STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. BUILDING _____ B. WING _____	C 11/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEWANEE CARE HOME	144 JUNIOR AVENUE KEWANEE, IL 61443

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F 309	Continued From page 11 and Food Service personnel. This form contained staff signatures to verify attendance.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030a)1)2) 300.1035a) 300.1210a) 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). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). Section 300.1035 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. 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	F9999		

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F9999	Continued From page 12	F9999		

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 to each resident to meet the total nursing and personal care needs of the resident.

These Regulations wer not met as evidenced by:

Based on record review and interview, the facility failed to provide physician ordered Cardio-Pulmonary Resuscitation (CPR) to one of one resident who had a full code order and was found non-responsive, without heart beat or breathing, (R5). R5 subsequently died.

Findings include:

On 10/26/09 at 11:20 A.M., a list of the last three months of discharged residents with disposition of resident at time of discharge was provided by E1, Administrator. R5 was listed as being discharged due to "EX." E1, Administrator verbally confirmed that "EX" was the facility abbreviation for "expired."

On 10/27/09 at 8:18 A.M., E1 stated that R5 was the only resident in the facility who had expired and was "Full Code" in the past three months. E1 clarified that a "Full Code" was an indication that there was a physician order to provide Cardio-Pulmonary Resuscitation (CPR) if a resident was found non-responsive, without a pulse and/or not breathing.

R5's "Resident Admission Information" sheet dated 09/16/09 indicated R5's "CODE STATUS: FULL CODE." R5's "Record of Death" form indicated that R5's date of death was 09/20/09 at

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F9999	Continued From page 13 12:50 A.M. R5's "Physician's Orders" sheets dated from: 09/16/09 to 09/30/09 indicated that under the section titled "Code Status" there is, hand-written, the word "FULL." R5's "Nurse's Notes" dated 09/20/09 at 12:50 A.M. indicated that, "CNA (Certified Nurses Aide) called this nurse into res (resident's) room. Res had (zero) pulse, (zero) B/P (blood pressure), lips bluish. Res family notified and came out to facility, Administrator all made aware." This note was signed by E5, Licensed Practical Nurse (LPN). There is no other nurse's note indicating any further description or action taken at time of R5's death, 09/20/09 at 12:50 A.M. On 10/27/09 at 8:27 A.M., E1, Administrator, upon being questioned whether residents who expire in facility have incident reports made out, stated, "No." When E1 was informed that R5's record review indicated that R5 was a "Full Code" but the "Nurse's Note" written by E5 had no indication that CPR had been given, and whether that would constitute or trigger a need for an incident report by facility policy, E1 asked if the rest of the questioning would be in regards to R5. When E1 was informed that some questions would be directly in regards to R5's death on 09/20/09, E1 asked whether E1 could have some other staff present as witnesses. E1 left and returned with E2, Director of Nurses (DON), E4, Administrator Mentor, E6, Regional Corporate Director, and E8, Care Plan/ Minimum Data Set (MDS) Coordinator. When it was re-iterated to E1, and all others present, that R5's record review indicated that R5 was a "Full Code" but the 09/20/09 at 12:50 A.M. "Nurse's Note" written by E5, LPN, had no indication that CPR had been given, and whether that would constitute or	F9999		

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F9999	Continued From page 14	F9999		

trigger a need for an incident report by facility policy, E1 stated "Yes," and indicated that a facility investigation of R5's death had been completed. E1 replied "No" when directly asked if CPR had been provided to R5 when found non-responsive, without pulse or breath on 09/20/09 at 12:50 A.M. After a copy of the facility investigation on R5's death was requested, provided by E1 and briefly reviewed, E1 confirmed that the CNA who first found R5 non-responsive was E7, and the other CNA involved was E14.

On the same date as noted in previous paragraph, at 8:45 A.M. while E1's interview was still in progress, E6, Regional Corporate Director, stated that facility's CNA's, by facility policy, do not initiate CPR. CNA's have to notify nursing and the nurse is responsible to determine resident's code status, assess resident and initiate CPR if indicated or direct a CPR certified staff to start CPR.

Facility policy titled "Upon finding a non-responsive resident," provided by E1 upon request made after 10/27/09 interview at 8:27 A.M., indicates that the staff person who discovers the non-responsive resident is to remain with the resident "if at all possible while signaling for help," "summon the nurse," "Get the chart for the nurse to review," and "The nurse will review the code status and designate whether to start CPR."

On 10/27/09 at 1:28 P.M., E14, CNA, stated that E14 was called by E7, CNA, from R5's room the night R5 died on 09/20/09. E14 stated she informed E5, LPN, who was R5's nurse, that R5 was non-responsive. E14 stated that, "(E5) said

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F9999	Continued From page 15	F9999		

(E5) couldn't find a Full Code or DNR in (R5's) chart so (R5) must be DNR (Do Not Resuscitate)." E14 added that no CPR was started on R5. E14 further stated that E14, "didn't find out (R5) was a Full Code till two days later when my supervisor called me in for an interview...I was very surprised when (R5) expired, he had been very responsive and his usual self at the last check I did a little after ten P.M."

