/07

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mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the Facility failed to ensure that 1 resident on the sample, R3, was assessed and monitored after a fall; failed to take corrective action on previous falls; and failed to initiate CPR when he was found on the the floor, non-responsive.

This failure resulted in R3 experiencing five falls in the Facility, from 1/19/07 until 3/1/07. On 3/1/07, R3 was found lying on the floor of his bathroom without vital signs. R3 had a physicians order and an advanced directive for a Full Code. The Facility failed to initiate Cardio Pulmonary Resuscitation (CPR). R3 was resuscitated by emergency room personnel and sent to the Intensive Care Unit (ICU). R3 was pronounced dead on 3/2/07 at 6:55 AM. R3's cause of death was a Subdural Hematoma.

This failure resulted in an Immediate Jeopardy.

While the Immediate Jeopardy was removed on 6/7/07, the Facility remained out of compliance at a severity level two as the Facility continues to educate staff concerning monitoring residents on anticoagulant therapy, assessing for falls, performing CPR, performing neurological checks for residents with head injuries, laboratory protocol and answering call lights during meals.

Findings include:

1. R3's Facility nurses notes show that on

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3/1/07, "6:30 PM, (R3) was found in the bathroom slumped over, had large food content emesis with large amount of blood. Was completely unresponsive. Taken to bed after being unable to obtain any vital signs. Call placed to 911 and stated code in progress. Call to inhalation therapist, arrived stat, ambulance arrived and continued code with successful intubation."

The report from the paramedics who arrived at the Facility in response to the 911 call for R3 reflects the following: "Call received from nursing home - 1912 (7:12 PM). Dispatched - 1914 (7:14 PM). Arrived at scene - 1917 (7:17 PM). Arrived at scene patient lying in bed being cleaned by nursing home staff. Per nurse, no CPR had been done prior to our arrival. Patient had fallen in the bathroom but was moved to bed by staff. Per nurse "I tried to take his vital signs but couldn't get any".

On 6/4/07, Z4, paramedic, was interviewed. Z4 stated that he was the lead paramedic on the team that picked up R3 on 3/1/07. Z4 stated that when the team arrived at the Facility there was only 1 Facility staff member in the room with R3 and she was cleaning fecal matter off of R3's lower body. She was identified as E4, Inhalation Therapist. Z4 asked E4 what had happened. E4 stated that R3 had been found lying on the bathroom floor. She further stated that they had tried to obtain vital signs but, could not get any. Z4 asked what the Facility had done so far. E4 said "nothing". The paramedics placed R3 on a backboard and onto the stretcher. Z4 stated he told E4 to begin chest compressions on R3 while Z4 put monitor leads on R3 and his partner began to "bag" R3. Z4 then successfully intubated R3. The paramedics then began to push the stretcher to the ambulance while E4 continued chest compression. The paramedics

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took over once they arrived at the ambulance and transferred R3 to the local emergency room.

Z4 said that he was rather "short" with the nurse at the desk, E3, because "they were not doing what they are supposed to do - there was no oxygen, no CPR and there was only 1 person in the room cleaning the feces and urine off of him". Z4 stated that when the staff found R3 lying in the bathroom, R3 should not have been moved. Facility staff should have been doing compressions as it is more important to "pump" on someone's chest in the first few minutes of a cardiac arrest. He stated that they "shouldn't have worried about getting paper work done and taken care of the patient". Z4 stated that another way that he could tell that the Facility had not done any CPR was because R3's ribs "popped" when chest compressions were initiated after the paramedics arrived on the scene. Z4 said that the cartilage in a persons ribs will make a "popping" sound when chest compressions are initiated. Z4 stated that it occurs because the cartilage in the bone is pushed against its normal range. Z4 also stated that if the Facility ever started CPR they should not have stopped it until the paramedics arrived on the scene. Z4 said that starting CPR immediately increases a patients chance of recovery.

