STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G099	A. BUILDING _____ B. WING _____	C 08/13/2008

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TURNER MANOR	**P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946**

(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 28 compliance with the plan. Although the Immediate Jeopardy is removed, non-compliance continues at the time of the exit since the facility has not fully implemented their plan and has not had an opportunity to evaluate its effectiveness.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060b)1)2) 350.1060c)1) 350.1060d)e)g)h) 350.1210b) 350.1235a)3)4)5)6) 350.1235b)1)2)3) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by 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 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each	W9999		

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W9999	Continued From page 29 resident in the facility. b) Each resident shall have individual evaluations which shall: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. 2) Provide the basis for prescribing an appropriate program of training experiences for the resident. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person	W9999		

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W9999	Continued From page 30 who is a Qualified Mental Retardation Professional. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1235 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 life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 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; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. b) For the purposes of this Section: 1) "Agent" means a person acting under a Health Care Power of Attorney in accordance with the Powers of Attorney for Health Care Law.	W9999		

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W9999	Continued From page 31 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgement of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing an airway, as indicated. 3) "Surrogate" means a surrogate decision maker acting in accordance with the Health Care Surrogate Act (Ill. Rev. Stat. 1991, ch. 110½, par. 851-1 et seq.) [755 ILCS 40]. 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 observation, interview and record review, the facility failed to implement its policy to prevent neglect for 1 of 1 sampled individual (R1) who died on 6/24/08 with the potential to affect 19 of 19 individuals who also sleep in a bed with padded rails (R2 - R20). R1 was found unresponsive, lying face down with her head on a chair, with her arms dangling down towards the floor and her lower body partially in bed between the padded bedrail and the headboard. The facility failed to:	W9999		

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W9999	Continued From page 32 1) Thoroughly investigate the circumstances surrounding R1's death; 2) Assess the need for padded siderails for R1; 3) Re-assess 19 other individuals who also sleep in beds with padded siderails; 4) Incorporate the use of siderails in R1's Individual Program Plan (IPP); and 5) Obtain a physician's order for the use of bedrails for R1. Findings include: The facility's undated Abuse and Neglect policy states "the facility is committed to ensuring that clients of the facility are not subjected to physical, verbal, sexual or psychological abuse or punishment." This policy includes an addendum which defines neglect as a "failure to provide adequate medical or personal care or maintenance which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition". Included with this policy, titled Investigation of an Incident, the "written incident report and all narratives will be compiled by the management team and formal interviews conducted with all relevant staff and clients." According to physician's orders, dated 6/1/08 to 6/30/08, R1 was a 35 year old female with diagnoses of Severe Mental Retardation, Cerebral Palsy, Scoliosis, Hypothyroidism, Peripheral Vascular Disease and Anxiety. R1's ICAP (Inventory for Client and Agency	W9999		

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W9999	Continued From page 33 Planning) dated 12/6/07 shows that R1's overall age equivalent was 7 months. Per review of the facility's incident report dated 6/24/08, R1 was put to bed around 7:10 P.M. R1 was found in her bed around 9:40 P.M. by direct care staff (DSP) "lying horizontal at the head of the bed and not breathing. Nurse was summoned and CPR was initiated. 911 called. Nurse continued CPR until ambulance crew transferred consumer. (R1) was pronounced deceased in ambulance." In the facility's undated investigative report completed by E1, QMRP (Qualified Mental Retardation Professional), E1 noted that she had interviewed all staff members who worked the evening of 6/24/08 and had them complete witness statements. Statements from E2, E3, E4, E9 (DSPs) and E5 (LPN) were included with the facility's report given to surveyor on 7/7/08. Surveyor interviewed E2 on 7/7/08 at 1:40 P.M. E2 explained that he found R1 "around 9:30 P.M. - 9:40 P.M." when he was doing his last bed check before his shift ended. He said R1 was lying at the head of her bed on her stomach with her head and torso positioned out of her bed and her chin resting on a quilt on top of the bedside chair. R1's lower body from the waist down was on the bed positioned between the siderail and the headboard but was not stuck according to E2. E2 said R1 was "blue and purple" when he found her. E2 said he pulled R1 back into bed, called E4 and the nurse. When the nurse and E4 came into R1's room they started CPR. E2 confirmed that he did not start CPR when he found R1	W9999		