On 10/28/09 at 8:40 A.M., E7, CNA, stated that on the day of R5's death, 09/20/09, E7 had gone into R5's room "for a bed check and (R5) wasn't showing any vital signs (pulse, respirations, temperature, blood pressure). (E5) came in and checked for (R5's) blood pressure and pulse and there wasn't none. (E5) stated she had checked (R5's) chart and said (R5) was a DNR." E7 verbally confirmed that CPR was not given to R5 and both E7 and E14 proceeded to clean and prepare R5's body for funeral home pick-up.

On 10/27/09 at 9:40 A.M., phone contact was attempted to E5, LPN, who had been the nurse on duty and had written last entry for R5 on 09/20/09 at 12:50 A.M. There was no answer and a message was left identifying need for R5 to return call. On 10/27/09 at 1:39 P.M. another phone contact was attempted to E5 and a man answered the phone and stated E5 was not home at that time. A message was given to this man asking that E5 return call. On 11/02/09 at 9:37 A.M. another phone contact was attempted with E5 and an automated message was received stating, "This phone number is no longer in service or has been disconnected."

On 10/27/09 at 10:24 A.M., E13, Social Services

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F9999	Continued From page 16	F9999		

Director, stated that E13 had worked for facility since 2006. E13 stated, "I do the DNR sheets. It's the first page in the (residents') chart. It's bright orange. The DNR sheet is the first page in the chart, otherwise they're (residents) a full code and it says so on my documentation and POS (Physician's Orders) sheets and the admit face sheet, too." E13 added that, "There's been a QA (Quality Assurance) meeting about CPR/DNR topics and issues. I'm on the QA Committee and this incident (R5's death) was reviewed and recommendations were made to follow-up with full house re-education so this kind of thing won't ever happen again."

On 10/28/09 at 11:17 A.M. E13, during further interviewing, asked if this interview would be in regards to R5 and requested E1, Administrator to be present. When E1 arrived, E13 stated that both R5 and R5's spouse were present during admission process. E13 explained that E13 directly asked R5, "If you (R5) were found not breathing or had no heartbeat, do you want someone to push on your chest and try to revive you? (R5) told me (E13), 'Absolutely,' looking directly at (spouse) who agreed saying, 'Yes.'" E13 further elaborated that E13 very clearly remembered this occurring and that full code status, as requested by R5, then was written into E13's Social Service notes for R5, was communicated to the admitting nurse and placed on (residents') admitting face sheet. " I (E13) know I wrote it, I have no doubts whatsoever." E13's statements correspond with what was found regarding R5 being a "full code" when R5's medical record was reviewed on 10/26/09 at 1:00 P.M. On 10/28/09 at 11:42 A.M., R5's admit social services note was found in a "to be filed pile," per E1. R5's admit social service note dated

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F9999	Continued From page 17 09/16/09 indicates that R5 was a "full code, as per (R5's) request," and signed by E13. On 11/02/09 at 2:19 P.M. E16, LPN, stated that E16 was the nurse who had admitted R5 on 09/16/09. E16 stated that R5 had come from the hospital where R5 had been under treatment for pneumonia. E16 verbally agreed that E13, Social Service Director, had spoken to the spouse of R5 and R5's spouse had stated they (R5 and R5's spouse) did not want a DNR (Do Not Resuscitate), "they wanted a full code." E16 stated she had been informed of this from E13 on R5's admission date. R5 was admitted to facility on 09/16/09 according to"Resident Admission Information" sheet dated 09/16/09. According to this same form, R5 was a 90 year old male. R5's "Physician's Orders" dated 09/16/09 through 09/30/09 indicate that R5 had diagnoses that included: Pneumonia, Diabetes Mellitus, Congestive Heart Failure, Chronic Kidney disease, and Coronary Artery disease secondary to a Myocardial Incident (heart attack). R5's Nurse's Notes indicate that the last written nursing entry on R5 before 12:50 A.M. entry of R5 being non-responsive was on 09/19/09 at 11:30 P.M. (one hour and 20 minutes previous). Facility's investigation report, titled, "Resident Investigation, September 20, 2009" indicates that on 09/21/09, while E8, Care Plan/ MDS Coordinator, was reviewing R5's "chart noticed that (R5) was a full code and no CPR was started." E8 notified E1, Administrator. This document also indicates that E5, LPN, "was in charge of (R5) at time of death." This same document indicates that on 10/02/09 E5, LPN,	F9999		

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F9999	Continued From page 18 was interviewed by E1 and E8. "(E5) stated (E5) did not find an advanced directive (in R5's chart) so assumed (R5) was a DNR... (E5) was disciplined with termination for failing to follow facility procedure regarding advanced directives." A "Notice of Termination" form included in this facility's investigation of R5's death indicated under the section "Severity of Consequences Warrant Immediate Discharge. Explain:" that "(E5) did not perform CPR on a full code resident (R5)." A copy of E5's current CPR card included in this facility report indicated that E5 had successfully completed the CPR and AED (Automatic External Defibrillator) course provided by the American Heart Association and E5 was certified to provide CPR through July, 2010. (A)	F9999		