On 6/4/07, Z1, R3's son and roommate at the Facility, was interviewed. Z1 stated that on 3/1/07, R3 went in to use the bathroom in their room. He did not come out for about 15 minutes so, Z1 got up, transferred to his wheelchair and went and checked on R3. R3 was lying on the bathroom floor, with his face on the floor. Z1 pushed the call light and went out into the hall and started yelling for help. He stated that he hollered for at least 10-15 minutes before anyone came. At approximately 6:30 PM, E3 came and

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F 309	Continued From page 12 checked on R3. E3 came out of the bathroom and Z1 asked E3 how his father, R3, was doing. E3 said "Do you want me to lie to you?" Z1 stated that he wanted to know the truth. E3 stated "He's dead". Z1 said that none of the staff at the Facility attempted to perform CPR and that all they did was put R3 into bed and clean him up. Z1 stated that paramedics arrived and began CPR. E3 heard Z1 crying and told Z1 not to cry because his father "was in a better place". Z1 said that R3 lived for 10 hours at the local hospital Intensive Care Unit (ICU), after being resuscitated at the emergency room. On 5/30/07, E3 was interviewed by telephone regarding the incident concerning R3 on 3/1/07. E3 stated that she found R3 in the bathroom slumped over and she grabbed him as he slipped to the floor. She called for help. A Certified Nurses Aide (CNA) came in, put R3 in bed and E3 tried to take R3's vital signs. E3 said that when she could not get any vital signs, she left the room, went to the nurses station and called 911 then, stayed on the phone and paged inhalation therapy. E3 said that she never started CPR. E3 said that the ambulance driver "hollered" at her when he got there because "they said we should have started CPR and done it immediately by laying him on the bathroom floor". On 5/31/07, both E5 and E6, CNA's, who helped E3 lay R3 in his bed were interviewed. Both stated that they do not remember anyone at the Facility initiating CPR however, E5 does remember E4 helping the paramedics do CPR after they arrived at the Facility. R3 was originally admitted to the Facility on 12/29/06. R3 shared a room in the Facility with his son, Z1. R3's diagnoses included, in part, Diabetes Mellitus, Atrial Fibrillation and a history of prostate cancer. R3's medication regime	F 309		

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included Warfarin Sodium, 4 milligrams once daily and Aspirin, 81 milligrams once daily. R3's Minimum Data Set (MDS), dated 1/3/07, shows that he had no short or long term memory problems, was independent in cognitive skills for daily decision making and required the limited assistance of one person for ambulation and transfers to and from his wheelchair. R3's Resident Assessment Protocols (RAP's), do not address falls.

R3's Facility plan of care, dated 1/17/07, shows a "Problem" of "Resident has a potential for falls". The short term goal for this is "resident will have no falls". The "Approaches" are all dated 1/17/07, with no revisions or additions to the "approaches". There is no assessment of R3's physical capabilities or fall risk present in the Facility clinical record. During an interview on 6/4/07, Z1 said that R3 kept falling out of his wheelchair and no one at the Facility did anything about it.

The Facility failed to assess and care plan for the potential dangers related to the use of Warfarin, a blood thinner. During an interview with E2, Director of Nursing, he stated that the Facility does not have a policy regarding reporting of abnormal laboratory values to the physician. The Facility does not have a policy concerning observation of residents who are taking anticoagulant medication.

During a review of R3's Facility incident reporting forms, it was noted that R3 experienced falls in the Facility on 1/19/07, 1/28/07, 2/5/07, 2/27/07 and 3/1/07.

