

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F 309	Continued From page 5 served R2 an unsupervised meal tray and staff delayed contacting 911 when R2 choked from food items from her meal tray. E1, Administrator, and E2, Director of Nursing were notified of the Immediate Jeopardy on 11-24-09 at 9:25a.m. FACILITY REMOVAL PLAN: 1. 9/26/09 - DON instructed staff that 911 in the event of an emergency. This should be done prior to calling physician and POA. 2. 9/27/09 Staff was interviewed regarding the circumstances of the resident 's choking 3. 9/28/09 Medical Director was contacted 4. 9/30/09 Nursing, Dietary and Housekeeping staff were given information about the importance of calling 911 in an emergency and of the person assigned to cover the halls during meals frequently check on any residents with room trays. 5. 9/30/09 The CAN and LPN involved in the situation were counseled by DON and written warning were issued 6. 11/20/09 A tray protocol was written 7. 11/24/09 A Protocol and Choke Risk Assessment were developed, residents that dine in their rooms were all assessed, and care plans updated.	F 309			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1030a)1) 300.1210a) 300.3240a) Section 300.610 Resident Care Policies	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	Continued From page 6 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	<p>Continued From page 7</p> <p>to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to supervise a resident dining and immediately contact 911 for 1 of 1 residents (R2). R2, who was care planned for supervised eating, was served a noon meal tray and left unattended for 30-35 minutes. When staff returned to R2's room they found her choking and did not contact 911 for over one hour. R2 died at the hospital that same day.</p> <p>Findings include:</p> <p>R2's Minimum Data Set (MDS), dated 9-13-09, documented that R2's cognition was severely impaired, limited assistance of one person physical assist with eating and drinking, and functional limitations in range of motion for neck, arm and hand.</p> <p>R2's Care Plan, dated 7-17-09, documented that R2 needed set up assistance and supervision with meals.</p> <p>E7, Licensed Practical Nurse (LPN), documented in R2's Nursing Notes, late entry dated 9-26-09,</p>	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	<p>Continued From page 8</p> <p>"R2 very lethargic at breakfast blood sugar checked and was 110. CNA (Certified Nursing Assistant) did remove eggs and toast from mouth before being taken to room." E7 stated, on 11/20/09, at 1:30p.m., that she did not see R2 until she assisted with R2's choking, at 1:00p.m.</p> <p>E6, Certified Nursing Assistant (CNA), stated, on 11-24-09 at 11:45a.m., that, on 9-26-09, she assisted R2 with breakfast. E6 also stated that R2's toast and eggs were not in R2's mouth. E6 stated R2 held her toast in her hand and that a small piece of egg was removed from her lip.</p> <p>E7 (LPN), stated on 11-24-09 at 12:10p.m., that her late entry Nursing Notes was correct in reference to eggs and toast being removed from R2's mouth at breakfast even though E7 could not accurately state the exact amount of toast and eggs removed from R2's mouth.</p> <p>R2's Nursing Notes, dated 9-26-09 at 1:00p.m., documented, "This nurse (E8, Licensed Practical Nurse (LPN)) was called to res (resident's) room. Res was in her recliner with half full lunch plate in front of her, her coloring was ashen, skin was cool to touch and resp (respirations) were labored and gurgally. VS (vital signs) 100/63, 101, 36, SPO2 (pulse ox) 52% on O2 (oxygen) at 3L/NC (3 liters per minute with nasal cannula). Increased O2 to 5L/NC. Sat res forward in chair and encouraged res to cough. Res was able to cough out pieces of boiled cabbage and mucous. When res became too tired to cough (time coughing is unknown), I began to suction her while another nurse went to call the MD (physician) and POA (Power of Attorney). When POA arrived she req (requested) that res be sent to ER (emergency room), ambulance was called</p>	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	<p>Continued From page 9</p> <p>at 2:00p.m.. Res was no longer responding when spoke to - pulse con't (continued) to be rapid and resp con't (continued) to be labored but not as noisy (noisy). Res left with ambulance at 2:20p.m."</p> <p>The Emergency Medical Services Report dated 9/26/09 indicated they received the call at 1356 (1:56p.m) and arrived at the facility at 1412 (2:12p.m.), left the facility at 1427 (2:27p.m), and arrived at the hospital at 1441 (2:41p.m.). When they arrived at the facility R2 was in serious respiratory distress and unresponsive; her pupils were fixed.</p> <p>E8 confirmed, on 11-21-09 at 2:00p.m., after she read her Nursing Note, that the Nursing Note, dated 9-26-09, accurately documented what had happened and the time it happened.</p> <p>E8 (LPN) stated, on 11-21-09 at 2:00p.m., "I came in at 10:00a.m. that day (9-26-09). I saw her (R2) with noon pills...administered between 11:30a.m. and 12:00pm. R2 woke up and spoke to me. I asked if she felt OK. She said 'Yes, I'm just tired' and took her meds." E8 also stated that on the way back from administering R2's medications she told E5, Certified Nursing Assistant (CNA), to hold R2's meal tray as R2 would fall asleep with food in her mouth after E5 told E8 that R2 had choked at breakfast.</p> <p>E5 (CNA) stated, on 11-19-09 at 2:20p.m., that, on 9-26-09, she assisted R2 to the dining room for breakfast and did not see R2 until lunch when R2 was asleep in her recliner. E5 stated E8 instructed her to hold R2's meal tray which she placed in the Sunroom and assisted other residents to dine. Later, E5 heard R2 repeatedly</p>	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	<p>Continued From page 10</p> <p>state "I got to pee" and entered R2's room with R2's meal tray. E5 stated that she positioned R2 for dining and left R2 with the meal tray. E5 returned to the Sunroom to assist other residents. E5 stated that staff, E4, was on hall duty and that E4 would go up and down halls to assist and monitor residents with hall trays. E5 stated that after 30-35 minutes, she heard R2's alarm ringing and entered R2's room. E5 stated that she and E4, Certified Nursing Assistant (CNA), pulled R2 forward. E4 removed food and slobber from R2's mouth. E8 was called to R2's room.</p> <p>E4 stated, on 11-20-09 at 10:30a.m., that she had not seen R2, on 9-26-09, until R2's alarm went off and she assisted E5.</p> <p>E3, Certified Nursing Assistant (CNA), stated, on 11-19-09 at 2:45p.m., that she had not seen R2 on 9-26-09 until she entered R2's room to assist E8 (LPN).</p> <p>E8 (LPN) stated, on 11-21-9 at 2:00p.m., that she had been in-serviced, after the 9/26/09 incident, on the difference between DNR (Do Not Resuscitate) and acute choking and that she "went through the MD (physician) route" (called physician first) and she should have called 911 right away.</p> <p>E2, Director of Nursing (DON), stated, on 11-20-09 at 9:05a.m., that R2 should not have been left alone with her tray and that staff had been given a warning. E2 also stated that E8 should have called 911 immediately when E8 assisted R2 and that staff, including E8, had been in-serviced.</p> <p>Z2, Physician, stated, on 11-20-09 at 10:05a.m.,</p>	F9999			

