Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009419	A. BUILDING: ______ B. WING ______	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUS MEM PRESBYTERIAN HOME	**513 NORTH WORTH STREET SULLIVAN, IL 61951**

(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) COMPLETE DATE
S 000	Initial Comments Incident Report Investigation to Incident of 2/1/15-IL74782	S 000		
S9999	Final Observations Statement of Licensure Violations 330.1110g) 330.1125a)1) 330.1125e) 330.4240a) Section 330.1110 Medical Care Policies g) At the time of an accident, immediate treatment shall be provided by personnel trained in medically approved first aid procedures. Section 330.1125 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 any life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 1) implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½, pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45]; e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70]. 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act). These requirements are not met as evidenced by: Based on record review and interview the facility neglected R1 by failing to initiate life sustaining measures following R1's collapse, failed to honor/implement R1's advanced directive, and failed to have a policy for advanced directives for one (R1) of 5 residents reviewed for advanced directives in a sample of 5. This failure resulted in a delay in treatment for R1 ultimately resulting in death. Findings include: The facility Incident report dated 2/1/2015 at 2:00PM documents "(R1) found lying on the floor unconscious, purple in the face. Non responsive. Paramedics came and did Cardiopulmonary Resuscitation (CPR)." R1's signed Advanced Directive dated 5/1/2014 documents the following : "Attempt Resuscitation/CPR, Medical Interventions: Intubation and Mechanical Ventilation and Artificially Administered Nutrition: Long-term artificial nutrition by tube. " On 2/5/2015 at 10:45AM, E2 (Caregiver) stated " I found (R1) laying on the floor with clear fluid under R1's face and urine on the floor on 2/1/2015 at 2:00PM. (R1) had no pulse and was	S9999		

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S9999	Continued From page 2	S9999		

making a gasping sound. (R1's) face was purple. I did not start CPR, but I had E3 (Assistant Administrator) call 911. R1 was a "full" code status."

On 2/5/2015 at 1:00PM, E3 (Assistant Administrator) stated " I had just talked to (R1) about 5-10 minutes before (R1) was found on the floor by E2. I called 911 as instructed by E2. I then went back to check (R1). (R1) did not respond when I shook (R1) and called (R1's) name. I did not start CPR. I didn't know (R1's) code status."

On 2/5/2015 at 11:57 AM, Z1 (Paramedic) stated " When I arrived to the facility (R1) was face down on the floor and staff was not performing CPR. When I turned (R1) over (R1's) eyes were fixed, no pulse, no respirations, cyanotic in color but (R1's) body was still warm. I immediately started CPR."

The ambulance "Patient Care Report" dated 2/1/2015 at 1:57PM, documents " Upon arrival at 2:02 PM (R1) was found face down on the floor with clear emesis, and urine on the floor and (R1's) pants. No respirations, no pulse, cyanotic. (R1) rolled over to back. Mottling noted to face, chest and abdomen. Pupils fixed and dilated. .... Started CPR."

On 2/5/2015 E1(Administrator) stated " The facility staff did not initiate CPR for (R1). E2 is CPR certified. E2 was not re-educated and did work one shift since the 2/1/2015 incident. The facility did not have a policy regarding Advanced Directives at the time on the incident of 2/1/2015."

Z3's (Coroner) hand written report dated 2/1/15 document the cause of death for R1 is Acute

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S9999	Continued From page 3 Cardiopulmonary Arrest. The Death Certificate dated 2/1/2015 documents the cause of death as Acute Cardiopulmonary Arrest. The facility "Admission and Discharge Policies" documents the following:" Medical Care Policies: C.) Any change in resident's condition will be reported to their physician. In case of accident, first aid treatment shall be provided by a person trained for this treatment and/or resident will be transported to the hospital for immediate medical evaluation." The facility policy "Abuse /Neglect" documents the following: " Procedure #1: Each resident is entitled to live in an environment free of abuse and neglect." (A)	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: TITUS MEMORIAL OF PRESBYTERIAN HOME
DATE AND TYPE OF SURVEY: INCIDENT REPORT INVESTIGATION OF:
FEBRUARY 1, 2015/IL74782

330.1110g)
330.1125a)1)
330.1125e)
330.4240a)

Section 330.1110 Medical Care Policies

g) At the time of an accident, immediate treatment shall be provided by personnel trained in medically approved first aid procedures.

Section 330.1125 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 any life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:

1) Implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½, pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45];

e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70].

330.4240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act).

Attachment B
Imposed Plan of Correction

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions for the employee(s) involved. Policies and Procedures for Emergency Procedures and Abuse and Neglect will be reviewed and revised as necessary.

II. The Do Not Resuscitate status of all residents and incidents involving CPR will be reviewed by the Director of Nursing (DON) or designee and appropriate interventions or follow-up will be conducted. The Administrator will review all incident reports and the significant ones will be reviewed at the Quality Assurance (QA) meetings. Audits of resident clinical records will be conducted monthly by the DON or designee for accurate documentation and follow-up care.

III. All staff will be in-serviced on The Living wills and/or Powers of Attorney for Health Care in accordance with the Living Will Act and Powers of Attorney for Health Care Law.

IV. All staff will be in-serviced on the Emergency Procedures as well as Abuse and Neglect Policy and Procedures and any revisions made as a result of Item I. Other topics to be included for staff training are Do Not Resuscitate (DNR) and Full Code procedures. Responsibilities of staff for implementation, documentation, and monitoring of these areas will also be covered.

V. Documentation of in-service training will be maintained by the facility.

VI. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this Imposed Plan of Correction.

Attachment B
Imposed Plan of Correction