On 1/19/07, at 4:30 AM, Facility nurses notes show and E2 confirmed that R3 was found sitting on the floor. Small abrasions were noted to his right and left shins. R3 stated "I guess I can't walk alone anymore". The corrective action for

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F 309	Continued From page 14 this fall was "(R3) agreed not to try to walk alone anymore". During a review of R3's clinical record, a physicians telephone order dated 1/20/07 was noted. This telephone order states "1/20/07, 1:50 AM, Sent out to (local) emergency room for evaluation". There is nothing else in R3's clinical record that states why R3 was sent to the emergency room on 1/20/07. On 6/5/07 E8, Licensed Practical Nurse, was interviewed. E8 stated that "if she remembers correctly" R3 was sent to the emergency room due to his fall on 1/19/07. No new orders or progress notes related to the 1/20/07 emergency room visit is present in the Facility clinical records. On 1/28/07 at 2:30 AM, Facility nurses notes show and E2 confirmed that "R3 was found sitting on floor in front of (his) wheelchair. States "I just slid out of the wheelchair when I was asleep. Resident complained of his tail bone hurting". There is no causative factors or corrective action for this fall. On 2/5/07 at 7:00 PM, Facility nurses notes show and E2 confirmed that "R3 was found in sitting position in front of his toilet. Resident states I was sliding off the toilet and I could not pull my self back up so I eased myself down to the floor". There are no causative factors given for this fall. The corrective action for this fall is "Encourage resident to use call light system in bathroom if unable to transfer self safely". On 2/27/07 at 7:10 AM, Facility investigation shows that "Resident was found lying on right side on the floor. Has hematoma on the the right side of his forehead. Resident got up and tried to walk to the bathroom without wheelchair, lost his balance and fell. Gait is unsteady". There is no corrective action for this fall. There is no record that any ongoing assessment was done after R3's fall, such as neurological checks. Facility	F 309		

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F 309	Continued From page 15 nurses notes show that only routine vital signs were taken on 2/28/07 and 3/1/07. Facility nurses notes dated 2/28/07, at 1:00 PM, state "Blood pressure 130/60, Temperature 97.4, Respirations 18 and Pulse 68. Right side of (R3's) forehead remains discolored, bruised, scratches on jaw, eyelid has a small amount of swelling. Area red and slightly purplish". Additional Nurse's Notes indicate vital signs and discoloration to R3's face, but there were no neurological checks noted. 3/1/07, 1:25 PM nurses notes show that R3's blood pressure was 88/92. On 5/31/07, Z3, R3's physician, was interviewed and asked about the blood pressure. Z3 stated that a blood pressure of 88/92 is "impossible". E2 said that the blood pressure of 88/92 was not accurate however he was unable to produce any documentation to show R3's actual blood pressure. Z3 stated that he would expect the Facility to at least perform neurological checks on R3 after his fall on 2/27/07. E2, Director of Nursing, confirmed that Facility staff did not conduct neurological checks on R3 after his fall with a head injury on 2/27/07. The Facility does not have a policy concerning assessing residents after a fall or head injury. On 5/31/07, during the same interview with Z3, it was stated that if the Facility had told Z3 that R3 was on Coumadin (Warfarin) he would have "done something very different" then leaving R3 at the nursing home for observation. Two different physician's names are written on the reports - not Z3's. Z3 said that since the physicians that come to the Facility are Resident's in-training, the Facility will call whoever is on duty and that physician may or may not let the patient/residents physician know about abnormal laboratory values. During an	F 309		

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F 309	Continued From page 16 interview with E2, it was stated that the Facility does not have a policy regarding reporting abnormal laboratory values to the physician. A review of R3's emergency room and ICU records from the local hospital where R3 was taken on 3/1/07 show that R3 arrived at emergency room at 1938 (7:38 PM), was resuscitated in the emergency room, stabilized and transferred to the Intensive Care Unit (ICU) at 2330 (11:30 PM). At 0640 (6:40 AM), on 3/2/07, R3 experienced heart rhythm changes while in the ICU. The ICU was unable to obtain a blood pressure and "code blue protocol was initiated". ICU notes show that on at 6:55 AM, "Dr. spoke to (R3's) son who is Power of Attorney, who wishes to end resuscitation". R3 was pronounced dead at 6:55 AM on 3/2/07. Autopsy report, dated 5/24/07, shows that R3's cause of death was a Subdural Hematoma. In a letter written by Z5, the physician who performed the autopsy on R3, the following statement is written: "I am attributing the cause of death to the subdural hematoma that (R3) had at the time of autopsy. I believe that the subdural hematoma was the result of the head trauma that he experienced when he fell at the nursing home. I note that he was on Coumadin which would make him more likely to experience a bleeding after the fall". The Pathology report for the autopsy conducted by Z5 states "Brain: reflecting the scalp shows that there is hemorrhage in the scalp on the right side. Removing the skull reveals a large subdural hematoma involving the entire right superior surface of the cortex and extending inferiorly. The brain is swollen". The Immediate Jeopardy was identified on 6/4/07. The Immediate Jeopardy was determined to have begun on 2/27/07, when the Facility failed to assess and monitor R3 after he	F 309		

