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F 492	Continued From page 177 Inform the Nurse Supervisor / Charge Nurse of any changes in the resident's condition so that appropriate information can be entered on the resident's care plan. Resident Rights: Ensure that you treat all residents fairly, and with kindness, dignity, and respect. Report any allegations of resident abuse	F 492		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1220b)2)4)6)7) 300.3240a) 300.3240b) 300.3240c) 300.3240d) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. Restorative measures shall include at a minimum the following procedures: b)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing	F9999		

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F9999	Continued From page 178 and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 4) Recommending to the administrator the number and levels of nursing personnel to be employed, participating in their recruitment and selection and recommending termination of employment when necessary. 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. 7) Coordinating the care and services provided to residents in the nursing facility. Section 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility	F9999		

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administrator. (Section 3-610 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility neglected to assess residents for two shifts that had changes in condition warranting emergent care, intervention, assessment, and medication administration by nursing personnel, and failed to notify the physician for two of two residents, (R2, R3) with unrelieved pain and a significant change in condition.

The facility failed to assess an unresponsive resident, R2. R2's declining condition change was repeatedly reported to one nurse, E6. The facility staff did not follow the Chain of Command reporting process, after repeated reports of R2's unresponsiveness were not addressed by E5.

The facility failed to assess resident pain, provide physician ordered pain medication, for R2 and R3. The facility failed to administer routine and as needed breathing treatment medication to R3. The facility failed to follow their policy and procedure for Pain and Charting. The facility nursing staff did not follow the Charge Nurse job

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The facility failed to investigate incidents of repeated staff communicated concerns to Administration regarding direct care staff (E5, E6), failed to implement corrective action, and did not monitor staff delivering care, resulting in two residents suffering neglect (R2, R3). The facility failed to follow their policies and procedures for Abuse/Neglect, Physician Notification, Pain and Charting. The facility nursing staff did not follow the Charge Nurse job description.

Findings Include:

1. The 2-1-2009 through 2-28-2009 Physician Order documents R2 as having diagnoses that include hypothyroidism, depression, osteoarthritis, weakness, and dementia. This same Physician Order documents pain medication as Acetaminophen 325mg. (milligrams) two tablets three times a day for pain and every four hours PRN (as needed) for pain, Tramadol HCL 50mg. one tablet twice daily and one tablet PRN for breakthrough pain.

The 12-1-2008 Minimum Data Set (MDS) documents moderate joint and soft tissue pain less than daily.

R2's 9-9-2008 and 12-2-2008 Resident Care Guide documents the following: Communication - Speech, "My speech is clear and I have no difficulty making my needs known." Pain - "I have arthritis, especially in my knees. They hurt especially at night. I take routine pain medication for this. If I complain of pain, am calling out for help, or appear restless and uncomfortable, please report this to my nurse / doctor so that I

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F9999	Continued From page 181 may receive further assessment and treatment." On 3-19-2009 at 10:34am. E9, CNA (Certified Nursing Assistant) stated, "I worked with (E7, CNA) the night before (R2) died. (R2) was moaning differently than other nights. (R2) said her back and legs hurt. We repositioned her more. (R2) had large bowel movements, not typical of her. I went to (E6, RN/Registered Nurse) three times to see if there was anything she could do, anything. I reported to her (R2's) pain was extreme. I could tell there was something different and wrong with (R2). I felt she (E6) could have assessed (R2) or given pain medication. (E6) said there wasn't anything she could give (R2). I talked to (E7) and she thought (R2) was in more pain, different than usual. I stayed with (R2) for twenty minutes and rubbed her back. She was in terrible pain, yelling out and moaning. I talked to (E4 the DON/Director of Nursing, at the time) and E4 had me come in due to complaints about (E6). I started working at the facility in January of 2009. (E6) wouldn't get up to help residents, answer call lights, or give pain medications to residents. (E6) had me give cough syrup to (a resident, R9). I witnessed (E6) tell (E12, CNA) to change a resident's (R5's) gastrostomy tube. I discussed all of this with (E4, DON). (E4) said it was wrong. I reported extreme, unrelieved, different pain to (E6) three times regarding (R2). (E6) never checked on (R2). (R2) could say yes or no if she had pain and tell you where it was or show you." On 3-19-2009 at 10:01am. E8, CNA stated, "(R2) was able to verbalize yes or no if she needed pain medication." On 3-19-2009 at 9:14am. E7, CNA stated, "The	F9999		

