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
	IL6010078	A. BUILDING: _____ B. WING _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDMILL NURSING PAVILION	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

(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
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010i) 300.1030a)1) 300.1035e) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/15/16

Illinois Department of Public Health

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S9999	Continued From page 1	S9999		

1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).

Section 300.1035 Life-Sustaining Treatments

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]

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 are not met as evidenced by:

Based on interview and record review, the facility failed to follow physician orders regarding Emergency Cardiopulmonary Resuscitation (CPR) and EMS(Emergency Medical Services). This failure applies to 1 of 2 residents(R2), reviewed for quality of care, in the sample of 7. This failure resulted in a delay of treatment and services in association with a non-responsive resident(R2).

Findings Include:

R2 admitted to facility on 7/28/15 with diagnoses

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S9999	Continued From page 2 including Deconditioning ; Hypertension ; History of Breast Cancer ; Pacemaker and Atrial Fibrillation. POS(Physician Orders Sheet) December 2015 review indicates that R2's Advance Directives includes: FULL CODE. Progress note dated 12/6/15 at 1:15pm, R2 was having shortness of breath. R2 was given a treatment of Levalbuterol 0.63MG/3ML per nebulizer. R2 had a PRN order for the treatment in the case of shortness of breath. E4(Registered Nurse) notified Z1 (MD) of R2's condition. Z1 ordered Oxygen at 2 liters per nasal cannula. Progress note dated 12/6/15 at 1:30pm E4 took R2's Oxygen Saturation, temperature, pulse and blood pressure. Oxygen Saturation 97%,Temperature 98.0 ,Pulse 76 , Respirations 22 , Blood Pressure 130/76. Progress note dated 12/6/15 at 2:15pm indicates that E4 entered R2's room and noted R2 was unresponsive,absence of breathing, unable to obtain blood pressure or/and pulse. Progress note dated 12/6/15 at 2:30pm indicates that Z1 was notified of R2's death. There is no documentation to indicate that CPR was initiated and that EMS(Emergency Medical Services) were notified. 2/2/2016 at 4:40pm, E3(Registered Nurse) was interviewed. E3 said was working in another unit of the building when asked to come to the 100 unit concerning R2. E3 found R2 not breathing, no pulse, cool to the touch with grayish mottled skin. E3 documented in R2's progress notes what	S9999		

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S9999	Continued From page 3	S9999		

she found. E3 did not know what occurred before 12/6/15 at 2:30pm. E3 was asked if E3 heard a code "Blue" called. "I don't know of any code 'Blue' being called. I had just returned from Lunch. Two nurses have to be present to assess whether or not a resident has expired and that's what I was there for. "

2/3/2016 at 2:15pm, Z1 (R2's Attending Physician) was interviewed by telephone. Z1 said that R2 should have been immediately sent out to the hospital, because of poor health associated with trouble breathing. Z1 also indicated that Z1 had repeatedly warned staff about R2's poor health.

2/9/2016 at 3:45pm, E7 (Licensed Practical Nurse/LPN) was interviewed by telephone. The Daily Nursing Staffing Sheet dated 12/6/2015 has E7 working the PM shift on the 200 wing. E7 said was giving a tour of the facility to family members, when E4 came out into the hallway and asked for help. "Because, I was busy giving the tour, I(E7) asked E3 (Registered Nurse/RN) to help E4." E7 was asked if a code "Blue" was called. "I don't recall hearing a code 'Blue'."

Several attempts were made to interview E4.

Policy-Emergency Procedure-CPR indicates the following:
Initiating CPR-Begin CPR if the adult victim is unresponsive and not breathing normally(ignoring occasional gasps) without assessing victim's pulse.

Initiate CPR Unless: It is known that a DNR(Do Not Resuscitate) order that specifically prohibits CPR ; or there are obvious signs of irreversible death(e,g., rigor mortis).

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S9999	Continued From page 4	S9999		

(A)

300.690b)
300.690c)

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.
(Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013

These Requirements Were Not Met As

Illinois Department of Public Health

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S9999	Continued From page 5 Evidenced By: Based on interview and record review, the facility failed to notify the Illinois Department of Public Health (IDPH) of the death in the facility of one resident (R2) in the sample of seven. R2 expired 12/6/2016 in the facility. R2 was not Hospice. Findings Include: R2's closed record was reviewed. R2 died in the facility 12/6/2015 at 2:15pm. R2 was not Hospice. E3 (Registered Nurse/RN) and E4 (RN) were present when R2 expired. The facility's reportable and non-reportable Incidents/Accidents were reviewed. No incident report was found concerning R2's death. The Illinois Department of Public Health was not notified about the death. R2's "DO-NOT RESUSCITATE (DNR)" order reads: Under A Attempt Resuscitation/ CPR (Cardiopulmonary Resuscitation) if R2 has no pulse and is not breathing. Under B Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated. R2's wishes were not carried out.	S9999		

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S9999	Continued From page 6 The following facility policies were reviewed: Change of Condition Emergency Procedure-Cardiopulmonary Resuscitation (CPR) Death of a Resident (AW)	S9999		

Imposed Plan of Correction

Facility Name: Windmill Nursing Pavilion

Survey Date: February 17, 2016

Complaint: #1690507/IL83029

#1690540/IL83069

Violation: A

300.610a)
300.1010i)
300.1030a)1)
300.1035e)
300.3240a)

Attachment 8
Imposed Plan of Correction

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid

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).

Section 300.1035 Life-Sustaining Treatments

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]

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)

This will be accomplished by:

1. **A committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding Emergency Cardiopulmonary Resuscitation (CPR) and EMS (Emergency Medical Services). This review will ensure that the facility's policies and procedures address, at a minimum, the following:**

   A. **Recognition of situations requiring immediate intervention and following physicians orders regarding Emergency Cardiopulmonary Resuscitation (CPR).**
   B. **The facility's responsibilities in taking appropriate corrective action to prevent further potential abuse while be respectful of the residents wishes.**
   C. **Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan .**

2. **The facility will conduct mandatory in-services for all staff that addresses, at a minimum, the following:**

   A).All staff will be informed of their specific responsibilities and accountability for the care provided to residents.

3. **Documentation of these in-services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the administrator's office.**

4. **The following action will be taken to prevent re-occurrence:**

   A). The above in-service education will be reviewed with all staff on a regular basis

B). Supervisory staff will ensure that the State Regulations regarding reports and follow-up are followed.

5. The Administrator and Director of Nursing will monitor items 1-4 to ensure compliance with this Imposed Plan of Correction.

Violation: A

300.690b)
300.690c)

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This will be accomplished by:

1. A committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding when the facility shall notify the Department of any serious incident or accident. Serious means any incident or accident that causes harm or injury to a resident. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

A). Recognition of situations that could be interpreted as any incident or accident that causes physical harm or injury to a resident.

B).Appropriate reporting procedures for staff.

C). Appropriate and thorough investigation of any serious incident or accident.

D). The facility taking appropriate corrective action when an accident or serious incident is verified.

2. The facility will conduct mandatory in-services for all staff that addresses, at a minimum, the following:

A).All staff will be informed of their specific responsibilities and accountability for the care provided to residents.

3. Documentation of these in-services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the administrator's office.

4. The following action will be taken to prevent re-occurrence:

A). The above in-service education will be reviewed with all staff on a regular basis

B). Supervisory staff will ensure that the State Regulations regarding reports and follow-up are followed.

5. The Administrator and Director of Nursing will monitor items 1-4 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten days from receipt of the Notice for the Imposed Plan of Correction