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F 309	Continued From page 17 fell and had injuries to his head. The Facility also failed to initiate CPR when R3 was found without vital signs, resuscitated by the local hospital emergency room and was later pronounced dead after being transferred to the ICU. E2 was notified of the Immediate Jeopardy at 12:45 PM on 6/4/07. The surveyor confirmed through record review and interview that the Facility took the following actions to correct the immediacy: 1. E3 was immediately terminated and actions were reported to the Illinois Department of Professional Regulation on 6/4/07. 2. Facility policy for neurological checks was written and given to all professional staff either in person or reviewed with them by telephone by 6/7/07. 3. A mandatory meeting was held for all direct care staff on 6/6/07 at 2:00 PM to review neurological checks, CPR, laboratory protocol, notification of fall risk assessments to MD's, monitoring resident on anticoagulant therapy, answering call lights during meals and plans to ensure access to current CPR certification. 4. Quality Assurance Committee met and reviewed Facility CPR protocol, as well as all other issues of concern, on 6/4/07. 5. Facility Medical Director was notified of the incident on 6/4/07.	F 309		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the	F 324		6/27/07

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Facility failed to assess 1 resident on the sample (R3), for the risk of falling and the use of Warfarin, a blood thinning medication. The Facility subsequently failed to implement progressive interventions to prevent R3 from falling.

This failure resulted in R3 experiencing five falls in the Facility, from 1/19/07 until 3/1/07. On 3/1/07, R3 was found lying on the floor of his bathroom without vital signs. R3 was taken by ambulance to the local emergency room where he was resuscitated. R3 was pronounced dead on 3/2/07 at 6:55 AM. R3's cause of death was a Subdural Hematoma.

Findings include:

1. During a review of R3's Facility incident reporting forms, it was noted that R3 experienced falls in the Facility on 1/19/07, 1/28/07, 2/5/07, 2/27/07 and 3/1/07.

On 1/19/07, at 4:30 AM, Facility investigation shows that R3 was found sitting on the floor. Small abrasions were noted to his right and left shins. R3 stated "I guess I can't walk alone anymore". The corrective action for this fall is "(R3) agreed not to try to walk alone anymore". During a review of R3's clinical record, a physicians telephone order dated 1/20/07 was noted. This telephone order states "1/20/07, 1:50 AM, Sent out to (local) emergency room for evaluation". There is nothing else in R3's clinical record that states why R3 was sent to the emergency room on 1/20/07. During an interview with E8, Licensed Practical Nurse, on 6/5/07, E8 stated that "if she remembers correctly" R3 was sent to the emergency room due to his fall on 1/19/07. No new orders or progress notes related to the 1/20/07 emergency room visit is

