STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

ARDEN COURTS OF GENEVA	0049619
Facility Name	I.D. Number
2388 BRICHER ROAD, GENEVA, ILLINOIS 60134	
Address, City, State, Zip	
02648	DECEMBER 10, 2009
Reviewed By	Date of Survey
COMPLAINT 0974587	02534
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

330.710c)2)
330.760e)f)
330.930
330.1125a)2)3)4)5)
330.1125b)2)
330.1125d)
330.1125e)
330.1125g)
330.1125h)
330.1720c)2)
330.4240a)

Section 300.710 Resident Care Services

c) These written policies shall include, but are not limited to, the following provisions:
2) Resident care services including physician services, emergency services, personal **s**ervices, activity services, dietary services, and social services.

Section 330.760 Personnel Policies

e) All personnel shall have either training or experience, or both, in the job assigned to them.

f) There shall be an ongoing planned in service program embracing orientation to the facility and its policies, skill training and ongoing education to enable all personnel to perform their duties effectively. Written records of program content and personnel attending shall be kept.

Section 330.930 Personnel Policies

The personnel policies required in Section 330.760 and other personnel policies established by the facility shall be followed in the operation of the facility.

Section 330.1125 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 any life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:
2) "Life-sustaining treatment" means any medical treatment, procedure, or

ARDEN COURTS OF GENEVA | 0049619
Facility Name | I.D. Number

CONT.

intervention that, in the judgment 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 the airway, as indicated.

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-ustaining 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)2) decline consent to any or all of the life-sustaining treatments available at the facility.

d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modification must also be recorded in the medical record.

e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70].

g) The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act, or the Right of Conscience Act.

h) If no choice is made pursuant to subsection (c) of this Section, and in the absence of any physician's order to the contrary, then the facility's policy with respect to the provision of life-sustaining treatment shall control until and if such a decision is made by the resident, agent, or surrogate in accordance with the requirements of the Health Care Surrogate Act.

330.1720 Contents of Medical Records

c)2) A physician's order sheet that includes orders for all treatments, diet, activities and special procedures or orders required for the safety and well-being of the resident. The physician's order sheet shall also include a record of the medications prescribed for the resident by the physician, and a statement that the resident is capable of self-administering these medications.

ARDEN COURTS OF GENEVA | 0049619
Facility Name | I.D. Number

CONT.

Section 330.4240 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 requirements are not met as evidenced by:

Based on record review and interview the facility failed to follow facility policies related to dealing with an emergency situation, location of emergency information for a resident and staff qualifications in dealing with emergency situations which resulted in a delay in treatment for one resident (R4).

Findings include:

According to the nursing notes, on 3/20/09 at approximately 11:35pm, R4 was found by the caregiver, on the floor of her room unresponsive. The note further documents that the caregiver stated that she heard the resident call for help and when she entered the room she found the resident this way. The caregiver called the nurse who noted that the resident was unresponsive with a rapid pulse of 120-130 bpm and with cyanotic lips and finger tips. The blood pressure was unable to be obtained. At 11:40pm, "911" was called. The nurse Z1 failed to initiate CPR and in fact left the resident with significant change in condition to go to the door and make the phone call to the paramedics.

The following entry at 11:45pm documents that paramedics arrived and began CPR and started an IV (intravenous) line. Review of the documentation from the paramedic report shows that on their arrival at 11:47 pm, they found R4 in cardiac arrest with an estimated time of 10-15 minutes duration prior to arrival. No intervention had occurred prior to their arrival. R4 was described as being unresponsive with cyanosis around the nose and mouth and finger tips. On monitor, R4 was in asystole.

Z1 the nurse on the scene at the time and author of the nurses' notes was interviewed by phone. Z1 stated that she did not do CPR because she said that R4 still had respirations. She described them as very shallow and about 10 per minute and then decreasing to 7 per minute. Z1 then stated that she left the resident to go wait by the front door to let the paramedics into the building. When asked why she left the resident she said that R4 was still breathing and she thought that the caregiver was still with R4.

When asked if she was certified in CPR as her signed job description required, she said she was unsure, but thought she was at the time. She could not find her card, was not now certified, and her personnel file contained no certification. E1 and E2 confirmed that there was no other location in the facility records to find this information.

The paramedic report documents that when asked about DNR (do not resuscitate) status, staff were unsure and were unsure of the location of medical information. Their statement quoted

ARDEN COURTS OF GENEVA | 0049619
Facility Name | I.D. Number

CONT.

facility staff as saying "they think she's a DNR, but aren't sure and they couldn't find the paperwork." One of the paramedics went with the staff to find the proper information. No DNR was found once medical records were produced.

Paramedics continued to work on R4. They did CPR and Manual ventilations via Ambu bag through the transfer to cot, out to the ambulance, and all the way to the hospital. R4 was placed on life support at the hospital. After evaluation by the neurologist, R4 was found to have suffered anoxic encephalopathy and the determination was made to remove life support measures. R4 expired on 3/24/09.

The facility holds a sheltered care license and is required to monitor and assess their resident as well as provide emergency care prior to paramedic arrival. The facility failed to know DNR status, failed to have appropriately certified staff on duty as per the job description reviewed for Z1, and failed to provide emergency procedures and nursing care per Nurse Practice Act when R4 suffered a medical emergency when found cyanotic and unresponsive.

(A)