STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	**310 BANBURY ROAD NORTH AURORA, IL 60542**

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F 309	Continued From page 18	F 309		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240e) 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. Section 300.1210 General Requirements for 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 19	F9999		

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.

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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to protect a resident from being physically abused by a staff on 10/6/2012,

This applies to 1 of 3 residents (R1) reviewed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

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F9999	Continued From page 20 abuse in the sample of 6. The findings Include: R1 was a 70 year old resident, who was admitted to the facility on 10/1/05 with diagnoses including Unspecified Psychosis, Unspecified Disorder of Bladder and Tourette's disorder according to the facility's Face Sheet. On 3/27/13 at 4:20 pm E1 (Administrator) stated R1 was sent to a local hospital on 9/27/12 and was readmitted to the facility on 10/6/12 at around 5:00 pm. The facility's investigation report shows on October 6th at 7:00 pm R1 was in the dining room while E4 (Housekeeper) was cleaning the dining room after the evening meal. E4 stated R1 had rolled herself out to the dining room. E3 (Certified Nursing Assistant, CNA) yelled R1 ' s name three times. E3 approached R1 who was sitting in her wheelchair. E3 struck R1 with open hands on both sides of her face and placed her hand over R1's mouth. R1 pulled E3's hands away and E3 took R1 out of the dining room. The report also documented E2 (Housekeeping/Laundry Supervisor) notified E1 (Administrator) of this abuse allegation on 10/7/12 at 3:20 pm and E3 was immediately removed from the schedule. E4 (Housekeeper) reported the physical abuse on 10/7/12 at 2:00 pm to E19 (Nurse). On 3/26/13 at 3:35 pm a video of the above mentioned incident was reviewed with E1. The video showed R1 was sitting in the dining room in her wheelchair dressed in a hospital gown. E4 was wiping the tables. E3 approached R1 from the back and with her right hand slapped R1 on her right cheek. R1 raised her right hand to	F9999		

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	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

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F9999	Continued From page 21	F9999		

protect herself and E3 slapped R1's hand. E3 then wheeled R1 to her room. The video showed E4 was seen observing this incident. The time registered on the video when E3 slapped R1 was 18:46:51 (approximately 6:47 pm).

A review of E3's timecard report dated 10/6/12 showed E3 punched out at 9:53 pm. E13 (Nurse) was interviewed on 3/26/13 at around 12:36 pm. E13 stated on 10/6/12 E3 worked her whole shift, until around 10:00 pm.

On 3/26/13 at 3:40 pm E2 was interviewed. E2 stated on 10/7/12 at 2:00 pm E4 told E19 (Nurse) about the allegation of physical abuse. E19 called him and stated E4 had something very important and he should come into the facility. So he came into the facility. E4 told E2 she saw E3 hitting R1. E2 then looked at the video tape and called E1. E2 stated he notified E1 at 3:20 pm. E2 further stated he saw E3 pulling into the parking lot so he told her she could not come into the building. E2 also stated he asked E4 why she did not report the physical abuse immediately and E4 told E2 she was scared of E3, as E3 had threatened another housekeeping staff 6 to 7 months ago.

On 10/12/12 at 3:00 pm E4 said on 10/6/12 (Saturday) she started work about 2:15 pm. Around 7:00 pm she was cleaning tables in the dining room after dinner. E4 said she heard E3 yell out R1's name, and said "come here" three times, and then she hit her. E4 said she was afraid to report this while E3 was in the building. She was afraid of retaliation by the CNA, E3.

The facility ' s policy and procedure dated 3/5/2009 and titled " Abuse Prevention Program "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

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F9999	Continued From page 22 under the subheading of " Orientation and Training of Employees " documented " During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and resident needs; Staff obligation to prevent and to immediately report abuse, neglect and theft to supervisory personnel ... " The same policy and procedure under the subheading of " Protection of Residents " documented " The facility will take steps to prevent mistreatment while the investigation is under way ... Employees of this facility who have been accused of mistreatment will be immediately removed from resident contact until the results of the investigation has been reviewed by the administrator or designee. Employees accused of alleged mistreatment shall not complete their shift as a direct care provider to residents ... " The facility failed to follow their policy by not immediately reporting physical abuse by a staff member to a resident to the supervisor/administrator and by allowing the accused staff to complete her shift as a direct care provider to the residents. (A) 300.610a) 300.1030a)1)2) 300.1030b) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

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F9999	Continued From page 23 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). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

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F9999	Continued From page 24 Section 300.1210 General Requirements for 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 observation, interview and record	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

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F9999	Continued From page 25	F9999		

review the facility failed to assess a resident who was identified as a full code and was found in cardiopulmonary distress. The facility failed to initiate basic life support (establishing airway, initiating cardiopulmonary resuscitation) when resident was found unresponsive on 10/6/2012.