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F 324	Continued From page 19 present in the Facility clinical records. There are no causative factors for the fall noted on the Facility investigation. On 1/28/07 at 2:30 AM, Facility investigation states "Resident found sitting on floor in front of (his) wheelchair. States "I just slid out of the wheelchair when I was asleep. Resident complained of his tail bone hurting". There are no causative factors or corrective action given for this fall. On 2/5/07 at 7:00 PM, Facility investigation shows "Resident was found in sitting position in front of his toilet. Resident states I was sliding off the toilet and I could not pull my self back up so I eased myself down to the floor". There are no causative factors noted for this fall. The corrective action for this fall is "Encourage resident to use call light system in bathroom if unable to transfer self safely". On 2/27/07 at 7:10 AM, Facility investigation shows that "Resident was found lying on right side on the floor. Has hematoma on the the right side of his forehead. Resident got up and tried to walk to the bathroom without wheelchair, lost his balance and fell. Gait is unsteady". There are no causative factor or corrective action for this fall. There is no record that any ongoing assessment was done after R3's fall, such as neurological checks. E2, Director of Nursing, confirmed that Facility staff did not conduct neurological checks on R3 after his fall with a head injury. The Facility does not have a policy concerning assessing residents after a head injury. The Facility does not have a policy concerning observation of residents who are taking blood thinning medication. During an interview with R3's physician, Z3, by telephone on 5/31/07, it was stated that if the Facility had told Z3 that R3 was on Coumadin	F 324		

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(Warfarin) he would have "done something very different" then leaving R3 at the nursing home for observation.

During an interview with Z1 on 6/4/07, Z1 stated that on 3/1/07, R3 went in to use the bathroom in their room. He did not come out for about 15 minutes so, Z1 got up, transferred to his wheelchair and went and checked on R3. Z1 said that R3 was lying on the bathroom floor, with his face on the floor. Z1 said that he pushed the call light and went out into the hall and started yelling for help. Z1 said that he hollered for at least 10-15 minutes before anyone came. At approximately 6:30 PM, E3 came and checked on R3. E3 came out of the bathroom and Z1 asked E3 how his father, R3, was doing. Z1 stated E3 said "Do you want me to lie to you?" Z1 said that he said no, I want to know the truth. Z1 said that E3 then said "He's dead". Z1 said that none of the staff at the Facility attempted to perform Cardio Pulmonary Resuscitation (CPR). Z1 said that paramedics arrived a little while later and began CPR. Local hospital records show that R3 was resuscitated in the emergency room, was stabilized and transferred to the Intensive Care Unit (ICU). R3 experienced heart rhythm changes while in the ICU. The ICU was unable to obtain a blood pressure. R3 was pronounced dead at 6:55 AM on 3/2/07. Autopsy report shows that R3's cause of death was a Subdural Hematoma.

The Facility did not investigate this incident therefore, there is no information present in R3's clinical record concerning possible causes or contributing factors.

R3 was originally admitted to the Facility on 12/29/06. R3 shared a room in the Facility with his son, Z1. R3's diagnoses included, in part, Diabetes Mellitus, Atrial Fibrillation and a history

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F 324	Continued From page 21 of prostate cancer. R3's medication regime included Warfarin Sodium, 4 milligrams once daily. R3's Minimum Data Set (MDS), dated 1/3/07, shows that he had no short or long term memory problems, was independent in cognitive skills for daily decision making and required the limited assistance of one person for ambulation and transfers to and from his wheelchair. R3's Resident Assessment Protocols (RAP's), do not address falls. R3's Facility plan of care, dated 1/17/07, shows a "Problem" of "Resident has a potential for falls". The short term goal for this "Problem", is "resident will have no falls". The "Approaches" are all dated 1/17/07, with no revisions or additions to the "approaches". The Facility failed to assess and care plan for the potential dangers related to the use of Warfarin, a blood thinner. There is no assessment of R3's physical capabilities or fall risk present in the Facility clinical record. During an interview on 6/4/07, Z1 said that R3 kept falling out of his wheelchair and no one at the Facility did anything about it.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1010i) 300.1030a)1)2) 300.1030b) 300.1030c) 300.1210a) 300.1210b)3)6) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	F9999		

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of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

Section 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 (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).

2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).

b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.

c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person

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meets the specified certification requirements.

