

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

PRINTED: 02/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2009
NAME OF PROVIDER OR SUPPLIER WEST GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE RURAL ROUTE #1, BOX 417 LAWRENCEVILLE, IL 62439		
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W 331	Continued From page 16 In the same interview, Z1 stated that had R1 required CPR prior to EMS arrival, R1 would have had to be repositioned. There is no way to perform CPR with an individual face down in the prone position. In a phone interview with Z3 (physician), on 9/22/09, at 2:22 p.m., Z3 stated that the best way to open the airway when an individual is lying face down, is to always roll the individual to the side or to back and tilt the head back. Repositioning from prone to side or back would help facilitate breathing. The hospital emergency room report (dated 7/31/09), documents that R1 was pronounced dead at 4:10 a.m. R1's death certificate of 8/3/09 documents Cardiac Arrest and Congestive Heart Failure as cause of death. The facility's undated policy entitled, "Medical Policies" was reviewed. It states, "The facility shall provide all services needed to promote and maintain good physical health of its individuals, by the following methods but not limited to:...Reporting of symptomatology by staff with follow-up evaluation by RN and referral to physician."	W 331			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)2)3) 350.3240a)	W9999			

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W9999	<p>Continued From page 17</p> <p>Section 350.620 Resident Care Policies</p> <p>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.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement their system to prevent neglect for 1 of 1 individual (R1) who expired on 7/31/09; with potential to affect 8 of 11 additional individuals of the facility (R's 2, 3, 4, 6, 7, 8, 9 &</p>	W9999			

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W9999	<p>Continued From page 18</p> <p>10). The facility failed to:</p> <p>a) Ensure staff were able to physically position R1 in order to open his airway and improve his breathing status during an emergency.</p> <p>b) Ensure staff are trained in techniques and can physically implement strategies for moving and repositioning individuals whose weights vacillate between 180-300 pounds, after the 7/31/09 incident.</p> <p>Findings include:</p> <p>1. In review of an 8/27/09 facility roster, there are currently eleven (11) individuals in the facility (R's 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 & 12).</p> <p>In review of June, July, August and September 2009 weekly weight charts, there were a total of nine (9) individuals with weights vacillating between 180 and 300 pounds (R's 1, 2, 3, 4, 6, 7, 8, 9 & 10). Between June and September of 2009, R2's weight fluctuated between 277 and 300 pounds. R2's 7/1/09 physician's order sheet documents medical diagnoses of Cardiac Arrhythmia, Anemia and AFIB (Atrial Fibrillation).</p> <p>In review of R1's 7/1/09 physician's orders, R1 functioned in the profound range of mental retardation. Additional medical diagnoses include: Acute/Chronic Congestive Heart Failure, Hypertension, and Down Syndrome.</p> <p>R1's 4/20/09 Inventory for Client Agency Planning (ICAP) documents an overall age level of 1 year and 5 months. His 2006 Slosson Intelligence Test (Clinical Psychologist update of 4/23/09) documents an estimated intelligence</p>	W9999			

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W9999	<p>Continued From page 19 quotient (IQ) of 10.</p> <p>R1's 4/23/09 Individual Program Plan (IPP) documents that R1 did have minimal speech and was ambulatory.</p> <p>R1's resident face sheet of 3/13/09 documents resuscitation orders as, "FULL CODE."</p> <p>A 7/31/09 facility incident/accident report states that at 3:15 a.m., "resident (R1) found on floor during routine bed checks face down." Vital signs were recorded with a temperature of 97, a pulse of 78, blood pressure 130/98, and respirations documented as, "abnormal." Level of consciousness is documented as, "unconscious." Witness to the above incident is listed as E4 (Direct Service Person - DSP).</p> <p>E4 (DSP), on 9/16/09 at 8:10 a.m., stated that she has been employed at the facility since 06/2007, is current for Cardio Pulmonary Resuscitation (CPR) training, and was the only staff on duty July 30-July 31/2009 from 11:00 p.m.-7:00 a.m. E4 stated she was in the facility dining room and heard R1 coughing in his bedroom. E4 went to check on R1 and found him on his bedroom floor lying face down. There was feces on the floor and on R1. E4 stated R1 was unconscious, but breathing. E4 left R1 to retrieve a phone and call 911. E4 stated she was unable to physically roll R1 over, and vitals for R1 were completed for R1 while in prone position. E4 concurred vitals were as listed on the facility incident/accident report dated 7/31/09 (temperature - 97; pulse - 78; blood pressure - 130/98; respirations listed as, "abnormal"). E4 further stated she did not time R1's respirations. E4 called the consulting nurse (E7) and the</p>	W9999			

