PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	COMPLETED		
		14G137	B. WIN	NG			4/ 2011
OUR PLA	ROVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE D1 NORTH 13TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	W	000			
	INCIDENT REPO	RT INVESTIGATION					
W 318	INCIDENT OF 08/0 483.460 HEALTH		w:	318			12/1/11
	The facility must en services requirement	nsure that specific health care ents are met.					
	Based on interview failed to implement	is not met as evidenced by: v and record review, the facility t policy and procedures ng measures as evidenced by:					
	Pulmonary Resusthe sample (R1) af was unresponsive	f failed to start CPR (Cardio citation) for 1 of 1 individual in ter discovering that she (R1) and was not breathing while on 08/06/11 at 3:50 A.M.;					
	retrained regarding the 08/06/11 incide	ure to ensure that all staff were glife sustaining measures after ent, affecting 15 of 15 acility (R2 - R16); and					
	staff are capable o individual from the CPR when working individuals of the fa	ure to ensure that third shift f transferring an unresponsive bed to the floor to perform g alone, affecting 15 of 15 acility who do not have "Do Not s (R2-R16). These failures ediate Jeopardy.					
	Findings include:						
	On 10/20/11 at 1:0	0 PM, an Immediate Jeopardy					
_ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

i ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G137	B. WIN	1G _			C 4/2011
OUR PLA	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET MURPHYSBORO, IL 62966	1170-	7/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 318	staff of the facility for at 3:50 A.M. Staff of R1 was breathing a not transfer R1 to the facility's training sustaining treatment the facility's policy at American Heart Ass R1 was pronounced (Z1) at 4:20 A.M. or certificate with an ist that the immediate Arrest. R1 was not nor did she have "Duthe time of her deat facility did not retrait transferring an unrebed to the floor to put the time of her deat facility did not retrait transferring an unrebed to the floor to put the time of her deat facility did not retrait transferring an unrebed to the floor to put the time of her deat facility did not retrait transferring an unrebed to the floor to put the time of her deat facility did not retrait transferring an unrebed to the floor to put the time of her deat facility did not retrait transferring an unrebed to the floor to put the facility did not retrait transferring an unrebed to the floor to put the facility did not retrait transferring and unrebed to the floor to put the facility did not retrait transferring and unrebed to the floor to put the facility did not retrait transferring and unrebed to the floor to put the facility did not retrait transferring and unrebed to the floor to put the floo	we begun on 08/06/11 when bund R1 in bed, unresponsive did not check to ensure that and/or had a pulse. Staff did ne floor from the bed as per on CPR to provide life at. CPR was not started as per and as recommended by the sociation Guidelines for 2010. If at the facility by the Coroner of 08/06/11. Her death as use of death was Cardiac receiving Hospice Services, so No Resuscitate" orders at th. After this incident, the in staff on CPR and/or esponsive individual from the rovide life sustaining and dual from the bed to the floor en working alone. E1 (RSD-Resident Services ediate Jeopardy on 10/20/11 at	W	318			
W 331	W331 - The facility nursing services in 483.460(c) NURSIN	must provide clients with accordance with their needs.	w	331			12/1/11
		ovide clients with nursing nce with their needs.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRU	CTION	(X3) DATE SURVEY COMPLETED	
							С
		14G137	B. WING	·		11/04	4/2011
OUR PLA	ROVIDER OR SUPPLIER		:	301 NORTH 13	S, CITY, STATE, ZIP CODE TH STREET DRO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHO REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	Based on interview failed to implement governing life savin 1) Direct Care staff Pulmonary Resuscithe sample (R1) aft was unresponsive a doing bed checks of the facility's failure trained regarding the 08/06/11 incider individuals of the facility's failustaff are capable of individual from the ICPR when working individuals of the faceuscitate" orders resulted in an Immediate include: On 10/20/11 at 1:00 was identified to has staff of the facility foat 3:50 A.M. Staff of R1 was breathing a not transfer R1 to the facility's training sustaining treatment the facility's policy are supplied in the facility's policy are supplied in the saving sustaining treatment the facility's policy are supplied in the saving sustaining treatment in the facility's policy are supplied in the saving sustaining treatment in the facility's policy are supplied in the saving sustaining treatment in the facility's policy are supplied in the saving sustaining treatment in t	s not met as evidenced by: and record review, the facility policy and procedures g measures as evidenced by: failed to start CPR (Cardio citation) for 1 of 1 individual in er discovering that she (R1) and was not breathing while on 08/06/11; are to ensure that all staff were life sustaining measures after int, affecting 15 of 15 cility (R2 - R16); and are to ensure that third shift transferring an unresponsive bed to the floor to perform alone, affecting 15 of 15 cility who do not have "Do Not s (R2-R16). These failures ediate Jeopardy. D PM, an Immediate Jeopardy ve begun on 08/06/11 when bund R1 in bed, unresponsive did not check to ensure that and/or had a pulse. Staff did the floor from the bed as per and on CPR to provide life and on the commended by the	W 3:	31			