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. Restorative measures shall include at a minimum the following procedures:
b)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.
b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 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 were not met as evidenced by:

Based on record review and interview, the Facility failed to ensure that 1 resident on the

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sample, R3, was assessed and monitored after a fall; failed to take corrective action on previous falls; and failed to initiate CPR when he was found on the the floor, non-responsive. This failure resulted in R3 experiencing five falls in the Facility, from 1/19/07 until 3/1/07. On 3/1/07, R3 was found lying on the floor of his bathroom without vital signs. R3 had a physicians order and an advanced directive for a Full Code. The Facility failed to initiate Cardio Pulmonary Resuscitation (CPR). R3 was resuscitated by emergency room personnel and sent to the Intensive Care Unit (ICU). R3 was pronounced dead on 3/2/07 at 6:55 AM. R3's cause of death was a Subdural Hematoma.

Findings include:

1. R3's Facility nurses notes show that on 3/1/07, "6:30 PM, (R3) was found in the bathroom slumped over, had large food content emesis with large amount of blood. Was completely unresponsive. Taken to bed after being unable to obtain any vital signs. Call placed to 911 and stated code in progress. Call to inhalation therapist, arrived stat, ambulance arrived and continued code with successful intubation."

The report from the paramedics who arrived at the Facility in response to the 911 call for R3 reflects the following: "Call received from nursing home - 1912 (7:12 PM). Dispatched - 1914 (7:14 PM). Arrived at scene - 1917 (7:17 PM). Arrived at scene patient lying in bed being cleaned by nursing home staff. Per nurse, no CPR had been done prior to our arrival. Patient had fallen in the bathroom but was moved to bed by staff. Per nurse "I tried to take his vital signs but couldn't get any."

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F9999	Continued From page 25 On 6/4/07, Z4, paramedic, was interviewed. Z4 stated that he was the lead paramedic on the team that picked up R3 on 3/1/07. Z4 stated that when the team arrived at the Facility there was only 1 Facility staff member in the room with R3 and she was cleaning fecal matter off R3's lower body. She was identified as E4, Inhalation Therapist. Z4 asked E4 what had happened. E4 stated that R3 had been found lying on the bathroom floor. She further stated that they had tried to obtain vital signs but could not get any. Z4 asked what the Facility had done so far. E4 said "nothing." The paramedics placed R3 on a backboard and onto the stretcher. Z4 stated he told E4 to begin chest compressions on R3 while Z4 put monitor leads on R3, and his partner began to "bag" R3. Z4 then successfully intubated R3. The paramedics then began to push the stretcher to the ambulance while E4 continued chest compressions. The paramedics took over once they arrived at the ambulance and transferred R3 to the local emergency room. Z4 said that he was rather "short" with the nurse at the desk, E3, because "they were not doing what they are supposed to do - there was no oxygen, no CPR and there was only 1 person in the room cleaning the feces and urine off of him." Z4 stated that when the staff found R3 lying in the bathroom, R3 should not have been moved. Facility staff should have been doing compressions as it is more important to "pump" on someone's chest in the first few minutes of a cardiac arrest. He stated that they "shouldn't have worried about getting paper work done and taken care of the patient." Z4 stated that another way that he could tell that the Facility had not done any CPR was because R3's ribs "popped"	F9999		

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when chest compressions were initiated after the paramedics arrived on the scene. Z4 said that the cartilage in a persons ribs will make a "popping" sound when chest compressions are initiated. Z4 stated that it occurs because the cartilage in the bone is pushed against its normal range. Z4 also stated that if the Facility ever started CPR they should not have stopped it until the paramedics arrived on the scene. Z4 said that starting CPR immediately increases a patient's chance of recovery.

On 6/4/07, Z1, R3's son and roommate at the Facility, was interviewed. Z1 stated that on 3/1/07, R3 went in to use the bathroom in their room. He did not come out for about 15 minutes so Z1 got up, transferred to his wheelchair and went and checked on R3. R3 was lying on the bathroom floor, with his face on the floor. Z1 pushed the call light and went out into the hall and started yelling for help. He stated that he hollered for at least 10-15 minutes before anyone came. At approximately 6:30 PM, E3 came and checked on R3. E3 came out of the bathroom and Z1 asked E3 how his father, R3, was doing. E3 said "Do you want me to lie to you?" Z1 stated that he wanted to know the truth. E3 stated "He's dead." Z1 said that none of the staff at the Facility attempted to perform CPR and that all they did was put R3 into bed and clean him up. Z1 stated that paramedics arrived and began CPR. E3 heard Z1 crying and told Z1 not to cry because his father "was in a better place." Z1 said that R3 lived for 10 hours at the local hospital Intensive Care Unit (ICU), after being resuscitated at the emergency room.