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W9999	Continued From page 34 unresponsive. Per interview with E7, (Activity and Safety Director), on 7/8/08 at 8:30 A.M., E7 said she was called around 9:40 P.M. and told R1 had been found unresponsive. She immediately went to the facility, arriving before the ambulance. E7 noticed E3 waiting at the door to direct the ambulance crew to R1's room. E7 went to R1's room and observed E4 and E5 doing CPR. E7 said when she first came into R1's room, she grabbed the CPR back board and put it under R1. E7 said she noticed the quilt from R1's bed had been folded and lying on the bedside chair. E7 explained they always take the quilts and bedspreads off the residents' beds and use top sheet and blanket for covering. E9 was interviewed on 7/8/08 at 3:05 P.M. E9 said R1 was put to bed around 7:10 P.M. after her snack. E9 stated that he went to R1's room for his last bed check before he left the facility. R1 was awake and turned her head toward him when he spoke to her. At this time R1 was clean and dry, her eyes were open and "everything was normal." In a later interview with E9 on 7/15/08 at 2:05 P.M., E9 said R1 would often stay awake until 9:30 or 10:00 P.M. When asked if R1 always went to bed early, E9 said residents are put to bed after snacks are finished around 7:10 P.M. and if R1 didn't fall to sleep right away would "just lay there, then look around if she heard something." R1 liked to lay on her left side and look out the window. R1 also liked to "ball up at the top of her bed" and he would have to	W9999		

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W9999	Continued From page 35	W9999		

straighten her out, moving her down on the bed. On 6/24/08, E9 said R1 was lying close to the bedrail and was stretched out fully.

Per interview with E12 (DSP) on 7/15/08 at 4:00 P.M., E12 confirmed that R1 would sometimes stay awake for awhile after being put to bed. E12 said R1 liked to scoot up to the head of her bed leaning into the side rails. R1 liked to sleep on her left side and could turn over by herself.

Surveyor asked E12 if R1 had ever attempted to get out of her bed prior to this incident. E12 said that she used to find R1 on the floor, probably about a year ago, but said this has not happened since bedrails were put on R1's bed. E12 said everyone knew that R1 used to crawl out of her bed and she told E8 (Administrator) that they "needed to do something about it." E12 said padded bedrails were put on R1's bed and as far as she knows R1 had no further incidents of getting out of bed.

During interviews with E3 on 7/7/08 at 1:40 P.M. and E4 at 2:02 P.M. both direct care staff confirmed that R1 often liked to sleep in different positions on her bed, sometimes way up on the bed near the headboard or at the other end of her bed.

E5 (LPN) was interviewed 7/8/08 at 7:10 A.M. E5 said she saw R1 when she was giving medication to R2 (R1's roommate) around 8:30 P.M. R1 was fine, lying in bed facing the window. Around 9:40 P.M., E5 was "down the hall" by the laundry area when E4 came to her, told her she "needed to come" to R1's room. E5 said R1 was lying in bed, on her back. R1's "neck didn't look right; she had a mark on her neck. Her chest and neck were

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W9999	Continued From page 36 purple" and R1 was unresponsive without breaths or heart rate. E5 confirmed that she and E4 started CPR and E3 called 911. In an interview with E3 on 7/8/08 at 3:15 P.M., E3 said that he and the nurse did CPR but when they saw the paramedics at R1's door, they stopped. Interview with E2 on 7/8/08 at 3:20 P.M. confirmed CPR was being done but they stopped when the paramedics came into the room. Surveyor asked E5 if she was satisfied with direct care staff's response to the emergency. E5 said yes, but she does "wish staff would have yelled for her" instead of coming down the hall to get her. When E4 came for her "at first didn't seem alarmed; didn't seem like an emergency." Review of the facility's undated policy titled "CHANGE OF CONDITION, EMERGENCY CARE, NOTIFICATION OF PHYSICIAN," states "If a resident expires, initiate CPR unless ordered otherwise. Call ambulance." The facility's policy does not address when CPR should be stopped. Per facility's procedure taught in DSP training classes, given to surveyor by E1 on 7/8/08, "a nurse is not required to authorize a 911 call." There is no evidence the facility identified this breakdown of communication with the nurse, identified whether the facility's emergency procedures had been followed or that staff were retrained on the facility's emergency procedures. There is also no evidence the facility identified that CPR had not been started immediately upon finding R1 unresponsive, that E4 and E5 had not used the back board before starting CPR, and that CPR had been stopped by facility staff prior to turning CPR over to the paramedics.	W9999		