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F9999	Continued From page 182 night before (R2) died she was yelling in pain. (R2) was able to verbalize pain and tell you where at. (R2) was yelling in pain for a couple of hours. (E9, CNA) and I went to (E6, RN) and asked her to give (R2) something, anything for pain. (E6) said she won't take anything. We said can you try and (E6) said she doesn't get anything. (E6) didn't go check on the resident. I wrote this up and gave it to (E4, DON). Oh yeah, I feel that (E6) should have and could have done more for (R2). I've been a CNA for twenty-nine years and (E6) should have and could have gotten up and checked on the resident and given pain medication. I'm not aware if (E6) called the doctor." On 3-18-2009 at 12:20pm. E5, (LPN/Licensed Practical Nurse) stated, "In shift report 2-16-2009 (E6, RN) said (R2) was up talking until early morning and went to sleep. The CNAs said (R2) was screaming all night. Third or first shift CNAs reported (R2) screaming. I went down between 8:30 and 9:00am for the 8:00am. medication pass and shook and talked to (R2). (R2) acted like in a really deep sleep. (R2's) eyes twitched but didn't open. (R2) didn't take her medication. I might have checked on (R2) around 10:00am. or 10:30am. I shook her and she didn't wake up, or open her eyes. Sometimes (R2) would sleep a lot. I can't remember if there was ever another time when I shook her and she didn't wake up or open her eyes. (R2) didn't take noon medications either. The CNAs told the DON about (R2). The DON asked me to send (R2) to the hospital, call the family and doctor. When I last saw (R2) her eyes were fixed, pupils unresponsive, and her head was to the left. It's no excuse but I was on my eighth day straight. The DON and Administrator asked me to resign	F9999		

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F9999	Continued From page 183 on 3-17-2009." On 3-19-2009 at 11:21am. E4, DON stated, "I was the DON in February 2009. February 16, 2009 around 2:00pm. I heard two CNAs in the hallway say (R2) was unresponsive. I went to (R2's) room and assessed her. (R2) did not respond when I called her, shook her, and did a deep chest rub. (R2) had sonorous snoring, was on her left side, I did not see her pupils, I wish I had. I went to (E5, LPN) and said the CNAs told me (R2) was unresponsive, she is not with us. We need to get her to the hospital right away. I left it up to the nurse. I had other issue to attend to. I did not know until the next day that (E5) had not checked on (R2). I started an investigation by pulling (R2's) chart and calling CNAs. I'm not aware of the physician being contacted by (E5) or (E6, RN) about pain the night before or unresponsiveness. (E6) did not document (R2's) pain the night before. When I spoke to (E6) she denied, and then said the CNAs might have reported (R2) was up all night. The CNAs told me (R2) was in pain. My focus was on the incidents of the next day, not the night before. I don't know if the outcome would have been different had I known about the night before, if the doctor had been contacted." On 3-18-2009 at 11:48am. R1 stated, "I've been a resident here since November 7, 2008. (R2) ate in the same dining room, I do. She died on a Tuesday. The night before on Monday at 3:00am. I went to the bathroom. I looked across the hall and it sounded like (R2) was having a seizure, yelling, and moaning. At 2:00pm the next day they took her to the hospital and she died the next morning. I looked at the clock, so I know it was 3:00am. The sheets were moving	F9999		

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and she was yelling and moaning. No staff were there then. The next day staff said she was sleeping. She didn't come out for breakfast or lunch. Staff just said she was asleep. I thought something wasn't right, because (R2) was always out to eat. I saw her when the Emergency Response System took her out on the stretcher. Her head was to the side, like this, (demonstrated head to side). Two other people have died, one fell on their head and the man who couldn't breathe and was up all night before he died screaming and asking for help, saying he couldn't breathe. He was on this hall. I think he died the next day."

R1's 11-17-2008 and 12-13-2009 MDS document that R1 has no memory problems, is independent with decision making.

The 2-1-2009 through 2-28-2009 Medication Administration Record documents R2 did not receive any medication on 2-16-2009 at 8:00am. and 12:00 noon, (a rationale for failing to administer these medications is not documented). This same Medication Administration Record documents R2 as receiving one PRN pain medication, Acetaminophen 2-325mg. tablets for back pain, once in February on 2-13-2009, (R2 did not receive PRN pain medication on 2-15-2009).

R2's Nursing Notes show documentation on 2-5-2009. The next Nursing note is 2-16-2009. R2's file does not contain documentation for 2-15-2009.

