STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G271	A. BUILDING _____ B. WING _____	05/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CLUB TERRACE	4900 WEST 183RD STREET COUNTRY CLUB HILLS, IL 60478

(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 441	Continued From page 19 The above findings were confirmed by E1, Qualified Mental Retardation Professional (QMRP), on 5/6/09 at 12 PM. She stated that 3rd shift drills run during sleeping hours, are done when the weather is mild. However, E1 stated the missing time from January 7 '09 was 1 AM.	W 441		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1235a)2)3)4)5) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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: 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 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	W9999		

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W9999	Continued From page 20 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. These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a policy and procedure regarding emergency procedures when finding a client unresponsive with no pulse or respiration, for one of one client (R16). Findings include: R16, per her Physician's Orders of 4/27/09 to 5/26/09, was a 52 year old female whose diagnoses include Profound Mental Retardation, Hepatitis B Carrier, Congenital Heart Disease with Mitral Valve Prolapse, Down Syndrome, Lupus, and Pleural Effusion. In review of the facility's Death Notification documentation sent to the Illinois Department of Public Health written by E1, Qualified Mental Retardation Professional, on 5/10/09, R16 was found unresponsive in her room at approximately 7:25AM. 911 was called. Bed checks were	W9999		

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W9999	Continued From page 21	W9999		

completed by staff every 30 minutes. R16 toileted at 4:30AM, returned to bed and was making sounds at 6:00AM. Staff were dressing and grooming others. When staff went to her room, she was laying by her closet unresponsive. She was pronounced expired at 8:16AM at the hospital. Guardian and Administrator were present at the hospital.

Nursing Progress Notes dated 5/10/09 7:39AM were reviewed. Residential Aide E14 wrote "...R16 had eaten all of her breakfast and lunch on 5/9/09. She seemed to be her normal self. When we did bed checks at 4:30AM she was woke and went to the bathroom. R16 was also making noises as usual between 4:30-5:45AM. Most of the residents was up getting dressed for the day. Around 6AM R16 and R4 was still laying in bed. She looked fine. At around 7:10AM I was passing meds. All though I was accountable for the girls, E7 was helping out getting them dressed. She discovered R16 laying on the floor facing the closet. E7 screamed E14, E14, I think R16's dead. We both panic because we were in the state of shock. I felt for a pulse. Couldn't make nothing out. Then we call 911, the nursing cell, and E1. The paramedics came in about 2-3 minutes. They worked on her until they took her to the hospital worked on her some more. They pronounced her dead about 20-30 minutes later." (all typed as written).

Residential Aide E7 wrote "R16 was up, but in bed around 5:00AM. She normally gets up early before all the others. When she gets up she will sit on the floor. This morning she was found on the floor and not responding. We called 911 and Nursing. When they got here, they went into R16's room and started CPR. They later took her

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W9999	Continued From page 22 out to the hospital." The Director of Nursing, E5, wrote a statement dated 5/10/09 7:39AM that she received a call from E15 that EMS was on site. E15 stated that R16 was not a DNR (Do Not Resuscitate). EMS transported R16 to the local hospital. At 8:30AM, E5 received word from Administrator, E11 that R16 was pronounced dead at 8:16AM Emergency Report Form (EMS) dated 5/10/09 was reviewed and noted receiving the 911 call at 7:27AM and arriving at the home to begin Cardio Pulmonary Resuscitation (CPR) at 7:30AM. In a phone interview with Administrator, E11 on 5/14/09 at 12:47PM, she stated that all agency staff are trained to do Cardio Pulmonary Resuscitation. E11 said staff panicked and failed to do CPR when they found R16 unresponsive in her bedroom. Current training records noted that E14 completed CPR in 10/07, and E7 completed CPR in 4/08. On 5/14/09 at 1:55PM, in phone interview, E11 stated the agency has no current policy and procedure regarding Do Not Resuscitate. E11 stated none of the individuals in the home R1 through R16 have a DNR order. (A)	W9999		