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W9999	Continued From page 37 In the facility's investigation, R1 was identified as being capable of repositioning herself while in bed but does not say how R1 was able to do this. Surveyor interviewed E1, QMRP (Qualified Mental Retardation Professional) on 7/7/08 at 2:30 P.M. E1 said R1 "repositions herself in bed and can roll herself over. She doesn't need help." E1 also stated that R1 had never tried to crawl out of bed. Surveyor also asked E1 if other individuals with siderails on their beds had been re-assessed after R1's death. E1 said "no." Per telephone call with E8 for the daily status meeting on 8/4/08 at 12:40 P.M., E8 said the siderails were used to help R1 reposition herself in bed. R1's IPP (Individual Program Plan) of 9/12/07 does not contain any information regarding the need for siderails, nor was there any type of assessment showing why siderails were used. E8 also told surveyor that after R1's death the facility had contacted Occupational and Physical Therapists to reassess all individuals with siderails but did not recall the date they called them. The facility did not provide any evidence of this notification or that individuals with siderails had been re-assessed. During telephone interview with E1 on 8/4/08 at 2:00 P.M. and documented on cover sheet accompanying the daily status form, E1 "called and scheduled PT come do bed rail assessments some time prior to 7-23-08." E1 confirmed PT was coming to the facility on 8/8/08 to evaluate individuals which was the first date available.	W9999		

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W9999	Continued From page 38 (Per telephone call from E1 on 8/11/08 at 11:38 A.M., the physical therapist "did not show up" as scheduled on 8/8/08. E1 called the therapist and he has rescheduled the assessments for 8/15/08.) The facility did not provide evidence of how clients with siderails will be safeguarded until they are re-assessed on 8/15/08 by the physical therapist. A prior physical therapy evaluation for R1, dated 8/25/07, recommended the facility should "practice transfers and bed mobility" for R1 but does not specify any method of training. The IPP did not incorporate objectives to address PT's recommendation. Additionally, the physicians's orders dated 6/1/08 to 6/30/08 do not specify using padded side rails. In an interview with E8 on 7/16/08 at 3:00 P.M., E8 said she was not sure why or when siderails were initiated for R1 but she would check past documentation. E8 gave surveyor a copy of R1's IPP dated 9/20/06 but it did not address R1's bed mobility, that there had been an issue with R1 having been found out of her bed or that padded siderails were needed. E8 said she thought the siderails were added some time around 10/06. No witness or interview statements from E7, E10 (DSP) or E12 were included as part of the facility's investigation. The investigation referenced "Other DSP staff were also interviewed the next day and no one had noticed anything unusual with (R1's) behaviors or condition.....She had no known	W9999		

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W9999	Continued From page 39	W9999		

history of attempting to get out of bed independently." The names of the staff who were additionally interviewed, questions asked and answered were not included in the facility's investigation report.

Additionally, there is no reproducible evidence that the facility determined where staff were located at the time of the emergency; nor was the level of supervision needed for R1 while in bed, whether asleep or awake, identified in the investigation or in R1's IPP.

During a telephone interview with the forensic pathologist (Z5) on 7/10/08 at 11:50 A.M., Z5 said that his preliminary findings show that R1's death is "consistent with positional or mechanical asphyxiation." Z5 said he noticed "pressure marks" on both sides of R1's neck. Petechiae was observed in both eyes "which goes with neck compression." Z5 said he "could find no reason for (R1's) death. There was no evidence of a stroke or heart attack." The pathologist said he was waiting for the toxicology report before he finalized his autopsy report.

Surveyor spoke with Z5 again by telephone on 7/17/08 at 9:05 A.M. Z5 had not received the toxicology report but he still believed the cause of R1's death was positional or mechanical asphyxiation. Z5 explained that R1's "scoliosis was a contributing factor and would definitely impede her breathing in the position she was found." Z5 confirmed that there was no natural reason for R1 to have died and he found no evidence of "lethal trauma."