R2's Admission Pain Assessment is incomplete. This pain assessment does not document location of pain, severity level of pain, and what

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should be done for pain relief.

R2's Blood Pressure, Pulse, Respiration and Temperature Monitor Sheet, (vital signs) documents the last entry as 12-1-2008.

On 3-25-2009 at 1:30pm. E11, Medical Records/Staffing Scheduler stated, "the only vital signs I could find on (R2) are from 12-1-2008 and one set in the 2-16-2009 at 12:00 noon Nursing Notes. I can't find the 24 hour staff report sheets for 2-15-2009 and 2-16-2009, that staff use for shift report. I know they were pulled, they must be with the DON or Administrator."

On 3-27-2009 at 11:50am. E1, Administrator stated, "I can't find the 2-15-2009 and 2-16-2009 24 hour shift report sheets."

R2's 2-16-2009 Hospital Admission note documents the following:
This morning found in bed apneic, no cardiopulmonary resuscitation was initiated and it is unclear the length of time that she was down. The emergency response system was notified, unclear how long she was apneic or at what point she may have started breathing on her own again. Neurologic: Pupils are fixed and dilated, corneal reflex is negative, left eye deviation, left tongue deviation, head turned to left. To deep noxious stimuli has a very minimal extensor posturing with the right lower extremity.

The 2-17-2009 Hospital Physician documentation is, "Patient (R2) was found to have a nonreactive pupil from the time of admission and during my examination, patient had about 6 millimeter fixed nonreactive pupils bilaterally. Patient had minimal response to painful stimuli."

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R2's Illinois Certificate of Death documents the date of death as 2-17-2009 and immediate cause of death as cerebral hemorrhage.

On 3-19-2009 at 5:30pm. Z2, Neurologist stated, "I saw (R2) at the hospital, as her neurologist. If I recall correctly (R2) had a pretty massive bleed." Z2 was informed of the events at the facility on 2-15-2009 and 2-16-2009 including the lack of assessment, failure to notify the physician, lack of interventions from the nurses, and failure to respond to the CNA concerns of extreme pain reported to the nurse, failure to administer pain medication, and the inability of the nurse to illicit a response, administer medication, including the day nurse shaking the resident and the resident not responding or opening her eyes, head positioned to the left with snoring respirations. After being informed of this information Z2 stated, "I can say the resident did not receive great nursing care and the facts lean to neglect and need to be investigated. It certainly leans to neglect."

2. The 12-26-2008 Physician Order Sheet documents R3 as being admitted to the facility on 12-26-2008 with diagnoses that include lung cancer, pneumonia, respiratory failure, hypertension, and fluid overload.

The 12-26-2008 and 1-1-2009 Physician Orders are: Albuterol, (bronchodilator) 0.83mg./ml. per nebulizer three times a day and every four hours PRN . Atrovent, (bronchodilator) 0.02% inhalation solution per nebulizer three times a day and every four hours as needed. Advair HFA 115-21 - 2 puffs twice a day. Oxygen at 3 lpm.,

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F9999	Continued From page 187 (liters per minute) per nasal cannula, continuous positive air pressure when sleeping. Vicodin (analgesic, combination narcotic) 5-500 one tablet every four hours as needed. Nitroglycerin (treatment of chest pain and pulmonary hypertension) 0.4mg. sublingual tablets, one every five minutes up to 3 times. The above medication pharmacologic category and use information was obtained from Lexi-Comp's Drug Reference Handbook 12th Edition, Geriatric Dosage Handbook. R3's 12-31-2008 MDS documents R3 has no memory problems, moderate bone pain less than daily, and is administered oxygen. R3's 12-26-2008 Nursing Admission Assessment regarding pain documents, "no pain." This same pain assessment does not document location and severity level of pain and what is done for pain relief. On 3-19-2009 at 9:14am. E7, CNA stated, "On New Year's eve, (12-31-2008) two other CNAs, (E8, E14) were working. I went out to get a gown and there were three call lights on. I asked (E6, RN) to help. (E6) said I have my own work to do. I heard (R3) yelling and saying help me, help me, I can't breathe. He looked like he was short of breath, his face was pale, he appeared to be having difficulty getting a breath, and in pain. His oxygen saturation was 79 to 81% with oxygen on at 4 lpm., I think. I went and told (E6). I assumed (E6) was going to get up. (E6) was eating and reading at the desk. (R3) continued to complain about shortness of breath and (E6) didn't go in there. About 1:34am. (E6) went down to (R3's) room. The next night (R3) was in the hospital. It was like pulling teeth to get (E6) to do	F9999		

