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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G237	A. BUILDING ______ B. WING ______	C 10/22/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNT TERRACE	1180 SOUTH FOURTH STREET KANKAKEE, IL 60901

(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
W 149	Continued From page 3 paramedics came, and they performed CPR and tried to revive her. They then brought her to the hospital." E3's personnel file was reviewed. It was noted that E3 started working for the facility on 5/7/07. A copy of E3's CPR card showed that he had completed CPR training on 5/14/07. The facility's policy and procedure on "Resident Death Within the Facility" was reviewed. It noted, among others, under Procedure: "In the event of the death of an individual in the facility, the following steps shall be completed: 1. The staff person shall immediately call 911 and begin CPR and other first aid as needed. Staff person shall notify QMRP (Qualified Mental Retardation Professional) or Administrator......" The facility neglected to implement the stated procedure when R1 was found unresponsive, with no pulse and breathing in her room on 8/27/07.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1235a)4)5) 350.3240a) Section 350.1235 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:	W9999		

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W9999	Continued From page 4 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. Section 350.3240 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 REGULATIONS are not met as evidenced by: Based on record review and interview, the facility failed to implement their policy and procedure on Resident Death Within Facility when they failed to ensure that staff initiated Cardio-Pulmonary Resuscitation (CPR) on 1 of 1 clients (R1) who was found unresponsive with no pulse and breathing in her room on 8/27/07 at around 11:33pm. R1 was pronounced dead at a nearby hospital on 8/28/07 at 12:05am. Findings include: R1, per her face sheet, was a 60 year old female whose diagnoses included Moderate Mental Retardation, Seizure Disorder, Borderline Anemia, Hyponatremia, and Mild Thrombocytosis.	W9999		

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W9999	Continued From page 5	W9999		

R1's record was reviewed. It had documentation written by E3 (direct care staff) dated 8/27/07. The progress notes included, "I (E3) came on duty at 11:30pm on 8/27/07. I did my nightly bed checks and came into R1's room at 11:33pm. She was kneeling on side of bed. I called out her name but no response. So, I checked her pulse and breathing. There was none. So I called 911. They arrived at the house at 11:40pm. They did rescue treatment and took her to the hospital. I also called E1 (Administrator) and E2 (former Administrator) then to report what happened."

E4 (nurse) was interviewed on 10/16/07 at 1:15pm. E4 was asked what R1's code status was. E4 answered, "She was a full code." Surveyor then asked E4 what a full code means. E4 answered, "A full code means if a person is found unresponsive with no pulse and no respiration, we (staff) would do CPR until the paramedics would take over."

E1 was interviewed on 10/16/07 at 11:45am. E1 stated, "I became aware when I got a call from E2 at about 11:41pm of 8/27/07. E2 called and stated that one of the staff found R1 and she was unresponsive. I hung up the phone, changed clothes, and drove over to the facility. When I got here (facility), the ambulance was at the front. I came in the house, and I met E3 at the front door. Obviously he was upset. I asked what happened, and he told me he found her laying over the bed. She (R1) was in a position that looked like she was praying, kneeling on the side of the bed. I told E3 that I was going to the hospital, and he said basically R1 passed away." E1 added, "E3 stated he didn't do CPR because she didn't have any vitals; my understanding was that she felt

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W9999	Continued From page 6 cold." E1 further added that R1 was pronounced dead at a nearby hospital on 8/28/07 at 12:05am. The cause of death is: Coronary Atherosclerosis and Hypertensive Coronary Vascular Disease. E3 was interviewed via phone on 10/17/07 at 12:55pm. E3 stated, "I came to work at 11:30pm. I do my bed-checks at 11:30. I saw R1 kneeling beside her bed like praying and I asked her how she was. She didn't answer. I came near her and felt her. She was cold and clammy. I checked her vitals two times--no pulse, no breathing. I called 911." Surveyor asked if E3 performed CPR on R1. E3 answered, "No because it was just a shock thing. To be honest, she was cold and clammy, and I thought she was dead." Surveyor asked what the paramedics did when they got to the facility. E3 answered, "The paramedics came, and they performed CPR and tried to revive her. They then brought her to the hospital." E3's personnel file was reviewed. It was noted that E3 started working for the facility on 5/7/07. A copy of E3's CPR card showed that he had completed CPR training on 5/14/07. The facility's policy and procedure on "Resident Death Within the Facility" was reviewed. It noted, among others, under Procedure: "In the event of the death of an individual in the facility, the following steps shall be completed: 1. The staff person shall immediately call 911 and begin CPR and other first aid as needed. Staff person shall notify QMRP (Qualified Mental Retardation Professional) or Administrator......" The facility neglected to implement the stated procedure when R1 was found unresponsive, with	W9999		

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W9999	Continued From page 7 no pulse and breathing in her room on 8/27/07. (A)	W9999		