STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G259	A. BUILDING _____ B. WING _____	C 01/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	**3360 FRANCIS LANE JOLIET, IL 60432**

(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 4 removal which includes: "Although the staff person who was present for the incident on December 22, 2007 was re-trained, the Immediate Jeopardy was due to the failure to re-train all staff regarding procedures for emergency situations, including unresponsive or unconscious individuals. All re-training for employees on the procedures for emergency situations, including unresponsive or unconscious individuals will be completed by January 5, 2008." Although the Immediate Jeopardy is removed, non compliance continues at the time of the exit since the facility had not fully implemented their plan and has not had an opportunity to evaluate it's effectiveness.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060h) 350.1235a)3)4)5) 350.1235b)2) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G259	A. BUILDING _____ B. WING _____	C 01/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	**3360 FRANCIS LANE JOLIET, IL 60432**

(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
W9999	Continued From page 5 Section 350.1060 Training and Habilitation Services h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. 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: 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. b) For the purposes of this Section: 2) "Life-sustaining treatment" means any medical	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G259	A. BUILDING _____ B. WING _____	C 01/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	**3360 FRANCIS LANE JOLIET, IL 60432**

(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
W9999	Continued From page 6 treatment, procedure, or intervention that, in the judgement of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing an airway, as indicated. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirments were not met as evidenced by: Based on record review and interview the facility failed to ensure that staff implemented their policy and procedure on a Death of an Individual when staff failed to: a) immediately notify 911 Emergency Response Services and b) initiate Cardio Pulmonary Resuscitation on 1 of 1 client . R1 was found unresponsive in her room on 12/22/07. R1 was pronounced dead on 12/22/07 at 6:01 by the county coroner. Findings include: R1, per her face sheet, was a 52 year old female whose diagnoses included Severe Metal Retardation, Down's Syndrome, Abdominal Hernia and Congenital Heart Disease.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G259	A. BUILDING _____ B. WING _____	C 01/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	**3360 FRANCIS LANE JOLIET, IL 60432**

(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
W9999	Continued From page 7 The facility's Internal Investigative Report dated 12/24/07 completed by E1, Program Director was reviewed. The facility's investigation included the following narrative: "At approximately 5am, I received a call from E3, Independent Living Counselor, from the facility. E3 reported that R1 was in her bed, unresponsive and her tongue was purple. I asked her if she had called 911 and she said she was calling me first, I asked her to hang up and call 911...." The narrative continued, "E2, Assistant Program Director, and I (E1) spoke with E3, and asked her to write down what had occurred from her perspective.....R1 routinely awakes around 5am to have coffee with staff and help with making lunches or setting the breakfast tables. When R1 did not come out, E3 stated that she went in to check on her and found her unresponsive, she stated that she nudged R1's shoulder and noticed that her eyes were open and her tongue was purple, she was cold to touch and she could not move her from the position she was in. E3, then called the on-call, and the program director, and was instructed to call 911...." E3 was interviewed on 1/4/08 at 11:55am. E3 stated, "I checked on R1. R1 (was) sitting up, her tongue (was) hanging out of her mouth, her eyes opened, little mucous coming out of her nose. So when I saw her tongue was blue, I goes (went) closer to R1. I shook R1, she felt a little cool to me, no response. So I ran and called the on-call (staff). No one answered, so I said to myself "get yourself together. I need to make sure that the next call I make I am accurate with what I'm gonna tell them." So I ran back to R1's room and I look at R1 real good, then I proceeded to do the same thing I did before. 'R1, R1 are you all right?'	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G259	A. BUILDING _____ B. WING _____	C 01/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY LIVING CENTER #3	**3360 FRANCIS LANE JOLIET, IL 60432**

(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
W9999	Continued From page 8 No response. I felt her again then I looked at her real hard. I proceeded to run back to the phone, and I called E1. I said to E1, 'I have a situation here, it's R1.' I said R1's tongue is blue and R1 is not breathing. E1 asked me 'did you call 911? I said no and she said hang up and call 911 so I called 911 and I talked to the dispatcher and crying and telling her that R1 is not breathing and her tongue is hanging out and it's blue. She (dispatcher) said , 'Calm down, we are sending the paramedics.' She said, 'Do you want to stay on the line until they (paramedics) come?' I said 'yes.' In the process , when paramedics were coming, I told the dispatcher about R1...." E4, Qualified Mental Retardation Professional (QMRP), and one of the facility CPR trainers, was interviewed on 1/4/08 at 2:18pm via phone. E4 met with E3 with regards to the CPR/First Aid policies and procedures following the death of R1. E4 was asked how the staff were trained about CPR. E4 stated, "If you find someone unresponsive, call 911 and perform CPR if no signs of life." Surveyor asked E4 if she was aware that E3 called the on-call staff then the Program Director first prior to calling 911. E4 answered, "I believe our policy states that staff have to call the Program Director first prior to calling 911." (A)	W9999		