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

PRINTED: 04/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2009
NAME OF PROVIDER OR SUPPLIER BARRY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 PRATT STREET BARRY, IL 62312		
(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	
F9999	<p>Continued From page 11</p> <p>a concern that staff left R2 with her tray (meal) unsupervised and that anything past that outcome would not have changed.</p> <p>The facility's Disciplinary Action Report, dated 9-30-09, documented that E8 (LPN) was disciplined for not providing back blows to a choking resident and not contacting 911 immediately in an emergency situation.</p> <p>The facility's Disciplinary Action Report, dated 9-30-09, documented that E5 (CNA) was disciplined for not following nurses directions to not deliver R2's meal tray, for giving a meal tray to a resident at risk for choking and for not providing resident with 1:1 supervision.</p> <p>The facility's Supervision of Resident Nutrition policy and procedure, not dated, documented that residents needing assistance in eating must be promptly assisted upon being served.</p> <p>E1, Administrator, stated, on 11-20-09 at 10:50a.m., that a Hall Tray Protocol had not been written until after R2's choking on 9-26-09. The Hall Tray Protocol documented, all residents receiving a hall tray are to be supervised by either 2 CNA'S (Certified Nursing Assistants) or Nurses's assigned to circulate and assist at all times while residents are eating.</p> <p>According to the hospital Admission Note/Clinical Resume, dated 9/29/09, E2 expired on 9/26/09, with the discharge diagnosis: 1)Aspiration pneumonia 2)Senile Dementia 3)Atrial Fibrillation 4)Hypertension 5)Type 2 diabetes 6)History of chronic obstructive pulmonary disease.</p> <p>(A)</p>	F9999			