This applies to 1 of 6 residents (R1) reviewed for advanced directives in the sample of 6.

The findings Include:

A speech therapy swallowing evaluation dated 2/13/12 shows R1 has a swallowing disorder with dysphasia. R1 has risk of aspiration, aspiration pneumonia, choking and delayed or slow swallow reflex.

R1 was a 70 year old resident, who was admitted to the facility on 10/1/05 with diagnoses including Unspecified Psychosis, Unspecified Disorder of Bladder and Tourette's disorder according to the facility's Face Sheet. On 3/27/13 at around 4:20 pm E1 (Administrator) stated R1 was sent to the local hospital on 9/27/12. R1 was readmitted to the facility on 10/6/12 at around 5:00 pm.

E13 (Nurse) was interviewed on 3/26/13 at 12:38 pm. E13 stated resident (R1) was readmitted to the facility from the local hospital on 10/6/12 at around 5:00 pm. R1 was alert oriented X 3. She was put into bed by the ambulance staff. R1's skin was checked, R1 had no issues. At 5:50 pm E3 (CNA) was asked to get R1 up for dinner. E3 came out of R1's room and stated R1 did not want to eat as she ate at the hospital. E13 said, "E3 told me twice R1 did want to eat, so I told her if she does not want to eat do not force her. I was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	**310 BANBURY ROAD NORTH AURORA, IL 60542**

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F9999	Continued From page 26	F9999		

about to start R1's readmission process like calling the doctor to verify the order I heard E3 screaming my name. It was around 6:50 pm. I went into R1's room, R1 was sitting in her wheelchair with her head forward and she was unresponsive. Her mouth was full of food. She had food all over, food was drooling from her mouth. I was surprised E3 was feeding her. I said how come you are feeding her now. I saw the tray in the room. E3 said nothing and was shaking " . I told E3 to call 911 right away. I called another Nurse (E17) and with the towel I tied to remove the food from her mouth. It was a lot of food. You do not know whether the resident was not swallowing and the CNA was feeding her. R1's mouth was full of food. I gave her oxygen via the nasal cannula at 4 L / Minute. We then removed R1's gown as she was dirty. We were going to lay her down on to the floor and paramedics came in."

E13 further stated when you see lot of food the first thing we think is Aspiration and Choking. If it is choking we have to do Heimlich, since the food was pureed it did not cross my mind she was choking. She said, "We do have an emergency kit. We have mask and stuff for suctioning. I did not suction her. I felt her radial pulse. Sometime I could feel it and sometimes I could not feel it. I did not see her chest going up and down. CPR was not started. Paramedics started the CPR. " E13 also stated the rescue breathing was not done because she had food in her mouth. R1 was quiet and calm. E13 stated " It was 7 minutes from the time E3 called my name and the Paramedics arrived. "

The Police report included statements from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 27	F9999		

Paramedics (Z4, Z5, and Z6). Z4 documented that on 10/6/12 R1 was in her room sitting upright, head back and unresponsive. R1 was pulseless. The report says, "Three representatives from the facility were present at our time of arrival. No CPR or other Life Preserving/Saving efforts were observed by me at the time our arrival. CPR was initiated by the paramedics."

Z5 documented on 10/6/12 R1 was seated in the wheelchair. R1 had her head back and appeared unresponsive. Z6 began asking questions while assessing the resident. Z6 checked for a pulse and stated he did not feel a pulse. The staff responded " neither did we " . R1 was moved out of the wheelchair onto a cot and Advanced Life Saving (ALS) interventions were started. Z5 began securing R1's airway and during intubation noticed a brown mush in the back of her mouth and upper airway. The brown mush was described as " mashed potatoes with gravy " .