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F9999	Continued From page 188 anything. Oh yeah, I feel (E6) should have and could have done more for (R3). (E6) should have and could have gotten up and checked on (R3), given pain medication, or PRN medication, or anything. I'm not aware of (E6) calling the doctor." On 3-19-2009 at 10:01am. E8, CNA stated, "I worked New Years Eve, (E7, CNA) and I. (R3) had used his call light several times and complained of breathing. (E7) checked his oxygen saturation and it was 79 -80%, so (E7) told (E6, RN) about the oxygen saturation and not being able to breathe. (E7) and I counted 17 -18 call lights from him before 2:00am. (E7) and I did first rounds and (R3) kept saying help me, help me, he said he was having a hard time breathing. (E7) and I told (E6) three or four times that (R3) was in respiratory distress. (E7) did a second oxygen saturation. (E7) and I were by (R3's) room and it was 1:34am., (R3) was supposed to have a breathing treatment at 12:00 midnight. (E6) said later when (E7) and I brought up (R3's) continued difficulty breathing, call lights, calling out repeatedly, and our concerns, (E6) said, (R3) will have that. (E6) then asked (E7) to go ask (R3) if he wants to go to the hospital. (E7) and I didn't, we told (E6) that she's the nurse and supposed to assess that and (E6) didn't go in his room again. Later that night, (E6) said (E10, LPN) will be here in the morning. I'll let him figure it out. (E6) told (E10) the CNAs didn't let me know about (R6) or I would have sent him to the hospital. I told the Director of Nursing, (E4) in January about the incident. (E4) told me she'd take care of it. I talked to (E4) three or four times about (E6) not assessing residents, giving pain medication, and checking body alarms."	F9999		

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On 3-19-2009 at 1:40pm. E10, LPN after reviewing R3's nursing notes, stated, "I took care of (R3) on 1-1-2009 day shift. Yes, these are my nursing notes, (Nursing Notes of 1-1-2009). (R3) was short of breath, the whole time he was here and needed more and more accessory muscles to breathe. I don't remember getting report on 1-1-2009. (R3) was physician ordered to get 3 lpm of oxygen. I don't recall if the night nurse (E6) gave me information about (R3's) condition during the night. I don't remember conversations with CNAs about (R3's) condition. I've heard third shift CNAs talk about (E6) not responding right away to residents concerns. I know the CNAs talked to the Director of Nursing quite a bit about (E6) not answering call lights, and failure to respond to residents on a few different occasions."

On 3-19-2009 at 11:00am. E4, DON stated, "I didn't hear about the concerns of New Years Eve and New Years Day regarding (R3) until later. I didn't need to go down that path, I didn't investigate."

The 1-1-2009 Daily Skilled Nurses Notes for nights and day shift Flow Sheet documents R3 as having no complaints of pain. Respiratory documentation is shortness of breath, oxygen at 5 lpm with oxygen saturations at 85 to 92%. This same Daily skilled Nurses Notes for nights and days document the following: 12 midnight nursing note is oxygen at 3.5 lpm. and short of breath, with substernal retracted breathing. "I can't get my breath." Oxygen saturations 85%. Oxygen increased to 5 lpm. Oxygen saturations improved to 90 - 92%. Very anxious throughout the night. Refused pain medication and to go to hospital if breathing did not improve. 6:00am.

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nursing note is awake all night with short rest intervals, used call light close to thirty times this shift, very restless. 8:00am. nursing note is resident notably short of breath, oxygen saturation 92% on 5 lpm oxygen. 11:00am. nursing note is resident continues to use accessory muscles to breathe. Oxygen saturation remains 90 - 92% ib 5 lpm. oxygen. 2:00pm. nursing note is family here, want resident sent to hospital. 3:05pm. nursing note ambulance called and resident sent to hospital.

The 12-31-2008 and 1-1-2009 Medication Administration Record lack documentation that R3 received Advair Diskas 2 puffs at 12 midnight, PRN breathing medication, Albuterol or Atrovent with nebulizer, Vicodin for pain or Nitroglycerine.

R3's State of Illinois Certificate of Death documents the date of death as January 7, 2009 and Immediate cause of death as metastatic lung cancer.

