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	14G037	A. BUILDING _____ B. WING _____	C 08/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	2150 EAST MCCORD CENTRALIA, IL 62801

(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 331	Continued From page 23 should have been given Albuterol as ordered per nebulizer for dyspnea. Z2 (Pulmonary Specialist) was interviewed on 7/21/08 at approximately 9:38 A.M.. He said he had seen R1 during his hospitalizations in November and December 2007 and he had performed a Bronchoscopy and bronchial washing during each of these hospitalizations. He said he had also seen him in April 2008 hospitalization when he again was admitted with Pneumonia. He said, "Both oxygen and C-PAP should have been put on as the C-PAP maintains positive air that keeps the airway open. He had multiple hospitalizations with respiratory problems and obstruction of his airway." When surveyor asked him if R1's physician should have been called when R1's SPO2 dropped to 84%, he said, "Yes." He continued saying, "he had many health and respiratory problems and when his O2 sats dropped to 84% he should have been sent to the hospital."	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.623a) 350.1220j) 350.1230b)3)6)7 350.1230d)1)2) 350.1230e) 350.1230g) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by	W9999		

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W9999	Continued From page 24 the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents.	W9999		

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W9999	Continued From page 25 e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide nursing care according to the needs of 1 of 1 in the sample (R1), who expired following signs and symptoms of respiratory distress. Nursing failed: 1.) to ensure nursing staff awareness of the importance of C-PAP (Continuous Positive Airway Pressure) use based on R1's sleep study 2.) to notify the physician, as per his orders, of a change in R1's condition when his SPO2 (Oxygen Saturation) dropped to 84% requiring oxygen 3.) to follow R1's physician orders to place C-PAP on R1 every evening 4.) to follow R1's physician orders to administer	W9999		

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W9999	Continued From page 26 Albuterol as needed for dyspnea 5.) to document pertinent information regarding R1's change in respiratory condition. Findings include: According to R1's Certificate of Death dated 5/22/08, R1 expired on 5/16/08 and age was 56. This certificate states he was "dead on arrival to (name of hospital)/CPR/code invain." The death certificate lists Asphyxia, Apnea, and Hypoxia in Sleep as the immediate cause of his death. Z1 (R1's physician) completed the Certificate of Death on 5/22/08 and beside the immediate cause of death he wrote "few hours" as the approximate interval between onset and death. Z1 listed Sleep Apnea, Seizure, and Hypothyroidism as conditions leading to the cause of death. The Physician orders for R1 dated 5/01/08 thru 5/31/08 list multiple diagnoses including Profound Mental Retardation, Cerebral Palsy, Contractures, Seizures, Hypothermia, History of Acute Renal Failure, Gastrostomy Tube, and Sleep Apnea. A Stanford Binet Intelligence Scale, form L-M dated 4/21/98 estimated R1's Intelligence Quotient to be less than 20. The Inventory for Client Agency Planning (ICAP) dated 2/11/08 lists R1's overall broad independence score at 0-4, placing him in a Profound Level of Mental Retardation. According to R1's IPP (Individual Program Plan) dated 2/14/08, he required staff to propel his adaptive wheelchair for all mobility and was	W9999		

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W9999	Continued From page 27 totally dependent on staff for all of his activities of daily living. His IPP states, "(R1) has severe limitations in his upper extremities and he is unable to bear weight on his lower body. (R1) is extremely limited in his functional communication skills. This individual does not possess the ability to understand much of what is said to him. He has no means of communication verbally." A History and Physical report dictated by Z1 on 11/12/07 lists multiple diagnoses as reason for admission to the hospital including Pneumonia, Tracheobronchitis, and Hypoxia. A consultation was done by Z2/Physician (Pulmonary Specialist) during the November hospitalization on 11/16/07. This consultation report states, "This gentleman has a Atelectasis of the lung with some narrowing in the Trachea. I believe this is all due to secretions with mucus plugging although Endobronchial tumor cannot be ruled out." Z2 recommended and conducted a bronchoscopy on 11/16/08. The Report of Operation dated 11/16/08 states, "Thick secretions bilaterally causing plugging of the Trachea without any Endobronchial lesion." According to another History and Physical report dated 12/29/07, R1 was again admitted to the hospital due to "1. High fever, rule out sepsis 2. Cough, congestion, rule out Pneumonia 3. Dehydration in a patient with known history of Congestive Heart Failure." A bronchoscopy was conducted by Z2 on 1/03/08. According to a progress note dated 1/04/08 written by Z2, "Yesterday, bronchoscopy showed a lot of mucus plugging on the left side. He has been started on Mucomyst and also started him on C-PAP because of the fact that he probably has sleep	W9999		