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W9999	<p>Continued From page 20</p> <p>Social Services Director/Activity Director - SSD/AD). E4 stated that prior to the ambulance arriving, she took R1's blood pressure again, but did not document the reading. No other vitals were repeated. E4 stated that R1 continued to breathe and she stayed with him until Emergency Medical Staff (EMS) arrived. E4 further stated that she placed R1's head on her knee while waiting on EMS. E4 stated that due to R1's weight, she could not physically roll R1 over. (Per the July/2009 facility weight chart, week 4, R1 weighed 180 pounds).</p> <p>In an interview with Z1 (EMS staff), on 9/17/09 at 7:50 a.m., Z1 stated that upon arrival at the facility, E4 met the ambulance crew about 3 feet from the front door. R1 was lying face down in his room, "face directly down on carpet" outside the bathroom located off R1's room. Z1 stated he has never seen anyone totally face down on the carpet. The facility staff told Z1 that R1 was breathing when she was with him. Z1 further stated that two (2) police officers came to assist with lifting Z1. (The emergency room record of 7/31/09 states, "They (EMS)...were unable to lift the individual without a lot of extra help....")</p> <p>The 7/31/09 emergency medical service (EMS) report documents that Z1 and Z2 were the emergency medical staff who responded to the dispatch, arriving at 3:30 a.m. The EMS report documents that upon arrival to the facility, R1 was, "lying prone on floor (with) face down," and per the facility staff, "was breathing during EMS arrival". Pupils were fixed and fecal matter was observed on R1. The report documents that at 3:32 a.m. and 3:33 a.m., R1 had no pulse, respirations, and no systolic or diastolic blood pressure, lung sounds absent. Initial and last</p>	W9999			

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W9999	<p>Continued From page 21 skin color noted as cyanotic.</p> <p>In the same interview, Z1 stated that had R1 required CPR prior to EMS arrival, R1 would have had to be repositioned. There is no way to perform CPR with an individual face down in the prone position.</p> <p>In a phone interview with Z3 (physician), on 9/22/09, at 2:22 p.m., Z3 stated that the best way to open the airway when an individual is lying face down, is to always roll the individual to the side or to back and tilt the head back. Repositioning from prone to side or back would help facilitate breathing.</p> <p>The hospital emergency room report, dated 7/31/09, documents that R1 was pronounced dead at 4:10 a.m.</p> <p>R1's death certificate of 8/3/09 documents Cardiac Arrest and Congestive Heart Failure as cause of death.</p> <p>The facility's plan to remove the Immediate Jeopardy, called on 9/17/09 at 2:15 p.m., documents that staff were trained on 9/18/09, in moving and repositioning individuals in excess of 170 pounds.</p> <p>It was not until after the Immediate Jeopardy was called (9/17/09, at 2:15 p.m.), that the facility provided staff training regarding moving and repositioning of individuals who weigh in excess of 170 pounds.</p> <p>In a phone interview with E1 (Administrator), on 9/22/09 at 11:38 a.m., E1 stated that this is the first time staff have received formal training</p>	W9999			

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W9999	<p>Continued From page 22</p> <p>specific to moving and repositioning of individuals who weigh in excess of 170 pounds.</p> <p>The facility policy for abuse and neglect was reviewed.</p> <p>Under this policy, neglect is defined as, "any failure to provide adequate care which results in physical or mental injury to a resident...Neglect...involves a failure to do something."</p> <p>The policy entitled, "Rights, Health, and Safety," states, "All incidents, including serious illness, injuries, and alleged cases of abuse and/or neglect are reported and reviewed and action is taken to resolve or prevent further incidents." The facility did not take action to prevent further incidents after staff was unable to position R1 to assist his breathing until after the Immediate Jeopardy was called (49 days after the incident).</p> <p>(A)</p>	W9999			