		TH AND HUMAN SERVICES			PRINTED: 09/28/2007 FORM APPROVED OMB NO: 0938-0391	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		145701	B. WING _		08/24/2007	
NAME OF F	PROVIDER OR SUPPLIER		í	REET ADDRESS, CITY, STATE, ZIP CODE		
LEXING	TON OF STREAMWO	700		815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	LD BE CROSS- COMPLETION	
F-309	Continued From pa	-	• F 309	 		
		ency personnel, are aware of	and the same	I		
•	code status in the	promptly determine a resident's event of a medical emergency.	. James .			
	The results of the	quality assurance process shall				
		the Medical Director and anagement Coordinator. Any				
		ive actions shall be taken upon				
	outcomes. The Adi	iministrator shall develop and		! !		
	implement these m	neasures by 08/23/07.				
حد	All inservices will t	performed by 08/23/07.				
F9999	1	•	F9999	**************************************		
!	LICENSURE "A" V	/IOLATION	+			
!	[!] 300.1030 a)		ı			
	300.1210 a)		ı	1		
4	300.3240 a)		,			
:	300.1030 Medical I	Emergencies	1			
:	a) The advisory ph	ysician or medical advisory	,			
į	committee shall de	evelop policies and procedures	!	1		
!		ing the various medical may occur from time to time in	į	,		
j	long-term care facil		1			
:	300.1210 General Personal Care	Requirements for Nursing and			·	
ļ :		t provide the necessary care	j.		•	
!	and services to atta	ain or maintain the highest	į	1		
		al, mental, and psychosocial esident, in accordance with		:		
i		mprehensive 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.

 -		AND HUMAN SERVICES				FORM	09/28/2007 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		145701	B. WII	NG	7.2.	į.	C 4/2007 i
	ROVIDER OR SUPPLIER ON OF STREAMWOO	OD.		81	EET ADDRESS, CITY, STATE, ZIP CODE 15 EAST IRVING PARK ROAD TREAMWOOD, IL 60107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From page	ge 9	F99	999			
	300.3240 Abuse an	d Neglect		:			
		ee, administrator, employee or all not abuse or neglect a -107 of the Act)					
	These requirements	are not met as evidenced by:		;			
	facility failed to prov medical intervention cardiopulmonary res	suscitation (CPR) was ctly and promptly for one					
;	continue CPR after to follow their emerg the arrival of E5 (T floor. The staff also backboard for effect	911 immediately and initiation. The facility failed pency plan while waiting for hird floor nurse) from another failed to place resident on live compression. There is riews that CPR was started the code.					
	emergency medical calling 911, and fail accessibility of the re	o provide appropriate intervention, the delay in ure to provide immediate esuscitator bag and cardiac this and other residents in ring a Code.					
	Findings include:						
	HTN (hypertension), ESRD (End Stage F	d male with diagnoses of Syncope, Osteoarthritis, Renal Disease), and Atrial admitted to the facility on 04/					

24/07.

PRINTED: 09/28/2007

DEPAR'	TMENT OF HEALTH	HAND HUMAN SERVICES			_): 09/28/2007 II APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JETIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	ETED	
_		145701	B. WING	>	1	C 24/2007	
NAME OF P	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO			
LEXING?	TON OF STREAMWOO	ac		815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107	PARK ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE	
F9999	Continued From pa	ige 10	F999	99			
	floor) charting on nu reflect:	Agency nurse in charge of first urses notes dated 06/04/07					
	resident. Nurse call response. Nurse ap	led out to resident with no oproached resident & shook					
	Certified Nursing Asstatus. Nurse check	sponse. Nurse called to CNA (ssistant) to ask resident's ked resident pulse, no pulse					
	that resident is usua	CNA entered room & stated ally moving about even in ed B/P cuff. Unable to detect				•	
	B/P. Unable to obta check resident statu	ain pulse ox, CNA asked to us. CNA responded 'full code.'					
	crash cart & call sup came & assisted. C	. CNA was asked to retrieve pervisor. Third floor nurse NA asked to move resident					
	assisted. CNA aske	econd floor nurse came & ed to call 911 & tell them we live resident. CPR remains in					
	progress." "6 AM- Paramedics	arrived & after approximately ly taken over CPR. "					
	When interviewed o	on 08/15/07 at 3:05 PM, Z1 (•	
	give the medication his name, shook him	ted "Went to (R2's) room to between 5 AM to 6 AM, called m no response, check vital		1			
	the other nurse on t	no pulse. I told the CNA to get the other floor. Started CPR by turses came. We did CPR and					
	the Paramedics can the ambulance or 9	ne. I don't know who called 11. I told the CNA to call the					
	the CPR Z1 stated	or asked how long did you do d "Maybe I did for 5 or 10 e. Did CPR by myself. "					
	Surveyor again aske	ed Z1, who was with you when! R. Z1 further stated "me and					

.DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES				: 09/28/2007 I APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	MULTIPLE CONSTRUCTION JILDING	(X3) DATE S COMPL	URVEY ETED
		44	B. WI	ING		C
		145701			08/2	4/2007
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	į
LEXING	TON OF STREAMWOO	OC.		815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107		ļ
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO FIX (EACH CORRECTIVE ACTION SI G REFERENCED TO THE APPROPI	HOULD BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	ge 11	FO	9999		
1 0000		-	1 3	7999		·
		(E5 and E6)." Per ZI the vere written were accurate.				
	O= 00/45/07 -4.0-40	D14				1
		PM, surveyor interviewed E6 her response to the code blue				1
		o first floor but I can not				
		and time and I did help. I				,
		the morning when I came.				
		sponsive, no B/P, no				
	respiration, no pulse	e. (Z1) was assessing the				į l
		pparatus in her hand and no				
		ne yet. (E5, Nurse) was on the				1 1
		hen I came down. I was the				1
) let's do the CPR and told (E				[
	5) to get the air pump." E6 further stated that they initiated CPR for 2 minutes when the paramedics arrived and took over.					¦ 1
]
	anned and took or	S1.				
	When interviewed of	on 08/20/07 at 10:25 AM, E5 (1
	Nurse) stated that	"at around 4:30 AM, (E7,				ļ 1
		at (R2) was unresponsive on				i l
		wn but on my way down I				
;	•	floor nurse) to help us. I went				
		rst floor to assess (R2) .				}
1		ted airway, shook him, ation in the sternum with my				
		ding. I went to get crash cart in				i l
		ick of the nursing station and				[
		On my way to Nursing				ì
		saw (E6) getting out of the				
	elevator. (E6) then went to (R2 's) room to give CPR. When I went to (R2's) room the first time, (
				:		1
		(R2) and taking vital signs B/		•		
		lse and Oxygen Saturation. I				
		alling 911 about 4:40 AM then				ŀ
		R2's) room. (E6, Nurse) was				ļ
		ssion then I handed (Z1) the discrepance board. While		•		<u>;</u>
		ent to (Z1), 911 personnel				}
	manang me equipin	to (= 1), o i i personnei				: 1

PRINTED: 09/28/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB</u> NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 145701 08/24/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST IRVING PARK ROAD LEXINGTON OF STREAMWOOD STREAMWOOD, IL 60107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG F9999 Continued From page 12 F9999 arrived and took over." When interviewed on 08/20/07 at 12:55 PM, E7 (CNA) stated "Basically I was doing my rounds around 2-3 AM and found (R2) not breathing, not moving and not usual self. I called (Z1) in the nursing station. (Z1) went to check (R2) and (Z1) told me to call (E5) and (E6) upstairs. Nurses came and then the paramedics." Surveyor asked E7 if she called 911. E7 said "I don't think so." Surveyor asked, Did you announce code blue? E 7 stated, "not my job." Z1's nurses note did indicate that the paramedics arrived at 5:55 AM and took over CPR. Review of R1's paramedic's report dated 06/04/07 indicated the following information: " Chief Complaint: Cardiac Arrest: dispatch: 05:48:00 en route; 05:51:00 location: 05:57:00 patient contact: 05:57:00 left scene: 07:10:00 at facility: 07:18:07 scene time: 01:13:00

and attached monitor."

transport; 00:08:00 "

Further review of Paramedic's report reflects, "Upon arrival we found nurse performing CPR. Nurse states she came into patient's room about 20 minutes prior to calling EMS and found patient not breathing and cold to touch. She states she immediately began CPR with no CPR board under patient. Nurse also states last time patient was checked was 0300. Crew took over CPR

Interviews indicated that the staff E6 and Z1 were

		I AND HUMAN SERVICES				FORM	09/28/2007 APPROVED 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 08/24/2007		
							NAME OF
LEXING	TON OF STREAMWOO	DD		1	B15 EAST IRVING PARK ROAD BTREAMWOOD, IL 60107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	the paramedics arriunresponsive at 5:3 promptly as require that she came to he to Z1. E6 indicated backboard for use of paramedics arrived compression on the were given the backboard for use of paramedics arrived compression on the were given the backboard for use of facility's factories and or facility's factories that a resider and or medical intentation and through a staff mention of the staff mention	oximately two minutes when ived. R2 was found to AM. CPR was not initiated d. In addition, E5 indicated and over the resuscitator bag that she handed the with CPR when the . Staff admitted doing a soft bed and admitted they aboard late. Procedure on Medical following: In assessment by a licensed at requires immediate nursing exertion, obtain assistance abort to page overhead, " nurse must initiate first aid ensure resident's safety. It licensed nurse must call. It is consed staff must report to provide assistance as at goes into cardiac arrest and Code", initiate CPR and follow	F9:	999			