	R1 was pronounced	sociation Guidelines for 2010. d at the facility by the Coroner n 08/06/11. Her death					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(3
		14G137	B. WIN	G		11/04	4/2011
OUR PLA	ROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE D1 NORTH 13TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	that the immediate Arrest. R1 was not nor did she have "D the time of her deaf facility did not retrait transferring an unrebed to the floor to p treatment. The fact third shift staff are curresponsive indivito perform CPR wh (Administrator), E2 Director) and E3 (Enotified of the Immed 1:08 P.M. The facility's undate Services: Life Sustathe policy of the fact treatment in any mesustaining treatment cardiopulmonary relatively in the policy of the medical performent of Publimemo states, "This fax is to report facility. R1 is a 49 y P***e (name of the functioned in the probetween 3:30 A.M. discovery, R1 passic checks according to of every 30 minutes in functioning, health	ge 3 ssue date of 08/17/11 identifies cause of death was Cardiac receiving Hospice Services, to No Resuscitate" orders at the After this incident, the notation that safe on CPR and/or esponsive individual from the provide life sustaining ility also has not ensured that capable of transferring an dual from the bed to the floor en working alone. E1 (RSD-Resident Services ediate Jeopardy on 10/20/11 at	W 3	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G137	B. WIN	IG			C 4/2011
OUR PL	PROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 1 NORTH 13TH STREET URPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	The facility's Inservidentifies that staff of training on this date (an) Unresponsive content of this inservice. "CPR Steps - Wher unresponsive - run co-worker to do this The person must be or in a chair or sofa Move the feet first a floor- protecting the the sheet under the of the bed and lower head." This inservice CPR steps to be us lowered to the floor. The facility's Incider regarding R1's dear staff (E4) did not in transferring an unreto the floor, nor did incident report state. "Facts: Shift began for above resident (minute basis. R1's used the toilet at 2 cleaned up the floor a bed check. (At be head light and look movement, signs or snoring.) At 2 AM c	the Deputy Coroner (Z1)" ice records dated 01/07/11 of the facility participated in e for, "CPR and Transfer of Body". Further review of the rvice report identifies, n you find a person and call 911 or tell a s Go back to the person. e on a firm surface. If in a bed n move them to the floor. and then the shoulders to the head. In bed you can drag m to move them to the edge er to the floor, protecting the ce record goes on to describe ed once the individual is ont Report dated 08/06/11 th identifies that direct care inplement trained skills for esponsive body from the bed she perform CPR. This	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		14G137	B. WI	NG			C 4/2011
OUR PLA	ROVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET IURPHYSBORO, IL 62966	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	turned on. At 3:00 A bed, moved when licheck - R1 was the side, breathing. At 3:50 AM - R3 go proceeded to men's on that end. Return began with R1 and the light and stood the room for a long I walked up to the side, facing out tow She was under the and her lips were sland her thigh and crespond. She looke and called 911. The mouth. The firs (Z2). He came in a confirmed he though there was nothing I paramedics arrived was gone. The cor supervisor (E2) to ratiol me (E4) she (E4 (Direct Care Sta 10/20/11 at 11:10 A at the facility since a trained in CPR. Who name. She didn't logot no response. I check her mouth." the facility's policy for do CPR on the flexible control of the side of the side of the facility of the side of the side of the flexible of the side of the	bed, moved when light was all check - same - R1 was in ght was turned on. At 3:30 AM same, lying slightly on her tup to smoke. I (E4) send to complete bed checks hed to women's end and R2's room. I (E4) turned on in the door way. I looked in time. R1 did not seem "right" led. R1 was laying on her left ard the center of the room. covers. R1's face was pale ightly blue. I touched her arm alled her name. She did not led gone. I went to (the) office to operator told me to check the responder arrived, Officer and looked at R1 and the she was gone. He said could have done. The and they confirmed that R1 oner was called. I called my notify her of the situation. She and they confirmed that R1 oner was called. I called my notify her of the situation. She and they confirmed that R1 oner was on her way." Iff) was interviewed on was interviewed on and stated, "I have worked April of 2010 and have been en I found R1, I called her look alive. I touched her and I called 911 and they told me to When E4 was asked what is or CPR, she stated, "We are not if they are in bed." When et did CPR on R1 on 08/06/11,	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G137	B. WI	NG			C 4/2011