Review of R1's death certificate dated 7/18/08 specifies the immediate cause of R1's death on

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W9999	Continued From page 40 6/24/08 as "Consistent With Positional/Mechanical Asphyxia." Per Falls Risk Assessment of 6/3/08, R1 was considered high risk for potential falls. The Occupational Therapy evaluation dated 8/13/07 indicates R1 had poor torso control and needed support when in wheelchair. R1 used pelvic/torso positioner while in her wheelchair for body alignment and support. However, there is no assessment and no reference in R1's IPP identifying R1's positional needs and the use of siderails while she was in bed. Review of the emergency services (EMS) "run" report dated 6/24/08, show they received the 911 call at 9:39 P.M., left for the facility at 9:41 P.M. and arrived at the facility at 9:45 P.M. The report states that upon EMS arrival "found 3 people in room (with) patient. (No) chest compressions being done.....mottling noted to both elbows & back of tricep area, mottling noted to buttocks, face blue, nail beds blue - skin cool to touch." R1 was pronounced dead at 9:51 P.M. by the paramedics while still in the ambulance. During a telephone interview with Z2 (paramedic) on 7/8/08 at 10:21 A.M., Z2 said that when she arrived at the facility 3 staff were by R1's bed "just standing there doing nothing." In a telephone interview with Z3 (intermediate paramedic) on 7/8/08 at 10:31 A.M., Z3 said he also observed facility staff standing around R1's bed but not doing "chest compressions, no bagging, no AED (defibrillator)." According to R1's chart, R1 was not identified as a DNR (Do Not Resuscitate). Z3 said that R1 was already showing signs of lividity and was "cold and	W9999		

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W9999	Continued From page 41 clammy". Z2 and Z3 both stated the nurse did not give them any kind of verbal report. (A) 350.620a) 350.1230b)3)6)7) 350.1230c(350.1230d)1)2)3) 350.1230e) 350.1230f) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by 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 350.1230 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.	W9999		

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W9999	Continued From page 42 c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. 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. 3) First aid in the presence of accident or illness. 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. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. 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 services to meet the needs of 1 of 1 sampled individual (R3) who was hospitalized on 7/14/08 with a diagnosis of pneumonia when they failed to: 1) Assess R3's health condition immediately when day training staff reported R3 was not feeling well;	W9999		

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W9999	Continued From page 43 2) Take all vital signs, including temperature at the time of assessment; 3) Assess R3 who has a diagnosis of Congestive Heart Failure and Deep Vein Thrombosis for edema; and 4) Re-assess R3 between his first assessment at 2:10 P.M. and 4:10 P.M. when the physician called back with orders to send R3 to the emergency room for evaluation. Findings include: According to physician's orders dated 7/1/08 - 7/31/08, R3 is a 57 year old male who functions at the profound level of mental retardation. Additional diagnoses include Epilepsy, Hypothyroidism, CHF (Congestive Heart Failure), and Deep Vein Thrombosis of Left Leg. Per review of nurse's notes dated 7/14/08 and timed 2:10 P.M., R3's pulse oxygen saturation (02 sat) was 88% - 89%. The nurse documented "Congestion noted bilat (bilaterally). Color pale." The physician was contacted. The next entry in the nurse's notes was timed 4:10 P.M. with new orders from the physician to send R3 to the emergency room for evaluation. On a separate monitoring sheet, R3's vital signs were as follows: Blood pressure 118/68, pulse 60 and respirations 24. R3 was "cool to touch." No temperature or oxygen saturation rate were noted. E11, LPN, was interviewed on 7/15/08 at 11:55	W9999		

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W9999	Continued From page 44 A.M.. E11 said she first became aware that R3 was not feeling well when on-site day training staff brought him to her around 2:00 P.M. E11 said she didn't take R3's temperature because R3 felt cool to touch. She said she called the doctor because R3 was congested and his pulse oxygen level was low. E11 told surveyor she didn't check R3 for lower extremity edema because he always has some edema and he wears therapeutic embolism stockings. E11 stated that she glanced down at R3's feet and legs and didn't notice that "they were any worse" than usual. In an interview with Z6 (on-site day training staff) on 7/15/08 at 10:15 A.M., Z6 said that she noticed R3 wasn't feeling well when he came to the on-site day training area at 8:30 A.M. Z6 stated R3 "just wasn't himself." Z6 said she mentioned this to the nurse (E11) then and again at lunch time when E11 came to the room to pass medications. R3 was not assessed by the nurse at this time however. Z6 said when staff took R3 for toileting around 2:00 P.M., then the nurse checked him. Z6 also confirmed R3 had not been acting like himself the prior week and when she informed another day nurse (E13) that something was wrong with R3 , the nurse's response was "that's just (name of resident R3)." Per interview with Z7 (day training staff) on 7/15/08 at 1:50 P.M., Z7 stated that R3 had not felt well for a couple of weeks. Z7 said she fed R3 around 11:00 A.M. on 7/14/08 and noticed he "was real pale and kept falling asleep." Z7 also stated that R3 "wouldn't eat. The food just oozed	W9999		

