STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007447	A. BUILDING: _____ B. WING _____	C 10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINECREST MANOR	414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1030a)2) 300.1210b) 300.1210c) 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 300.1030 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 things as: 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999		

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Based on interview and record review the facility failed to initiate Cardio Pulmonary Resuscitation (CPR) when a resident had no vital signs or respirations. The resident had made the decision to be a Full Code in case of cardiac arrest on April 23, 2017.

The resident was found unresponsive at 2:45 AM on September 22, 2017. No resuscitative efforts were initiated by facility staff.
This applies to 1 of 11 residents (R1) who were designated as a Full Code if cardiac arrest occurs in the sample of 11.

This past non-compliance occurred from September 22, 2017 to September 26, 2017.

The findings include:

The physician transfer orders dated September 11, 2017 show R1 was transferring to the facility with a resuscitation status of Modified code - do not intubate (CPR would still be initiated) and a diagnosis of status post aspiration pneumonia.

On October 3, 2017 at 11:45 AM, E5 CNA (Certified Nursing Assistant) said she had observed R1 on September 21, 2017 at 10 PM, then again around 12: 30 AM. E5 said at approximately 2:30 AM on September 22, 2017 she found R1 to be unresponsive and her nail beds appeared bluish in color. E5 said she immediately notified E4 RN (Registered Nurse) of R1's condition.

On October 3, 2017 at 12:30 PM, E4 said he had observed R1 at the beginning of his shift at 10 PM, and again at approximately one hour later. E4 said R1 appeared to be fine and made a

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grunting noise as he flushed her feeding tube. E4 said he was notified by E5 that R1 had possibly died and immediately went to the room. E5 said he grabbed R1's chart and a stethoscope, and assessed R1 and found her to have no vital signs and determined she had died. E4 said he did not immediately look at R1's POLST (Practioner orders for life-sustaining treatment) form to verify code status.

On October 3, 2017 at 12:30 PM, E4 said after determining R1 had died he notified the on call physician and the coroner. E4 said the coroner requested for an ambulance crew to evaluate and verify the resident death. E4 said he called for paramedics and upon their arrival was asked about R1's code status. E4 said at that time he advised the paramedic R1 was a do not resuscitate and no CPR had been performed, but offered to show him R1's POLST form. E4 said it was then he realized R1 was full code, and was advised by the paramedic that too much time had passed and CPR was no longer an option. R1 was pronounced dead by the ambulance crew. E4 said he did not open the chart, he looked at the spine of the chart for a heart sticker to indicate a full code, and there was no sticker. E4 said he also looked at R1's name plate outside the doorway and found no full code sticker.

On October 3, 2017 at 1:15 PM, E9 (Social Service) said she spoke with R1's family at the time of her admission and they had presented a POLST form indicating R1 was a full code. E9 said she placed the signed POLST form on the chart. E9 said when any resident requests to be a full code heart stickers are placed on the spine of the chart, on the name plate outside the resident room, and the nurses will place a sticker on the MAR (Medication Administration Record).

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E9 said she did not place stickers in any of these locations for R1, and could not say why this did not happen. E9 said she will place the stickers or sometimes the nurses will place the stickers, but in this instance no one placed a sticker in any of the locations. E9 said she does not recall making any statements about the full code to the nursing staff, she assumed they would see the POLST on the chart.

On October 3, 2017 at 1:00 PM, E2 DON (Director of Nursing) said on September 22, 2017, E4 had left her a voicemail regarding R1's full code status and no CPR had been performed. E2 said social service was discussing the POLST form with families upon admission, and R1 had a form already filled out and signed by the physician. E2 said it would vary as to who would place the heart stickers on the chart and the name plate. E2 said she now realized this sticker system gave a false sense of security regarding code status. E2 said in an intense situation like finding a resident without vital signs, she would not have looked in the chart if there were no stickers on the door or the spine of the chart.

The facility's advance directive policy and procedure states it is the policy of the facility to establish, implement, and maintain written policies and procedures for advance directive.

The facility's undated policy for residents requesting CPR shows: At the time of admission all residents/Power of Attorney complete or review the resident advanced directives (POLST) form, and the form is kept on the resident's chart; If the resident requests CPR, a heart sticker is placed on the binding of their chart and on the name plate of their particular room to designate that the resident requests CPR; If a resident is

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S9999	Continued From page 5 noted to not be breathing and/or have no heartbeat, the nursing staff will initiate basic CPR; a call is placed to 911 for EMT/ambulance response. The nursing staff provides CPR until the EMT arrives. On October 5, 2017 at 2:40 PM, Z1 (Medical Director) stated if a resident had Full Code listed on the POLST form, resuscitation should happen immediately. (A)	S9999		