On 5/30/07, E3 was interviewed by telephone regarding the incident concerning R3 on 3/1/07.

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F9999	Continued From page 27 E3 stated that she found R3 in the bathroom slumped over and she grabbed him as he slipped to the floor. She called for help. A Certified Nurses Aide (CNA) came in, put R3 in bed and E3 tried to take R3's vital signs. E3 said that when she could not get any vital signs, she left the room, went to the nurses station and called 911, then stayed on the phone and paged inhalation therapy. E3 said that she never started CPR. E3 said that the ambulance driver "hollered" at her when he got there because "they said we should have started CPR and done it immediately by laying him on the bathroom floor." On 5/31/07, both E5 and E6, CNA's, who helped E3 lay R3 in his bed, were interviewed. Both stated that they do not remember anyone at the Facility initiating CPR, however E5 did remember E4 helping the paramedics do CPR after they arrived at the Facility. R3 was originally admitted to the Facility on 12/29/06. R3 shared a room in the Facility with his son, Z1. R3's diagnoses included, in part, Diabetes Mellitus, Atrial Fibrillation and a history of prostate cancer. R3's medication regime included Warfarin Sodium, 4 milligrams once daily and Aspirin, 81 milligrams once daily. R3's Minimum Data Set (MDS), dated 1/3/07, shows that he had no short or long term memory problems, was independent in cognitive skills for daily decision making and required the limited assistance of one person for ambulation and transfers to and from his wheelchair. R3's Resident Assessment Protocols (RAP's), do not address falls. R3's Facility plan of care, dated 1/17/07, shows a "Problem" of "Resident has a potential for falls".	F9999		

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F9999	Continued From page 28 The short term goal for this is "resident will have no falls." The "Approaches" are all dated 1/17/07, with no revisions or additions to the "approaches." There is no assessment of R3's physical capabilities or fall risk present in the Facility clinical record. During an interview on 6/4/07, Z1 said that R3 kept falling out of his wheelchair and no one at the Facility did anything about it. The Facility failed to assess and care plan for the potential dangers related to the use of Warfarin, a blood thinner. During an interview with E2, Director of Nursing, he stated that the Facility does not have a policy regarding reporting of abnormal laboratory values to the physician. The Facility does not have a policy concerning observation of residents who are taking anticoagulant medication. During a review of R3's Facility incident reporting forms, it was noted that R3 experienced falls in the Facility on 1/19/07, 1/28/07, 2/5/07, 2/27/07 and 3/1/07. On 1/19/07, at 4:30 AM, Facility nurses notes show and E2 confirmed that R3 was found sitting on the floor. Small abrasions were noted to his right and left shins. R3 stated "I guess I can't walk alone anymore." The corrective action for this fall was "(R3) agreed not to try to walk alone anymore." During a review of R3's clinical record, a physicians telephone order dated 1/20/07 was noted. This telephone order states "1/20/07, 1:50 AM, Sent out to (local) emergency room for evaluation." There is nothing else in R3's clinical record that states why R3 was sent to the emergency room on 1/20/07. On 6/5/07 E8, Licensed Practical Nurse, was interviewed.	F9999		