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W9999	Continued From page 45 back out." R3 also would not drink much of his liquids. Z7 said R3 normally has a very good appetite so this was unusual for him. Z7 said she heard Z6 tell the nurse that R3 was not feeling well on 7/14/08 when the nurse came in to pass medications but the nurse did not check R3 at this time. When R3 was incontinent around 1:30 P.M. - 1:45 P.M., Z7 and Z9 took him to the bathroom. Z7 said R3 "looked real bad" and they took him to the nurse who then assessed him. An interview with Z9 (day training staff) on 7/16/08 at 9:00 A.M. confirmed that R3 was "just wasn't acting right" on 7/14/08. Z9 said you "could tell he didn't feel well." Z9 said she and Z7 took R3 to the nurse after toileting him in the afternoon. She said R3 was "cold, clammy and weak." An interview with Z8 (day training staff) on 7/15/08 at 1:35 P.M. also confirmed she heard Z6 tell the nurse a couple of times that R3 wasn't feeling well on 7/14/08 - in the morning around 9:00 A.M. and again at med pass time but the nurse "didn't do anything" until staff took R3 to the bathroom around 1:45 P.M. and again informed the nurse that R3 was ill. Review of the hospital's emergency room record of 7/14/08 shows that R3 was seen at the emergency room at 5:06 P.M. with symptoms of congestion, coughing, and overall weakness. R3's vital signs were documented as B/P 121/57, pulse 54 and respirations 36. The report states R3's temperature "will not register - multiple attempts" made. R3's skin condition was dry, pale and cool.	W9999		

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W9999	Continued From page 46 The emergency room physician (Z10) was interviewed by telephone on 7/17/08 at 10:22 A.M. Z10 said R3 had a "pretty good infiltrate when he arrived." R3 was admitted with a diagnosis of pneumonia. Z10 said individuals with pneumonia do not always run a temperature but when R3 arrived at the emergency room his temperature would not even register because it was low. Z10 said at the first sign of low O2 sats, R3 should have been re-checked quickly and if still low nurse should have put R3 on oxygen and sent him to the emergency room. Z10 emphasized that he would have expected frequent assessments especially since R3 had shown signs of bilateral lung congestion. Z10 explained that individuals who are non-verbal need frequent assessments and often the first sign of illness is that they "just don't act right." Z10 also said that individuals with CHF should also be checked for edema even though they do not always develop edema with pneumonia. Z10 said he did not know why the doctor did not call the facility back sooner but "2 hours is too long." Z10 reiterated the nurse should not have waited for the call back but should have sent R3 to the hospital for evaluation. Surveyor interviewed Z4 (guardian) at 10:45 A.M. on 7/16/08 at the facility. Z4 said she had spoken with R3's physician on 7/15/08 when he called her requesting a Do Not Resuscitate Order (DNR) for R3. The physician informed Z4 of R3's illness and poor prognosis. Z4 visited R3 at the hospital on 7/15/08 at 2:10 P.M. and said he was unresponsive. Z4 said the nurse told her R3 temperature was low (91.9 degrees) even with	W9999		

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W9999	Continued From page 47 warm fluids running through his I.V. The nurse also said R3's blood pressure and heart rate had been fluctuating. Surveyor reviewed the facility's undated policy titled, CHANGE OF CONDITION, EMERGENCY CARE, NOTIFICATION OF PHYSICIAN. This policy states that if "resident's condition has changed, call attending physician and report changes and nursing observations. Provide emergency care as needed....Always take, report and record vital signs when a resident's condition has changed." This policy does not include any parameters of what constitutes a change of condition, when to take follow-up vital signs, or when to re-assess the individual after the initial assessment. The facility's policy does not include a protocol to address abnormal oxygen saturation levels or when oxygen should be applied. E6, RN/DON was interviewed on 7/15/08 at 9:50 A.M. E6 said that the facility's medical director requested the facility call him when there is a change in a resident's condition. E6 stated the nurse should have re-assessed R3 between 2:00 P.M. and 4:00 P.M. while waiting for the doctor to call back. E6 confirmed that the facility has oxygen but it was not used for R3 even though his oxygen saturation levels were below normal. In addition, review of R3's IPP (Individual Program Plan) of 10/10/07, shows that R3 is to have a weekly skin assessment and as needed (PRN), vital signs monthly and PRN, and to wear therapeutic anti-embolism stockings during waking hours. However, the IPP does not address how often nurses are to check R3 for	W9999		