On 3-26-2009 at 1:20pm. Z3, (R2 and R3's Physician) was informed of the events of 12-31-2008 and 1-1-2009 for R3, including repeated requests for assistance, lack of routine and as needed medication, physical symptoms of respiratory distress, a low oxygen saturation with increased oxygen needs, documented thirty call lights for staff assistance, failure to notify the physician, lack of interventions from the nurses, and failure to respond to the CNA concerns of extreme pain and difficulty breathing reported to the nurse, lack of vital signs and assessments. At this same time Z3 was informed of the events of 2-15-2009 and 2-16-2009 for R2, including the lack of assessment, failure to notify the physician, lack of interventions from the nurses, and failure

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to respond to the CNA concerns of extreme pain reported to the nurse, failure to administer pain medication, and the inability of the nurse to illicit a response, administer medication, including the day nurse shaking the resident and the resident not responding or opening her eyes, head positioned to the left with snoring respirations. After being informed of this information Z3 stated, "There appears to be a lag in onset and change in condition and contact to the physicians. From the information you presented to me I share your concerns of neglect, improper nursing care, lack of assessment, failure to provide an intervention or pain medication.

3. The following interviews are applicable to R2 and R3 in above examples.

On 3-18-2009 at 11:37am. E1 (Administrator) stated, "All employee information and discipline information is contained in their personnel file."

On 3-24-2009 at 2:20pm. E1 (Administrator) stated, "We have an abuse/neglect committee which is comprised of the Administrator, DON (Director of Nursing), and the Social Service Director. If an allegation of abuse or neglect comes to our attention we do the investigation as a team. Outside of investigations we do not meet as an abuse/neglect committee. We do meet daily for our Leadership Meeting, Monday through Friday. The Quality Assurance Committee meets quarterly and we discuss if there have been incidents or allegations of abuse or neglect. Since January of 2008 I do not believe we have had an incident or allegation of abuse or neglect. I have not seen an abuse/neglect compilation report. If there's no

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F9999	Continued From page 192 allegations there's not a report. I don't recall having one in the Quality Assurance reports. I did the abuse/neglect training at the Inservice Blitz last October of 2008. (Consultant) did the actual training under Resident Rights. Employees go through abuse and neglect training with the Social Service Director at the time of hire. It can be one on one or as a group." On 3-24-2009 at 2:45pm. E3 (Social Service Director) stated, "I am involved with abuse and neglect sometimes, yes. If concerns of abuse or neglect were with nursing the DON took care of it, or with staff members, and I wasn't involved. My name is on the committee, yes. If it was a full out investigation I would help, yes. Lately I haven't done abuse or neglect training. I do Resident Right Training which includes the Resident Statement that the Resident is to be free of abuse or neglect. I tell staff if they notice abuse, to report to a staff nurse or DON, and that we do an investigation. We did training about a year ago in March 2008. A Resident Right abuse/neglect bingo, and in February 2008 we had a bulletin board up of Resident Rights in the hall for the month of February 2008. We should probably do another Resident Right bingo, it's about time. I helped with an investigation of abuse and neglect, one resident said an employee called another resident a (racial slur) and we terminated that employee. It would have been in 2007 or 2008 with the prior Administrator. I can't recall any other incidents I helped investigate. Sometimes (E4) the DON would share the investigation information with me and sometimes just (E1, Administrator). I remember her, (E4) calling me about a resident upset over a staff member. (E4) sent the staff member home, but felt the situation was not abuse or neglect.	F9999		

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The resident was (R10). The staff member was a third shift CNA, (Certified Nursing Assistant). (E4, DON) and (E1, Administrator) met regarding this situation, a couple months ago, after Christmas. (E4) told me about another incident, staff complained about each other and the DON, (E4) had to come in, involving (E6, RN/ Registered Nurse) and (E8, CNA). She (E4) and (E1) took care of it. These are the only situations, these three, I can recall in the last six months."

On 3-18-2009 at 9:15am. E1, (Administrator) stated, "(E4, DON's) last day was 3-13-2009."

