STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING _____ B. WING _____	C 12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVILLE HEALTHCARE & REHAB	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.610c)2) 300.1210b) 300.1210d)2) 300.3240a) Section 300.610 Resident Care Policies 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. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 8 Nursing and Personal Care b) The facility shall 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 resident care plan. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to follow it's policy to call a Code Blue and call for 911 Emergency Services for 1 of 3 residents (R2) reviewed for emergency care in the sample of 3. This failure resulted in the facility not adequately providing Cardio Pulmonary Resuscitation (CPR), and R2 being pronounced expired.	F9999		

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F9999	Continued From page 9 Findings include: A review of R2's Admission Record dated 9/21/11, documented the following diagnoses in part; Unspecified Cardiovascular Disease, Unspecified Essential Hypertension, Diabetes without complications, Acute/unspecified Cerebral Vascular Disease, and Unspecified Hemiplegia. The Admission Record documents "Advanced Directive - Full Code". R2's nurses notes dated 11/9/12, by E4, Licensed Practical Nurse (LPN), documented; 11/3/12, at 5:52 AM, resident was noted unresponsive with color pale, lips and finger tips were blue, lying on her back with her mouth open. CPR was started with no return pulse or heartbeat. A second nurse confirmed absence of pulse, resident was expired. Z1, Physician of R2, and Coroner and Funeral Home were notified. Call placed to Director of Nursing to make her aware. On 11/29/12 at 11:30 AM, in a phone interview with E5, Certified Nurses Aide, she stated, "On 11/3/12, R2 was fine all night. I saw her at 2:00 AM and 4:00 AM on rounds, we changed her. R2 was alert and could talk to you. The nurses were in there around 5:00 AM, and I heard the resident talking to E6, LPN, when she was doing accuchecks. Some time between 5:30 AM and 5:40 AM, I went to R2's room to get her up and called her name twice, but she did not respond. I walked over to R2's bed and touched her hand and arm because she looked asleep. She had her eyes closed, and her lips were slightly open, and she was still warm to touch. She did not respond so I went and told E4, LPN. E4 came down to the room, she did not ask me to get the	F9999		

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crash cart, and I don't know what happened after that because I went on to get the other residents up for the day. I think E4 went to get the other nurse. I don't think 911 was called. Later E4 told me she did try CPR, but R2 was gone."

On 11/29/12 at 12:27 PM, in a phone interview E4, LPN, she stated " I saw R2 alive at about 5:10 AM, when I was passing medications. She was alert, spoke to me and did not have any complaints of feeling ill. I think around 5:40 or so, E5 came and told me that R2 looked like she had passed. I was passing medications, and went down to R2's room to check her. At 5:52 AM, R2 was lying on the bed with her mouth slightly open, and her lips were bluish. I pulled back the bed covers and R2's finger tips were bluish and felt cool to touch. I felt her carotid and did not find a pulse, I tried to listen for a breath with my ear, and I listened to R2's heart with my ear also, but did not hear any thing. I thought R2 looked like she had been dead long enough if we tried CPR, she probably wouldn't come back.
E5 had left the room, but I thought I should try CPR, and did it by myself. I think after 15 minutes or so I stopped. I did not call for the crash cart or call anyone to help with CPR. I think now, I was wrong not to call 911, but I did not know R2 was a Full Code when I first got there. I probably should have called 911 first, or asked someone else to call 911 while I did CPR. I'm not sure what the facility policy is for 911. I had E6, LPN, verify R2 was dead, then I called the doctor and told him she had passed, and then I called the coroner, funeral home, and family."

On 11/29/12 at 1:15 PM, in a phone interview with E6, she stated "On 11/3/12 at 5:05 AM, I saw R2,

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and she was fine, alert and talking. I know E4, saw her shortly after me because she was passing medications that morning behind me on the hall, and they were talking. I went on to the other side of the building to do my work, and returned at 6:15 AM. At that time E4 told me that R2 had passed away around 5:53 AM. E4 said she had tried CPR but was not successful. E4 said she had not called 911 because wasn't sure if R2 was a Full Code or not, and R2 was already gone. E4 said she had already called Z1 and the coroner. I was surprised that E4 didn't call 911, especially since we had just seen R2 alive about 30 minutes earlier. I told E4 to call the DON and ask if we needed to call 911 or what else if anything E4 needed to do. I wish E4 would have called for help or called a Code Blue, but she didn't. I did not confirm R2's death until 6:15 AM, after E4 had called Z1 and the coroner.