OUR PLA	ROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET URPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	she was too heavy bed." During this in has not received fu transferring an unrebed to the floor after bed on 08/06/11. In reviewing the stafacility's Resident D 08/06/11, the Residual statement dated 08 passing of R1, I revensure that all were lt was concluded the In-Service training to 01/07/2011 included current staff. I feel Support Person) stace CPR and First Aid. conducted the CPR included primarily the unresponsive body. E2 (RSD) was inter A.M. and stated, "W (08/06/11), I told he When E2 was aske R1, E2 stated, "No" and or any other staretrained since 08/0 individuals from bed alone at nights with the facility, she state asked if R1 was Ho Do Not Resuscitate	o, I couldn't do CPR because and I couldn't pull her off the aterview, E4 stated that she of the training in CPR and or esponsive individual from the er finding R1 unresponsive in tements contained within the reath Investigation dated lential Services Director's (E2) /06/11 states, "Due to the riewed all employee files to ecurrent in CPR and First Aid. at they were. Also the that was completed on as the staff on duty (E4) and that all current DSP (Direct aff are adequately trained in (E5) (prior) Administrator and First Aid training, which the Transfer of (an) I viewed on 10/20/11 at 11:30 when E4 called me that day or she needed to do CPR." I dif E4 had performed CPR on when E2 was asked if E4 aff of the facility had been 16/11 on CPR and transferring to the floor when working the other fifteen individuals of ed, "No." When E2 was aspice and/or had orders for	W:	331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTI LDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G137	B. WI	1G _		11/04	C 4/2011
NAME OF F	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET MURPHYSBORO, IL 62966	11/0-	7/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	midnight shifts for conterview, E3 stated the facility had only midnight shift. Whe had been retrained E1(Administer), E2 Director) all stated, asked if staff had been transferring and the bed to the floor with the other fiftee E1(Administer), E2 Director) all stated, The Medical Certific date of 08/17/11 ideo fage at the time opronounced at the fa:20 A.M. on 08/06, that the immediate result of, "CARDIAC receiving Hospice is No Resuscitate" or The facility's investive regarding R1's dear (E4) did not complet unresponsive in beat 3:50 AM. This investive address any type of corrective action tall staff on CPR and/of individual from the facility. These fall mmediate Jeopard	//11 we placed two staff on one month." During this at that as of this date (10/20/11) one staff working alone on the en the surveyor asked if staff on CPR since 08/06/11, (RSD) and E3 (Executive "No." When the surveyor een retrained since 08/06/11 in responsive individual from when working alone at nights in individuals of the facility, (RSD) and E3 (Executive "No." Cate of Death with an issue entifies that R1 was 49 years f her death. R1 was facility by the Coroner (Z1) at (11. This certificate identifies cause of her death was a CARREST." R1 was not dervices, nor did she have "Do ders at the time of her death. gation dated 08/06/11 at stigation dated 08/06/11 at stigation also does not frecommendations and or ken by the facility in retraining in transferring an unresponsive oved to the floor when working the other fifteen individuals of ailures resulted in an	W	331			

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING		COMPLETED	
		14G137	B. WING _		C 11/04/2011	
NAME OF P	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH 13TH STREET MURPHYSBORO, IL 62966	11/04/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION	
W 331	on 10/20/11 at 1:08 The Immediate Jeo 11/03/11 at 1:25 P.I an acceptable plan 1) The facility will er on the Life Sustaining staff will complete Conon responsive untives. Staff have acknowledging this this policy will be incorrentation on an or Administrator (E1) wan ongoing basis. 2) The facility will er retrained in CPR to unresponsive individe initiate CPR and the 10/23/11. This trainemployee's orientate Administrator (E1) wan ongoing basis. Although the Immediate 10/20 per	ed of the Immediate Jeopardy P.M. pardy was removed on M. when the facility submitted which includes: sure that all staff are trained ng Measures Policy and that CPR on any individual found I emergency medical services signed a statement policy by 10/23/11. Training of cluded in new employee's	W 331			
W9999	FINAL OBSERVAT		W9999			
	LICENSURE VIOL	ATIONS				
	350.620a) 350.1210					

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	— с	
		14G137	B. WING _		11/04	4/2011
OUR PLA	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa 350.1230d)2)3) 350.1235a) 350.3240a) Section 350.620 Re	ge 9 esident Care Policies	W9999			
	procedures governi facility which shall be involvement of the a shall be available to public. These writte	have written policies and ng all services provided by the performulated with the administrator. The policies of the staff, residents and the n policies shall be followed in a y and shall be reviewed at				
		lealth Services ovide all services necessary to lent in good physical health.				