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F9999	Continued From page 29 E8 stated that "if she remembers correctly" R3 was sent to the emergency room due to his fall on 1/19/07. No new orders or progress notes related to the 1/20/07 emergency room visit is present in the Facility clinical records. On 1/28/07 at 2:30 AM, Facility nurses notes show, and E2 confirmed, that "R3 was found sitting on floor in front of (his) wheelchair. States 'I just slid out of the wheelchair when I was asleep.' Resident complained of his tail bone hurting." There are no causative factors or corrective action for this fall. On 2/5/07 at 7:00 PM, Facility nurses notes show, and E2 confirmed, that "R3 was found in sitting position in front of his toilet. Resident states I was sliding off the toilet and I could not pull my self back up so I eased myself down to the floor." There are no causative factors given for this fall. The corrective action for this fall is "Encourage resident to use call light system in bathroom if unable to transfer self safely." On 2/27/07 at 7:10 AM, Facility investigation shows that "Resident was found lying on right side on the floor. Has hematoma on the the right side of his forehead. Resident got up and tried to walk to the bathroom without wheelchair, lost his balance and fell. Gait is unsteady." There is no corrective action for this fall. There is no record that any ongoing assessment was done after R3's fall, such as neurological checks. Facility nurses notes show that only routine vital signs were taken on 2/28/07 and 3/1/07. Facility nurses notes dated 2/28/07, at 1:00 PM, state "Blood pressure 130/60, Temperature 97.4, Respirations 18 and Pulse 68. Right side of (R3's) forehead remains discolored, bruised,	F9999		

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scratches on jaw, eyelid has a small amount of swelling. Area red and slightly purplish."

3/1/07, 1:25 PM nurses notes show that R3's blood pressure was 88/92. On 5/31/07, Z3, R3's physician, was interviewed and asked about the blood pressure. Z3 stated that a blood pressure of 88/92 is "impossible." E2 said that the blood pressure of 88/92 was not accurate however he was unable to produce any documentation to show R3's actual blood pressure.

Z3 stated that he would expect the Facility to at least perform neurological checks on R3 after his fall on 2/27/07. E2, Director of Nursing, confirmed that Facility staff did not conduct neurological checks on R3 after his fall with a head injury on 2/27/07. The Facility does not have a policy concerning assessing residents after a fall or head injury.

On 5/31/07, during the same interview with Z3, it was stated that if the Facility had told Z3 that R3 was on Coumadin (Warfarin) he would have "done something very different" then leaving R3 at the nursing home for observation. Two different physician's names are written on the reports - not Z3's. Z3 said that since the physicians that come to the Facility are Resident's in-training, the Facility will call whoever is on duty and that physician may or may not let the patient/resident's physician know about abnormal laboratory values. During an interview with E2, it was stated that the Facility does not have a policy regarding reporting abnormal laboratory values to the physician.

A review of R3's emergency room and ICU records from the local hospital where R3 was

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taken on 3/1/07 show that R3 arrived at emergency room at 1938 (7:38 PM), was resuscitated in the emergency room, stabilized and transferred to the Intensive Care Unit (ICU) at 2330 (11:30 PM). At 0640 (6:40 AM), on 3/2/07, R3 experienced heart rhythm changes while in the ICU. The ICU was unable to obtain a blood pressure and "code blue protocol was initiated." ICU notes show that on at 6:55 AM, "Dr. spoke to (R3's) son who is Power of Attorney, who wishes to end resuscitation." R3 was pronounced dead at 6:55 AM on 3/2/07.

Autopsy report, dated 5/24/07, shows that R3's cause of death was a Subdural Hematoma. In a letter written by Z5, the physician who performed the autopsy on R3, the following statement is written: "I am attributing the cause of death to the subdural hematoma that (R3) had at the time of autopsy. I believe that the subdural hematoma was the result of the head trauma that he experienced when he fell at the nursing home. I note that he was on Coumadin which would make him more likely to experience a bleeding after the fall." The Pathology report for the autopsy conducted by Z5 states "Brain: reflecting the scalp shows that there is hemorrhage in the scalp on the right side. Removing the skull reveals a large subdural hematoma involving the entire right superior surface of the cortex and extending inferiorly. The brain is swollen."

The Facility also failed to initiate CPR when R3 was found without vital signs, resuscitated by the local hospital emergency room and was later pronounced dead after being transferred to the ICU.

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