On 11/29/12 at 1:35 PM, Z2, Coroner's assistant, verified that the Coroners office had been called on 11/3/12 at 6:07 AM, and informed of R2's death. Z2 stated that the coroner did not come out to verify the death.

On 11/29/12 at 1:52 PM, Z1, Physician of R2, stated "I signed the death certificate, and noted the cause of death as "Sudden Death". I was called early in the morning, not sure of time, on 11/3/12 and informed of R2's death. I asked E4, what had been done for R2, and she told me "she did not do anything for her". I asked E4, Did you try CPR, and she told me no she did not. I asked E4 if R2 was a Full Code or a DNR, and E4 told "I do not know". I told E4 she had to check the resident's chart immediately and find out what her code status was and do what is necessary, that

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is, call 911 if full code, or call the coroner if a DNR. I did not know if R2 was a full code or not, but upon finding her unresponsive, I would expect the nurse to immediately check the chart and find out. Any resident found unresponsive, I would expect the nurse would call 911 and try to revive as long as indicated in the facility policy. No one from the facility called back regarding R2's status, and I assumed everything was done according to policy.

On 11/30/12 a copy of R2's Death Certificate dated 11/3/12, documented; Cause of Death - 1. Sudden Death, 2. Hypertension. Approximate interval between onset and death, unknown.

On 11/30/12 at 11:20 AM, in a second interview with E4, she stated "I did not know R2 was a Full Code when I saw her, and I did not call a Code Blue. I did try CPR by myself but quit after 15 minutes as R2 looked like she would not come back. When I called Z1 he asked if I had done CPR and I told him I tried but was unsuccessful, then he told me to call the Coroner. No, Z1 didn't say anything else." The signs of death E4 described were that R2 had no palpable pulse, and no respirations, had blue lips and blue finger tips, and was "cool, not cold to touch". During these interviews, E4 was asked if she found or noticed any other other presumptive signs of death (e.g.: no response to painful stimuli, corneal reflexes, absence of eye movement, no blood pressure, profound cyanosis) and E4 said she did not think so.
E4 stated she did not confirm R2's death with another nurse until after she had called the Coroner and Funeral Home, sometime around or after 6:15 AM, but not at the time of actual death

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or after CPR was stopped. E4 stated she called E3, Acting DON, at 6:30 AM to inform her of R2's passing.

Review of R2's nurse's notes dated 11/3/12 at 5:52 AM by E4, found no documentation that R2 had been checked for presumptive signs of death except for; "no pulse or respirations, color pale, lips and finger tips blue".

On 11/30/12 at 11:30 AM, A review of the facility policy Cardiopulmonary Resuscitation and Emergency Response Notification, documented;
1. If an individual is observed unresponsive, with no pulse and cessation of breathing, a licensed staff person who is certified in CPR/BLS shall initiate CPR, call "code blue", designate a staff person to call 911 and make the crash cart available at the site unless:
The individual has a Do Not Resuscitate / DNR order that specifically prohibits CPR and or external defibrillation for that individual.
There are obvious signs of irreversible death, e.g.: absence of respiration, absence of blood pressure, absence of pulse, rigor mortis, algor mortis, livor mortis, fixed/dilated pupils.
2. Emergency Medical Response (911) is not necessary to be contacted when a resident death has occurred by natural disease process and there are obvious signs of irreversible death.

On 11/30/12, at 12:00 PM, E1, Administrator stated that the above facility policy for Cardiopulmonary Resuscitation was not in the facility at the time of R2's death, but sent to E1, by electronic delivery from the corporate office on 11/30/12.

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F9999	Continued From page 14 On 12/4/12, at 11:25 AM, in a phone interview with E3, Acting DON, she stated on 11/3/12 she was called early in the morning and told by E4 that R2 had passed, that CPR was tried, and that R2 was not able to be revived. E4 told E3 that R2 was a full code, and 911 had not been called as E4 described R2 as not having respirations, pulse, and some blood pooling on her backside when found. On 12/4/12 at 11:50 AM, in a phone interview, E1 stated that E4 had been interviewed about R2's death, and had told the facility that R2 had signs of obvious death, and therefore 911 was not called. E1 stated she had no written documentation of this interview and no documentation from E4. (B)	F9999		