

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

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN GROVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH ELM, P.O. BOX 5 FRANKLIN GROVE, IL 61031		
(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	
W 000	INITIAL COMMENTS	W 000			
W9999	<p>INCIDENT INVESTIGATION Incident Report Investigation 7-21-13 / IL65013 - 9999- 350.1235a)3,4 350.3240a)</p> <p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS 350.1235a)3,4 350.3240a)</p> <p>Section 350.1235 Life-Sustaining Treatments</p> <p>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. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:</p> <p>3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;</p> <p>350.3240a) Abuse and Neglect AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)</p> <p>This regulation is not met as evidenced by:</p>	W9999			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

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W9999	<p>Continued From page 1</p> <p>Based on interview and record review the facility staff failed to follow facility policy to administer CPR (Cardio Pulmonary Resuscitation) to R1 when he was unconscious. R1 subsequently expired at the facility.</p> <p>Findings include:</p> <p>Per record review of the Facility Data Sheet Dated 7-18-13, R1 was a 58 year old male who functioned in the Profound Range. R1 ' s diagnoses included Down Syndrome and Prolapsed Hemorrhoids.</p> <p>According to the Investigative Report dated 7-29-13 is as follows: The allegation is a charge of egregious neglect towards R1; specifically not giving R1 Cardiopulmonary Resuscitation (CPR) when he became unconscious and not calling 9-1-1. The accused staff members are E2 (Direct Support Person) and E3 (Direct Support Person). The investigative report dated 7-29-13 includes the following for summary of evidence: According to E2 and E3, R1 awoke on 7-21-13 limp and lethargic. Each describes taking R1 to the bathroom where he went limp and slumped to his side while he was on the toilet. E3 reports getting his vitals and E2 said the cuff read error. Each stated R1 urinated and had a large bowel movement, looked up as if he was coming out of it, and then slumped over again and was not conscious. Both staff report E4 (Licensed Practical Nurse) was called rather than beginning CPR and calling 9-1-1 according to Facility ' s policy. E3 stated she thought she was to call E4 (LPN) first and follow her direction. E3 stated E4 told her to get R1 to bed and try to get his vitals again and then be prepared to use the Automatic</p>	W9999			

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W9999	<p>Continued From page 2</p> <p>External Defibrillator (AED) and CPR. E3 stated she thought they were to use the AED and then call 9-1-1. E2 stated he did what E3 told him to do.</p> <p>The investigative report of 7-29-13 states that both employees are current in First Aid and CPR. When asked why they didn't do CPR, E2 replied E3 told him E4 said to do the AED first. E3 stated initially the nurse said to do the AED then CPR: so that was the order she thought it needed to be. When E3 was asked what her CPR class taught her she said CPR first, when asked why she didn't do it first she replied can't answer. When asked how the AED was used E2 stated it told him twice to stand back but never told him to push the shock button. E3 stated it said stand back, shock, stand back, call 9-1-1. When asked why E2 didn't say it said that she then said she was in the hall outside the bedroom and she must have heard it wrong. According to the data stored in the AED, no shock was administered.</p> <p>The investigative report states the initial findings of the autopsy showed no preliminary cause of death. They were able to determine CPR was not used. They could not tell if the AED was used or not however there were no markings as they have seen before in other cases when the AED was used.</p> <p>The investigative report concludes that no CPR was administered to R1 when he became unconscious. R1 did not have a Do Not Resuscitate Order (DNR) so CPR should have started. Both staff stated they were taught that CPR is to be administered as soon as a person is unconscious. The policies (Nursing On Call, Notification of Death and Employee Health and Safety Handbook state that when a client is unconscious 9-1-1 is to be called and CPR is to be administered until help arrives. then notify the</p>	W9999			

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W9999	<p>Continued From page 3</p> <p>nurse on call. In addition the first aid policy refers to employees following their training in CPR and First Aid. These policies were not followed.</p> <p>The investigative report recommendations states the allegation of egregious neglect is substantiated.</p> <p>Interview with E5 (Administrator) at 1:53 p.m. on 8/21/13 confirmed the information provided in the facility investigative report. E5 said that both E2 and E3 did not do CPR and confirmed a delaying in calling 9-1-1. E5 confirmed that both E2 and E3 did not follow facility policy on Nursing On Call, Serious Illness or Injury, Client emergencies for CPR and the use of an AED, and Abuse / Neglect Prevention. E5 confirmed that this incident was substantiated as egregious neglect.</p> <p>Per record review of the Facility Policy Procedure for Nursing On Call dated 2-20-95 states Emergency Medical/ Definitely Life Threatening Conditions: For clients having a definite life threatening symptoms such as unconsciousness, not breathing, apparent heart attack symptoms, staff trained in the emergency resuscitations techniques shall immediately initiate resuscitation of the client. Other staff involved in the resuscitation efforts will call 9-1-1 and request an ambulance. In the event there is only one staff on duty staff will call 9-1-1 and request an ambulance be sent to the home then initiate resuscitation to the client. As soon as the ambulance has arrived and paramedics have taken over , staff will call the on call nurse and the administrator on duty to inform them of the clients status. E2 and E3 failed to implement this policy.</p> <p>Per record review of the Facility Policy on Abuse and neglect Prevention dated 2/2011 states the</p>	W9999			

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W9999	Continued From page 4 facility will protect the individuals right to live free of abuse and neglect. In compliance with this policy all personnel will be trained and made familiar with prevention practices and established procedures regarding abuse and neglect. Neglect shall include but is not limited to failure to carry out prescribed services as ordered by the physician; failure to provide medical care; failure to provide adequate supervision, thereby exposing a client to potential harm. Substantiated means the report has been investigated and that the investigation determines that credible evidence of the alleged abuse or neglect exists. The facility substantiated neglect in this incident. (A)	W9999			