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W9999	Continued From page 28 apnea syndrome.... " Per the same report under Assessment is written " 1. Pneumonia, Left Lower Lobe with Atelectasis..." R1 was readmitted to the facility on 1/05/08. The Discharge Summary report dated 1/05/08 listed nineteen final diagnoses including, "1. Pneumonia 2. Lung Collapse 3. Mucous Plug 4. Sepsis 5. Hypotension 6. Dehydration 7. Tracheobronchitis...." E16/R.N. (Registered Nurse) completed a Quarterly Health Status Review on 1/30/08 regarding R1's hospitalization of 11/12/07 to 11/26/07. This review states, "admitted to (listed name of hospital) with a dx of Pneumonia, Atelectasis and MRSA of nares and urine and bronchial washings - while in hospital they did a bronchoscopy and washed out the lungs due to a large mucous plug. He rec'd IV fluids and antibiotics..." This same health status review, regarding R1's hospitalization of 12/29/07 to 1/05/08, states, "Admitted to hospital with a dx pneumonia and was treated while there with IV fluids and antibiotics and HHN tx's and also had a bronchial washing again due to mucous plug - he returned home with a new order for a sleep study, possible tracheostomy permanent if continues to have problems - he returned home with new orders and was on contact and droplet precautions due to MRSA of urine and nares and bronchial washings..." On 2/03/08 R1 underwent a sleep study conducted by Z2. According to the All Night Sleep Study/Polysomnography dated 2/03/08, it was an "abnormal sleep study...The patient had a	W9999		

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W9999	Continued From page 29	W9999		

significant number of apnea/hypopneas. Most of these episodes were obstructive. They were more than 10 seconds in duration and there was associated desaturation. The total events were 81....The lowest saturation was 75%. This is consistent with moderate obstructive sleep apnea syndrome with significant hypoxemia and the patient would benefit from C-PAP titration.... The patient will be fitted with a nasal CPAP."

On 2/26/08 a C-PAP titration was done by Z2 due to the diagnosis of sleep apnea and prescription was written for R1's use of a C-PAP every evening from 9 P.M. to 5 A.M.

On 4/18/08, R1 was again hospitalized. History and Physical conducted by Z1 on 4/18/08 lists multiple diagnoses for hospitalization including Pneumonia and History of Congestive Failure. A chest x-ray was done on 4/17/08 at the emergency room and complete opacification of the left lung was found and he was admitted to the hospital for further treatment. A Consultation report dated 4/19/08 lists additional diagnosis of Obstructive Sleep Apnea. On 4/18/08 Z1's Progress Note report states, "the patient is admitted with pneumonia with pleural effusion. He has spells of hypoxia. Last night he had a hypoxia of 87% and he was placed on oxygen by mask.... He is on 3 liters of oxygen by non-rebreather mask." The progress note also notes "he requires suctioning often."

Per review of R1's Physician Orders dated 5/01/08 thru 5/31/08, he was to have oxygen at 2 Liters per minute per nasal cannula to maintain his Oxygen saturation above 90% and/or Dyspnea and call MD.

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W9999	Continued From page 30 Another order dated 1/18/08 was found on the 5/2008 physician orders for "Albuterol Solution 2.5 MG. (Milligram)/3 ML (Milliliter) to be inhaled per Nebulizer every 4 hours as needed for shortness of breath/Dyspnea occurs." Also an order dated 3/03/08 "to place C-PAP with chin strap and mask every evening (fill humidifier bottle with distilled water.)" During the investigation of R1's death of 5/16/08, the Nurses Notes dated 5/15/08 and 5/16/08 were reviewed. On 5/15/08 no documentation was found in the nurses notes from midnight until 10:30 A.M., when E12/LPN (Licensed Practical Nurse) documented R1 had a one centimeter scratch to his forehead. She also documented "cool compresses applied to his eyes due to redness, sclera edematous with a small amount of periorbital edema." At 12:30 P.M. she documented "an increase in the edema and redness and the eye clinic contacted." E11/LPN worked the 200 wing of the facility where R1's room was located, from 1:00 P.M. to 9:30 P.M. on 5/15/08. She documented at 1:15 P.M. R1 was "sent out to Dr.(physician's name) due to increased redness and swelling of bil eyes." The only other documentation for this shift in R1's nurses notes was at 4 P.M. "Return from eye MD with n.o. see MAR." There is no documentation in the nurses notes of signs of respiratory distress and no evidence the physician was notified. According to the facility's Nursing Assessment Flowsheet dated 5-15-08 for the 1-9 shift, E11 circled under the heading of Respiratory "clear all fields equal." No information is documented regarding R1 having any signs of respiratory	W9999		