On 3-19-2009 at 11:00am. E4, (DON) stated, "I was the DON in February 2009. I was the DON for not quite a year. I worked at the facility since 2005 as a Restorative Nurse, Minimum Data Set Nurse, Assistant Director of Nursing and in February of 2008 became the Director of Nursing. Greater than 3 times CNAs complained of (E6, RN) not giving medication and pain medication to residents, not assessing residents. I believe in education prior to discipline. I verbally counseled (E6) about not assessing residents. I had (E6) come in and counseled her of the CNAs multiple complaints. I was called in by the CNAs last fall, about (R6) not assessing residents. I had discussed these incidents with the Administrator, (E1). I don't recall her (E1) response. I would hope she has my written documents. I also had complaints of CNAs hanging feedings. I didn't hear about (R3) until later. I didn't need to go down that path. I didn't investigate. I just tried my best. That's why I left. I couldn't take the responsibility for others' actions. I counseled (E6) numerous times about not assessing residents with CNA complaints. I

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came in one night due to CNA complaints. I was told about CNAs with feedings and administration of the cough syrup, and (E6's) attitude. I had the documentation to terminate (E6) for the cough syrup administration by the CNA. R2 and R3 had expired and E5 had resigned so I didn't need to investigate. (E5, LPN) terminated her employment. I don't recall if (E1) the Administrator asked her to resign. It was a very stressful day, it was the day after (R2) was transferred. I handed it over to (E1) the Administrator. I discussed calling the Department of Professional Regulation. I gave her (E1) my investigation and said I don't know how to do that. I'm not aware of any Incident Reports to Illinois Department of Public Health."

On 3-19-2009 at 11:50am. E1 (Administrator) stated, "(E4, DON) brought me in this morning her notes from (R2's) investigation completed internally. I have some notes from the CNAs. An Incident Report wasn't filled out because we looked at this as a situation where the nurse (E5, LPN) was not responding to the CNAs. Communication was a concern. After the CNAs were questioned we found out about the length of time (R2) hadn't been responding, or was unresponsive. We didn't investigate this situation as abuse or neglect. (E5) resigned and (E6, RN) was fired and the residents (R2, R3) had expired. (E6's) investigation began when an allegation of a CNA (E9) giving a resident medication, (R9). I did not send Incident Reports to the Illinois Department of Public Health about (R2, R3). The Department of Professional Regulation was not contacted about (E5 or E6). The Nurse Aid Registry was not contacted about (E9). An internal investigation was not completed on (R3). When we received that information he (R3) was

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F9999	Continued From page 195 already gone. I began as Administrator in January of 2008. My recollection is this was a condensed period of time in which the DON received complaints from CNAs about (E5) and (E6) and then it was over. (E5) chose to resign rather than terminated. (E6) was fired. These nurses were a problem and they're gone. We've resolved the problem by them no longer working here. (E6) was terminated due to the medication the resident information became apparent then." R3's State of Illinois Certificate of Death documents the date of death as January 7, 2009 On 3-19-2009 at 11:50am. E1, (Administrator) provided two undated, unsigned, partially documented in pencil, notes on a providers note pad paper as follow: 1. First name, (presumably E9, CNA). "Cough med." "(R2) had been in pain all night, back and legs severe." "Reported three times, no meds." "Patient had BM (bowel movement) two aids in room." "alarm going off during care. (?) and he pulled out IV (intravenous), (first and last name initials (presumably E6, RN) sitting at desk and didn't check on it. Aid came out and got alarm." "Do not interrupt her while she does her work." 2. "Still talking on an outside line, giving specifics about residents and staff." E5, LPN's personnel file does not contain any disciplinary information. R5's 2-17-2009 signed note is, "Effective as of today, I hereby resign my position as LPN." R5's 3-2007 through 3-2008 Employee Job Performance Evaluation Section Attitude: Personality, temperament, cooperation and loyalty toward others - Comments: "Perceived as negative by peers and leadership team, this makes them reluctant to approach you	F9999		

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F9999	Continued From page 196 with concerns." Safety Awareness: Adherence to institutions safety standards - Comments: "Has had two medication errors in past year. Has been warned about setting meds and leaving meds with residents." E6, RN's personnel file contains verbal and written warnings regarding tardiness by Administration. The staff written documentation of concerns regarding incidents involving residents and staff members is also in E6's personnel file, however this is not documented as being addressed by Administration. E6's 2001 through 12-11-2008 annual Employee Job Performance Evaluations document concerns of verbal reports from co-workers and CNAs regarding communication and reported resident conditions not being reflected in charting and/or not being addressed. Some examples of the many documented comments in E6's Employee Job Performance Evaluations are as follow: 12-1-2007 through 12-11-2008, "Peers report that she can be difficult to get along with." 12-11-2006 through 12-11-2007, "Some CNAs have expressed concern that even if you are nearby or not busy at the Nurses' Station, that you do not respond to call lights or alarms. It is the responsibility of all staff to respond to residents requiring assistance to ensure their safety and meet their needs." 12-11-2005 through 12-11-2006, "It is vitally important to recognize CNA input and respond to their resident concerns." 3-4-2005 through 3-4-2006, "Verbal reports from CNAs regarding resident conditions are sometimes not reflected in the nurses notes -especially noted with night time behaviors. I have received comments from staff that they don't feel that you always respond to their	F9999		

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requests in a timely manner. Social Service reports that they have had occasional resident concerns that your approach at times borders on being slightly condescending when speaking to them."
3-4-2003 through 3-4-2004, "Numerous difficulties lately working with co-workers."
12-2001 through 6-2002, "Need to address pertinent topics, especially pain at time of occurrence."