	Section 350.1230 N	Iursing Services				
	are not limited to, the 2) Basic skills required and problems of the	red to meet the health needs				
	Section 350.1235 L	ife-Sustaining Treatments				
	to make decisions r	Il respect the residents' right relating to their own medical the right to accept, reject, or treatment.				
	Section 350.3240 A	buse and Neglect				
	a) An owner, licens	ee, administrator, employee or				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		14G137	B. WIN	NG _			C 4/ 2011
NAME OF P	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH 13TH STREET MURPHYSBORO, IL 62966	11/0-	7/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
W9999	agent of a facility shresident. (Section 2) These Regulations by: Based on interview failed to implement governing life saving. 1) Direct Care staff Pulmonary Resuson the sample (R1) aftewas unresponsive adoing bed checks of the facility's failure retrained regarding the 08/06/11 incider individuals of the factor of individuals of i	and record review, the facility policy and procedures g measures as evidenced by: failed to start CPR (Cardio citation) for 1 of 1 individual in er discovering that she (R1) and was not breathing while in 08/06/11; are to ensure that all staff were life sustaining measures after nt, affecting 15 of 15 cility (R2 - R16); and are to ensure that third shift transferring an unresponsive ped to the floor to perform alone, affecting 15 of 15 cility who do not have "Do Not	W98	999			

Facility ID: IL6007017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		14G137	B. WIN	۱G _		11/04	C 4/ 2011
NAME OF F	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH 13TH STREET MURPHYSBORO, IL 62966	11/0	72011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	memo states, "This fax is to repor facility. R1 is a 49 y P***e (name of the functioned in the probetween 3:30 A.M. discovery, R1 passe checks according to of every 30 minutes in functioning, healt to this incident. Ca receipt of report by The facility's Inservidentify that staff of training on this date (an) Unresponsive content of this inservice. "CPR Steps - When unresponsive - run co-worker to do this The person must be or in a chair or sofa Move the feet first a floor- protecting the the sheet under the of the bed and lower head." This inservice CPR steps to be us lowered to the floor The facility's Incider regarding R1's deal staff (E4) did not im	t the death of a resident of this year old lady who lived at O*r facility) for 10 years. She ofound level (On) 08/06/11 bed check and 3:50 AM ed away. (Staff completed bed of the recommended schedule st.) R1 had no noted changes the status, etc immediately prior use of death is pending the Deputy Coroner (Z1)" Ince records dated 01/07/11 the facility participated in e for, "CPR and Transfer of Body." Further review of the roice report identifies, and you find a person and call 911 or tell a status. Go back to the person. The on a firm surface. If in a bed a move them to the floor. The floor is and then the shoulders to the head. In bed you can drag m to move them to the edge are to the floor, protecting the ce record goes on to describe ed once the individual is	W98	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	14G137		B. WING			C 11/04/2011	
NAME OF PROVIDER OR SUPPLIER OUR PLACE				3	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH 13TH STREET MURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD B		ULD BE	(X5) COMPLETION DATE
W9999	to the floor, nor did incident report state "Facts: Shift began for above resident (minute basis. R1's used the toilet at 2 cleaned up the floor a bed check. (At be head light and look movement, signs of snoring.) At 2 AM c covers as she norm - same - R1 was in turned on. At 3:00 A bed, moved when licheck - R1 was the side, breathing. At 3:50 AM - R3 go proceeded to men's on that end. Return began with R1 and the light and stood if the room for a long I walked up to the bide, facing out tow She was under the and her lips were sland her thigh and c respond. She looked and called 911. The her mouth. The first (Z2). He came in a confirmed he thoughtere was nothing I paramedics arrived	she perform CPR. This	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C 11/04/2011	