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W9999	Continued From page 31 distress during the 1 P.M. - 9:30 P.M. on 5/15/08. The next documentation on 5/15/08 was entered by E3/RN (Registered Nurse), who worked the 9 P.M. to 5:30 A.M. shift. She documented at 10:45 P.M. in the nurses notes that R1's temperature was 97, his Oxygen saturation (SPO2) 96% and Oxygen on per mask. She entered that his C-PAP was kept off this shift due to Oxygen being used by R1. Then on 5/16/08 at 1 A.M. she entered "T 98 R24 SPO2 95%. Resting quietly...." E3 next documented, "3:25 A.M. SPO2 89% B/P 95/52 P58 T.97.7 R12 et very shallow. Cheyne Stokes Resp O2 (arrow up) to 5L/m. 35 - 45 sec.periods of apnea. SPO2 fluctuating from 85% to 91%...End tips of fingers cyanotic. Res repositioned. (name of ambulance) call for transport to take to ER. DR (name) called condition report given. Order recd to send to ER." E3 documented at 3:30 A.M., R1's "BP 85/45 P61 SPO2 92%. Resp very shallow. O2 switched to tank from concentrator. 3:35 A.M. BP 73/35 P60 SPO2 93%. (Ambulance) in route. SPO2 (arrow down) 90%. (Ambulance here.)" The Emergency Room Record dated 5/16/08 documents R1 arrived at the hospital at 3:55 A.M. It states, "Arrived with no pulse, CPR and being bagged. Very cyanotic low chest up... Pupils fixed and dilated." The Certificate of Death lists R1's time of death as 4:00 A.M. on 5/16/08. On 7/14/08 at 10:35 A.M., an interview was conducted with E3. She said she was the nurse working on R1's wing (200) on the night of 5/16/08. She said she works at the facility as a prn (as needed) nurse and is hired by the facility. She said she began working at the facility during	W9999		

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W9999	Continued From page 32 the 3rd week of April 2008. She remembered working with R1 one time maybe 2 times prior to 5/15/08. She went on to say, "he wasn't doing bad - his O2 sats were good all night (95 -96) until the hab tech called her and said he was having trouble breathing. Went into his room and his respirations were 12 with 35-45 seconds of apnea." She said two other nurses, E14/LPN and E16/LPN, came to his room. She stated she remembered E16 calling the ambulance and the doctor, while E14 helped her change his O2 from a concentrator to a tank, and they put his bed up higher. E3 continued saying she knew he wore a C-PAP at night, but when she arrived about 9 P.M. the nurse prior to her said she had put O2 on him per mask during her shift. E3 said she asked E14/LPN, who was working on 100 wing, if he should stay on O2 and leave the C-PAP off of him. She said E14 questioned why he went to the eye doctor earlier today if he was "this way." The decision was then made to leave the C-PAP off and use the O2 at 2 liters per mask. Before the interview was completed, E3 looked at R1's treatment record and said, "this shows this was the fourth night to work with him since I was hired at the facility. She said he had not required oxygen the other nights and had worn the C-PAP. When E3 was asked about a physician order dated 3/3/08 for Albuterol 2.5 Mg. per nebulizer to be used as needed every 4 hours for dyspnea, she said she didn't know about the order until the surveyor brought it to her attention. She continued saying, "it wouldn't have helped at this point."	W9999		

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W9999	Continued From page 33 E4/DSP (Direct Support Person) was interviewed at 12:20 P.M. on 7/14/08. She said she had worked a double shift starting at 1:00 P.M. on 5/15/08 on R1's wing. She said she and E13/DSP went into R1's room after 7:45 P.M., but before 9:00 P.M.. She said she knew it was during this timeframe because "we start at 7:45 P.M. putting clients to bed and it was before (E13) left at 9:00 P.M." She continued saying "he was in his room sitting in his wheelchair and his lips were bluish and he didn't look right. His face is usually reddish and it wasn't, so we yelled for the nurse (said name of E11/LPN). (E11) came in and told us to put him into bed and she put oxygen on him. It scared me when his lips were blue. It was very scary for us. I'm not exaggerating." E4 said she was going in and out of the clients rooms on 200 wing during the 9 P.M. to 5:30 A.M. shift on 5/16/08 when she found R1 having trouble breathing again. She said this was at approximately 3:25 A.M., and she notified E3 immediately. E13 was interviewed at 11:30 A.M. on 7/15/08. E13 said, " What happened was when (said name) E4 and I went into his room he didn't look right. His lips were purple, he wasn't breathing right, and his face was purple. We got the nurse and she told us to put him in bed and then she checked his oxygen sats. I remember they were low, but I can't remember what they were. She put oxygen on using the concentrator in his room. I feel he should have been sent to the hospital. The nurse told (name) E4 and I to keep an eye on him. I stayed in his room as much as possible until going home at 9:00. (Name) E4 was staying	W9999		