On 3-19-2009 at 1:40pm. E10, (LPN) stated, "I've heard third shift CNA's talk about (E6, RN) not responding right away to resident concerns. I discussed with (E4/ Previous DON) (E6's) tardiness and staying over. Not what I overheard from the CNAs. I know the CNAs talked to (E4) quite a bit about (E6). I've seen the CNAs in talking to (E4) and overheard their complaints of not answering call lights and her failure to respond on a few different occasions. I was in the Medication Room right by the Nursing desk."

On 3-19-2009 at 10:34am. E9, (CNA) stated, "(E6, RN) sent me down to give cough syrup to (R9). I gave over the counter cough syrup to him. It was discussed with (E4, previous DON) and she said it was wrong. (E4) called me later and asked me to come in and write up the information."

E9's 3-2-2009 signed note is, "I was asked to take cough syrup down to (R9's) room about two weeks ago. (E6) was the nurse in charge that asked me. I witnessed (E6) ask another aid to replace G (gastrostomy) tube feeding bottle on Friday 2-27-2009."

E7's signed undated note is, "Approximately

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three weeks ago (E9, CNA) told me that (E6, RN) had her go to (R9's) room and give him his cough syrup. She asked me what I thought about that and I told her that I wouldn't have done that. But, I couldn't tell her what to do. This would have been the last time (E9) and I worked together. (R2) died the next day."

On 3-19-2009 at 10:34am. E9, (CNA) stated, "I witnessed (E6, RN) telling (E12, CNA) to change (R5's) Gastrostomy tube feeding. (E12) was licensed in Missouri to do it. (E12) did it. All this was discussed with (E4, Previous DON) and she said it was wrong."

On 3-24-2009 at 8:30am. E1 (Administrator) after being made aware of concerns regarding E6's Annual Employee Job Performance Evaluation Documented Comments, stated, "I've been the Administrator since January of 2008, how would I know that information, the pattern, it was before me."

On 3-25-2009 and 3-26-2009 Documentation of investigations, Illinois Department of Public Health notification, and if applicable The Department of Professional Regulation and Nurse Aide Registry notifications regarding incidents involving R2, R3, R5, R6, R10 and E5 (LPN/Licensed Practical Nurse) E6 (RN), E7 (CNA), E9(CNA) and E12 (CNA) were requested of E1 (Administrator) and E2 (DON). No additional information was provided.

On 3-24-2009 at 8:35am. E1 (Administrator) stated, "We're doing an All Staff Meeting on 3-25-2009 on what steps to take if you cannot get through to your supervisor with resident concerns."

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On 3-26-2009 at 9:40am. E1 (Administrator) was discussing identified facility concerns and stated, "I can't argue the pain issues."

On 3-24-2009 at 10:40am. E2 (DON) stated, "When a resident is admitted a physical assessment and pain assessment are completed." After reviewing the Nursing Admission Assessment, E2 stated, "Yes, this is the pain assessment completed at admission. The nurse completing the admission completes the pain assessment typically."

On 3-26-2009 at 1:35pm. E2 (DON) stated, "We developed this pain assessment 3-25-2009 for quarterly pain assessments, which are being completed on every resident now. This form is being used now. Nursing will complete a pain assessment on every resident every shift."

On 3-25-2009 at 3:50pm. E2 (DON) stated, "We will be inservicing today, this afternoon. All nursing personnel on pain assessment, oxygen, change in resident condition, physician notification, chain of command, the new intake and output form, and documentation. Our plan is to start inservicing on all these policies.

On 3-25-2009 at 4:00pm. Z4 (Clinical Director) stated, "We've started pain assessments on all the residents and put pain assessment on the Treatment Administration Record. So staff can document and address pain each shift."

On 3-24-2009 at 1:01pm. E2 (DON) stated, "any nurse working is considered a charge nurse. This job description (Charge Nurse) is in the employee packet and given at the time of hire.