	14G137		B. WI	NG _			
NAME OF PROVIDER OR SUPPLIER OUR PLACE				3	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH 13TH STREET MURPHYSBORO, IL 62966		-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
W9999	supervisor (E2) to r told me (E4) she (E E4 (Direct Care Sta 10/20/11 at 11:10 A at the facility since a trained in CPR. Wh name. She didn't logot no response. I check her mouth." the facility's policy for to do CPR on the fleet was asked if she she (E4) stated, "No she was too heavy bed." During this in has not received fur transferring an unrebed to the floor after bed on 08/06/11. In reviewing the sta facility's Resident D 08/06/11, the Resid statement dated 08 passing of R1, I revensure that all were It was concluded th In-Service training to 01/07/2011 includes current staff. I feel Support Person) sta CPR and First Aid. conducted the CPR included primarily thurresponsive body.	anotify her of the situation. She 2) was on her way." Iff) was interviewed on and stated, "I have worked April of 2010 and have been en I found R1, I called her took alive. I touched her and I called 911 and they told me to When E4 was asked what is or CPR, she stated, "We are cor if they are in bed." When e did CPR on R1 on 08/06/11, o, I couldn't do CPR because and I couldn't pull her off the atterview, E4 stated that she of the training in CPR and or esponsive individual from the reath Investigation dated dential Services Director's (E2) 1/06/11 states, "Due to the diewed all employee files to be current in CPR and First Aid. They were also the hat was completed on the staff on duty (E4) and that all current DSP (Direct aff are adequately trained in (E5) (prior) Administrator and First Aid training, which the Transfer of (an)	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 11/04/2011	
	14G137		B. WII	NG _			
NAME OF PROVIDER OR SUPPLIER OUR PLACE				3	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 13TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	A.M. and stated, "W (08/06/11), I told he When E2 was aske CPR on R1, E2 star asked whether E4 a facility had been ref and transferring ind when working alone fifteen individuals of When E2 was asked had orders for Do N "No." On 10/20/11 at 1:08 stated, "After 08/06 midnight shifts for cointerview, E3 stated the facility had only midnight shift. When had been retrained E1(Administer), E2 Director) all stated, asked if staff had been transferring and the bed to the floor with the other fiftee E1(Administer), E2 Director) all stated, The Medical Certific date of 08/17/11 ideof age at the time of pronounced at the face of 08/17/11 ideof age at the time of pronounced at the face in the immediate result of, "CARDIAC receiving Hospice is stated."	When E4 called me that day or she needed to do CPR." It whether E4 had performed ted, "No." When E2 was and/or any other staff of the trained since 08/06/11 on CPR dividuals from bed to the floor of at nights with the other of the facility, she stated, "No." of if R1 was Hospice and/or lot Resuscitate, she stated, B P.M. E3 (Executive Director) one month." During this one month." During this one staff working alone on the enthe surveyor asked if staff on CPR since 08/06/11, (RSD) and E3 (Executive "No." When the surveyor een retrained since 08/06/11 in responsive individual from when working alone at nights in individuals of the facility, (RSD) and E3 (Executive (RSD)	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
14G137			B. WII			C 11/04/2011	
NAME OF PROVIDER OR SUPPLIER OUR PLACE				30	EET ADDRESS, CITY, STATE, ZIP CODE D1 NORTH 13TH STREET IURPHYSBORO, IL 62966	,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	The facility's investi regarding R1's dear (E4) did not comple unresponsive in bed 3:50 AM. This inveaddress any type of corrective action tall staff on CPR and/o individual from the line.	ge 15 gation dated 08/06/11 th does not identify that staff the CPR after finding R1 d the morning of 08/06/11 at stigation also does not f recommendations and or ken by the facility in retraining r transferring an unresponsive bed to the floor when working the other fifteen individuals of (A)	W9	999			