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over on the next shift and I knew she would check on him as she was assigned to be the staff walking the hall and going into each room checking on the clients on 200 wing as they slept." E13 said she had asked about R1 when she came to work the next day, and was surprised to hear he didn't go to the hospital until 3:30 A.M..

An interview was conducted with E5/DSP on 7/14/08 at 12:50 P.M. He said he had worked on the 200 wing on 5/15/08 from 1 P.M. to 9 P.M. shift. He said he went into R1's room when E13 told him R1 "was not doing well." He said, "His lips were blue and I was really surprised he did not go to the hospital then." He did not remember the exact time, but said it was between 8 P.M. and 9 P.M.

E11/LPN was interviewed by phone on 7/14/08 at 4:45 P.M. regarding R1's condition during the shift she worked (1 P.M.- 9:30 P.M.) on 5/15/08. She could not remember what time she put oxygen on R1. She stated, "I can't remember when I put oxygen on him. Remember we checked his O2 sats all evening due to his shortness of breath and he was a little purple, but he had this color sometimes. I think he had a standing order for O2 and we used a mask because he was mouth breathing. The night shift put the C-PAP on him." Then she said, "I don't know if evening or night nurse put the C-PAP on him. I took his vitals. Can't remember them - may have been his heart rate was down." When surveyor asked if she contacted the doctor about R1's condition, she said, "Surely I did with his O2 sats being down, but not sure if I did." She could not remember if she had administered Albuterol per nebulizer per the physician orders for

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W9999	Continued From page 35 dyspnea. The surveyor asked E11 during this interview if she had documented R1's vital signs and use of oxygen on 5/15/08. The surveyor read E11's documentation in R1's nurses notes for 5/15/08 to E11. She could not remember why she did not document any of the information regarding R1 and his change in his condition. According to R1's MAR (Medication Administration Record)dated 5/01/08 to 5/31/08, there is no documentation that Albuterol was administered as ordered for dyspnea during the 1 P.M. - 9:30 P.M. shift on 5/15/08. According to the 200 wing nurse's shift report dated 5/15/08 for the 1 P.M. to 9:30 P.M., E11 documented the following regarding R1: "Red area bil eye - left eye worse - out to see eye doctor - n.o. eye gtts - see MAR (Econopred Ophthalmic Sol. - (arrow down) SPO2 -84 O2 at 2 L per mask - T 95.9." No further documentation was found regarding R1's change in condition during E11's shift nor is there any documentation of physician notification. E11 confirmed, during this same interview, that she no longer worked at this facility giving the cost of commute the reason she had resigned. Employee records indicate she started working at the facility on 3/10/08 and resigned on 5/22/08. These records indicate she worked on 1:00 P.M. to 9:30 P.M. on 5/16/08 and 5/20/08 after R1 expired on 5/16/08. E9/QMRP (Qualified Mental Retardation Professional) and E10/Activity Director were interviewed on 7/14/08 3:40 P.M. and at 3:55	W9999		

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	14G037	A. BUILDING _____ B. WING _____	C 08/05/2008

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W9999	Continued From page 36	W9999		

P.M. regarding R1's condition at the time he went with them to see the eye doctor on 5/15/08. Both of these staff said R1 was breathing without any difficulty during the trip. They left the facility about 1:30 P.M. returning about 4:00 P.M. E9 said R1 "was as usual. Nonverbal and sitting in his wheelchair and kept his tongue out of his mouth as he usually did. His lips were pink and his face was reddish. No shortness of breath. Some drooling noted, but normal for him." E10 said, "His left eye seemed to be protruding outward and was red. The doctor ordered eye drops and said she thought it was allergies. His respirations and breathing were ok."