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F9999	Continued From page 200 The nurses sign they receive it and I assume it is in their employee file." 4. The following Policies are applicable to R2 and R3 in above examples. The undated Abuse and Neglect Prevention Protocol Policy, Screening of Abuser Policy, and Reporting Protocol provided on 3-25-2009 documents the following: Abuse and Neglect Prevention Protocol Policy: Key Protocol Operational Terms 1. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 5. Neglect may include but is not limited to: a. Failure to carry out required clinical or habilitation services as directed or ordered by a physician or authorized personnel. Screening of Abuser Policy: Documentation of Abuse Investigation Protocol: All abuse, neglect, or misappropriation of resident property reported incidents shall be documented on the Abuse Incident Report Form. The completed form shall be submitted to the Administrator for review. If the findings indicate credible evidence of abuse or misappropriation, the Administrator will be informed within twenty-four hours. If the evidence meets the serious incident or accident guidelines, the incident shall be reported by phone to Illinois Department of Public Health within twenty-four hours of the incident and in writing within five days of the incident. Reported incidents that do not have credible evidence as the investigation	F9999		

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unfolds, shall be reported to Illinois Department of Public Health in no less than five working days from the reported incident. The Abuse Coordinators are responsible to make sure all internal and state reporting requirements are done properly and timely.

The Abuse Coordinators shall submit an Investigative Compilation Report of the number of referrals and findings of investigations of reported incidents at least quarterly. This report shall be submitted to the Quality Improvement Committee and the Administrator during the appropriate quarterly meeting. The Abuse Prevention Coordinators, Administration and others, as appropriate, shall examine the Abuse Compilation Report, analyze the findings utilizing all available information, including the nursing home's Quality Indicator Report, and make pertinent recommendations to the Administration regarding findings.

Reporting Protocol:
Staff Member Reporting of Suspected Abuse Protocol:
A staff member who observes or witnesses abuse or neglect shall immediately report the matter to the designated Abuse Coordinators. The designated Abuse Coordinators shall inform the Administrator as indicated by the findings of the Investigation. If the Abuse Coordinators and the Administrator are unavailable, staff members who observe or witness abuse or neglect shall immediately report the matter to the Charge Nurse on duty. The Charge Nurse will then notify one (of) the Abuse Coordinators or the Administrator, as appropriate.

The revised 2007 Pain Policy is:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146123	A. BUILDING ______ B. WING ______	C 04/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH NURSING HOME	401 9TH STREET LACON, IL 61540

(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
F9999	Continued From page 202	F9999		

Pain - Clinical Protocol
Assessment and Recognition:
c. Such assessments should occur on admission to the facility, at each quarterly review, whenever there is a significant change in condition and at any time pain is suspected.
Treatment / Management
2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain.
3. The staff will evaluate and report how much and how often the individual asks for as needed, (PRN) pain medication.
4. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain.
Monitoring
1. The staff will reassess the individual's pain and consequences of pain at regular intervals; at least every shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain.
3. The staff will discuss significant changes in levels of comfort with the attending physician who will adjust interventions accordingly.

The Charge Nurse Policy provided on 3-24-2009 is:
Policy Interpretation and Implementation
3. The charge nurse, as a minimum, is responsible for:
a. Making daily resident visits to observe and evaluate the resident's physical and emotional status.
c. Reviewing individual resident care plans for appropriate goals, problems, approaches, and revisions based on nursing needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Continued From page 203
d. Assuring that the resident's plan of care is being followed.
g. Keeping the Director of Nursing services informed of status of residents and other related matters through written reports and verbal communications.
h. Providing direct resident care as necessary or appropriate.

The Charting Policy provided on 3-24-2009 is:
Policy Interpretation and Implementation
1. All observations, medications given, services performed, "etcetera" must be recorded in the resident's chart.
3. All incidents, accidents, or changes in the resident's condition must be recorded.

The revised 4-05 Oxygen Administration Policy is:
Policy: The administration of oxygen is performed under a physician's order with attention to safety and prevention of nosocomial infections.
Procedure:
1. Obtain physician's order for oxygen therapy to include liter flow, frequency, method of deliver (mask, cannula), and parameters for pulse oximetry if indicated.
6. Documentation needs to include, but is not limited to:
Date and time oxygen was initiated, if there was a change in resident condition.
Resident response to oxygen administration and on-going response to treatment.

(A)