Z6 documented on 10/6/12 they were dispatched at 6:52 pm. When he arrived in R1's room he saw staff gathered around the resident. The resident was sitting upright in her wheelchair, her head was back and she was unresponsive. R1 did not respond to verbal or painful stimuli. Z6 was unable to palpate R1's carotid and radial pulse and while informing his coworkers (other paramedics) he did feel a pulse. At that time the staff member in front of R1's wheelchair said ' I didn ' t get a pulse either. " Z6 asked that staff member to move, as she was moving Z6 heard another staff member telling her, " It's okay, it's not your fault. " R1 was moved from the wheelchair to the cot and interventions were

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	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

(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 28 started. The report from the local fire department dated 10/6/12 documented they received the call at 6:52 pm. Upon arrival to the facility at 6:57 pm R1 was unresponsive and pulseless and CPR was initiated. Cardiac Arrest prior to the arrival of the EMS (Emergency Medical Services). The etiology of cardiac arrest " Respiratory " , estimated time of arrest " 8-10 minutes " R1's hospital records were reviewed. The consultation report dated 10/8/12 documented R1 was found to be unresponsive and paramedics were called in. There was possibility of aspiration and she was found to be in a pulseless situation with full cardiopulmonary arrest The Critical Care Medicine (CCM) Note dated 10/13/12 documented R1 was found unresponsive in her room by EMS. R1 had acute respiratory failure and cardiac arrest. R1 had severe anoxic brain damage, anoxic brain injury secondary to cardiac arrest and cardiac arrest probably secondary to aspiration. On 11/7/12 at 4:00pm Z7 (R1's Attending Physician) when asked, stated anoxia would cause brain damage and the longer the anoxia persist the damage would be worst. Z7 further added if R1 aspirated any food then the cause of the cardiac arrest would be respiratory. American Heart Association 2010 Guidelines documented, " ... The purpose of CRP is to bring oxygen to the victim's lungs and to keep blood circulation so oxygen gets to every part of the body. When a person is deprived of oxygen,	F9999		

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	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

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F9999	Continued From page 29	F9999		

permanent brain damage can begin in as little as four minutes and death can follow only minutes later. So the main objective is to intervene as soon as possible. Table below represents the likelihood of brain damage or death and typical timing after the heart stopping

0 to 4 minutes after exhibiting symptoms - Chances of Brain Damage Minimal
4 to 6 minutes after exhibiting symptoms - Chances of Brain Damage Possible
6 to 10 minutes after exhibiting symptoms - Chances of Brain Damage Likely
Greater than 10 minutes - Chances of Brain Death Likely. "

The facility's policy and procedure dated 10/06 titled " Cardiopulmonary Resuscitation " documented " ...The following procedure shall be directed by a licensed nurse in the event of cardiac distress: ...4. If respirations are non existent or cease, place resident on a hard surface (floor or back board) and initiate artificial respirations. a. Position resident on back on hard surface. b. Open the airway by chin lift and remove any foreign objects/dentures. c. Give rescue breaths or provide respirations through an ambu bag ...5. If pulse is absent, initiate artificial circulation/chest compression 6. Continue CPR until a. Advanced life support systems are available ...7. Document all observations and occurrences in the medical record ... "

On 3/26/13 at 1:22 pm the Emergency Cart/Crash Cart was observed with E13 and E20 (DON). The cart was covered with a red mesh plastic cover. When the cover was removed the cart was very dusty. The cart had two suction machines with

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F9999	Continued From page 30	F9999		

only one suction canister. E20 was asked to show whether the suction machine was working. At 1:37 pm E20 tried to get the suction machine to work. When asked how do we know that the suction machine is functioning E20 replied " I don't know how. I don't know where the tubing goes. " At 1:45 pm E21 (ADON) tried to hook up the tubing to the suction and she stated " there are missing parts. " When asked whether there was a functioning suction machine, E21 stated " No, we have to order the parts. " A review of the Emergency cart Checklist showed there was no Yankauer (suction tip) or airway on the cart. There was no oxygen tank on or by the cart. E20 stated the oxygen tank is in the oxygen room. The oxygen room was checked with E20. The oxygen tank in the portable stand was observed to be empty and this was verified by E20. There was no oxygen set up. E20 when asked stated " It was here, I don't know where it is. " E20 was asked who was responsible to check the Emergency cart. E20 stated it was checked by the Nurse on the Night Shift. E20 showed the January and February 2013's Emergency Cart Checklist. E20 was made aware the Emergency Cart Checklist was not consistently filled. E20 replied " I know " . When asked to show the checklist for March 2013, she stated " They did not do it " . At 4:40 pm E21 brought the Emergency Cart Checklist for March 2013. The checklist was reviewed along with the March 2013 staffing schedule. At 4:42 pm E21 verified that the signature on the checklist from 3/4/13 to 3/26/13 was that of E20. E21 also stated " It is the DON ' s signature and she (E20) said she filled them. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	**310 BANBURY ROAD NORTH AURORA, IL 60542**

(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 31 (AA)	F9999		