E2/DON (Director of Nursing) was interviewed on 7/15/08 at approximately 11:00 A.M. regarding R1's death. She presented the surveyor with a protocol for the nursing staff to follow in the use of C-PAP device and one for administering oxygen. These protocols were not dated. She said the protocol for nursing to follow in the use of C-PAP device was written after R1's death. She also gave the surveyor information regarding an inservice she held for all of the facility's nurses after R1 expired.

These nursing procedures were reviewed. The use of C-PAP device states as part of the procedure the nurse is to "obtain oxygen saturation prior to putting on headgear and obtain another saturation in the first few minutes that the CPAP is turned on. May administer and titrate oxygen (bleed in through port) to keep sats above levels specified by physician. Check oxygen saturations at least every two hours and prn if is exhibiting signs or symptoms of distress."

The nursing procedure for administering oxygen

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W9999	Continued From page 37 states in part: "The nurse will obtain an oxygen saturation on any resident having signs and symptoms of respiratory distress, any condition change that warrants a pulse oximetry assessment, or per physician's order as part of a routine assessment. Oxygen will be applied per physician's orders. Verify the physician's order for the amount of oxygen to be used and the route.... At regular intervals, check liter flow contents of oxygen and assess the resident's respirations to determine efficiency of oxygen and further need. Obtain oxygen saturations as needed, or per physician's order. Notify physician as needed for changes in status or need for further orders." A nursing inservice held after 5/16/08 regarding the use of CPAP device was reviewed and states "when assessing respiratory status, if the status is not normal oxygen saturations must be checked and documented. Administer oxygen per standing orders and notify physician. The standing orders are a guideline of what to do until the physician is notified. It does not take the place of calling the physician and reporting the change in condition." On 7/15/08 at 10:00 A.M., E1 (administrator) said the facility's Director of Nursing had conducted a case review of R1's medical record regarding his death. She said, "We should have conducted a more thorough investigation of (R1's) death. We need to tighten our policy of how we investigate. I still want to continue doing a review of the chart, but I also want an investigation in unexpected deaths like we do for injuries of unknown origin." Reviewing the Case Review of R1's death, it was noted E2 had written areas of concern to be: "unclear charting on 5/15/08 1 p.- 9 p.shift. The	W9999		

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W9999	Continued From page 38 nursing report sheet indicate that (R1) had decreased O2 stats and that oxygen was started at 2L per mask, however there is nothing indicated in the nurse's notes. The only note from the 1 p.- 9 p. shift is that he returned from the eye doctor with new orders. The charting on 5/15/08 9p-5a shift indicate that oxygen was on per mask, but does not indicate how much." Recommendations based on E2's review were "to inservice nursing staff regarding charting and that any changes in a clients status and or plan of care must be documented." There is no mention of concerns in this Case Review regarding E11's lack of notifying the physician of R1's change in his respiratory condition on 5/15/08 between 7:45 P.M. and 9:00 P.M. nor is there mention of the physician orders not being followed regarding E3's failure to put R1's C-PAP on, and administering only oxygen when his SPO2 dropped to 84%. Also E3 and E11 did not administer Albuterol per nebulizer as ordered to be given for dyspnea. Z1, R1's physician was interviewed per phone on 7/15/08 at 10:50 A.M. He said the nurse should have notified him of R1's change in condition during the evening of 5/15/08. He said he would have sent him to the Emergency Room at the hospital. He said, "I have told the nurses to always send him to the ER due to his history of respiratory problems. He should have been sent to the hospital when his O2 sats were down to 84% due to his history of having mucous plugs resulting in recent hospitalizations and bronchial washings." He said the facility should have had a protocol for monitoring oxygen saturations and should have called him about leaving the C-PAP off and only using oxygen. He also said R1	W9999		

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W9999	Continued From page 39 should have been given Albuterol as ordered per nebulizer for dyspnea. Z2 (Pulmonary Specialist) was interviewed on 7/21/08 at approximately 9:38 A.M.. He said he had seen R1 during his hospitalizations in November and December 2007 and he had performed a Bronchoscopy and bronchial washing during each of these hospitalizations. He said he had also seen him in April 2008 hospitalization when he again was admitted with Pneumonia. He said, "Both oxygen and C-PAP should have been put on as the C-PAP maintains positive air that keeps the airway open. He had multiple hospitalizations with respiratory problems and obstruction of his airway." When surveyor asked him if R1's physician should have been called when R1's SPO2 dropped to 84%, he said, "Yes." He continued saying, "he had many health and respiratory problems and when his O2 sats dropped to 84% he should have been sent to the hospital." (A)	W9999		