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W 382	Continued From page 18 brought this matter to the attention of the night supervisor, E22 at this same time. E22 asked Z9 if they could just keep this matter to themselves, and not bring it to the attention of administration. Z9 stated to E22 that this was a reportable matter, and that she needed to report it to their administration. E22 then did report this information to administration. During an interview with E1(Administrator) on 4/15/11 at 10:00am, E1 confirmed that E21 left the bottles of liquid medication on the top of the counter of the nursing station, unattended. E1 stated that when she interviewed E21, E21 explained that she took the medications out of the refrigerator, in preparation of the medication pass. E21 stated that she was asked to assist with a transfer, and left the medications unattended. E21 told E1 that she knew better, but that she only left the medications unattended for a minute.	W 382		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.1030a)2) 390.1030c) 390.1030j)1) 390.1040k)3) 390.1040m) 390.1420a) 390.1430d) 390.3240a) Section 390.1030 Physician Services a) General Requirements for Physician Services	W9999		

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W9999	Continued From page 19 2) Physician services are to include a complete physical examination at least annually and formal arrangements to provide for medical and behavior emergencies on a 24 hour seven day week basis. c) The resident shall be seen by a physician as often as necessary to assure adequate medical care. (Medicare/Medicaid requires certification visits.) j) Physician Notification 1) The facility shall immediately notify the physician of any significant accident, injury, or unusual 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 390.1040 Nursing Services k) Nursing care shall include at a minimum the following: 3) All objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical, nursing or psychosocial evaluation and treatment shall be provided. m) Skin care shall be given to prevent pressure sores, heat rashes or other skin breakdown. Each resident with pressure sores, heat rashes or other skin breakdown shall be checked at least every two hours and given care as needed	W9999		

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W9999	Continued From page 20 including clothing and diaper change. Skin care shall be given with each diaper change. Section 390.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 390.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. Section 390.1430 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 390.3240 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) These Requirements were not met as evidenced by: Based on record review, observation and	W9999		

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W9999	Continued From page 21 interview, the facility failed to ensure the facility provided nursing services in accordance with client needs, when the facility failed to: 1. Prevent 4 of 5 clients from developing decubitus while under the care of the facility (R3, R4, R7, R15). 2. Update the physician timely for 1 of 1 client with Aspiration Pneumnia who was running elevated temperatures and had a 43 hour delay in receiving her prescribed antibiotic therapy(R14). 3. Ensure that 1 of 1 client (R16) reviewed with a hospital discharged order for IV (intravenous) antibiotic, which occurred over a year ago, received her medication as prescribed. 4) Ensure that staff seek timely medical help for 2 of 5 deaths (R13, R17) reviewed between the period of 2/23/10 through 3/30/10; and 5) Ensure that the physician returned the page from staff promptly for 2 of 5 deaths (R16, R18) reviewed between the period of 2/23/10 through 3/30/10. Findings include: 1) R3, per review of undated face sheet, is a 21 year old male whose diagnoses include Profound Mental Retardation, Infantile Cerebral Palsy, and Quadriplegia, not otherwise specified. R3's nursing notes were reviewed. The entry dated and timed 3/1/11 at 10:55pm reads, in part, "Noted the resident's R(right) hip old wound opened up. No bleeding noted. Cleanse c(with) nss.(normal saline). 1.2 x 0.5cm(centimeters)." The Weekly assessment of Skin Alteration Form sheet dated 3/1/10 notes the same	W9999		

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W9999	Continued From page 22 measurements, plus a depth of 0.1cm. The stage of the ulcer is checked as a Stage two. The next entry on this same form is dated 3/10/11 with the measurements of 1.5 x 0.7 x 0.1, and is still documented as a Stage 2. The next entry on this same form is dated 3/23/11, with the following measurements: 2.0 x 1.0 x 0.2, and the wound to the right hip has now progressed to a Stage 3. The last entry noted on this form is dated 3/30/11 with the measurements of 2.5 x 1.5 x 0.5, also documented as a Stage 3, with tunneling noted at 1-3 o'clock. A second Weekly Assessment of Skin Alteration Form noted to the L(left) ear was documented on 3/19/11 with the measurements of 0.5 x 0.4 x 0.1, and is checked as a Stage 2. The second entry noted for the left ear is from 3/23/11 with the measurements of 0.4 x 0.4 x 0.1, still as a Stage 2. The last entry noted for the left ear is from 3/30/11 with the measurements of 0.4 x 0.4 x 0.1, documented as a Stage 2. A nursing note dated and timed 3/17/11 at 8:00am, reads, "Resident went to school. Will endorse to next shift to monitor L(left) hip reopened wound." An entry dated and timed 3/19/11 at 6:00am, reads, "...Due meds given as ordered and tolerated well. Left hip wound dressing dry, clean, and intact." A nursing note dated and timed 3/19/11 at 2:00pm reads, "...scheduled appointment for wound on the R thigh." A second nursing note for this same date at 9:00pm reads, "L hip wound dressing intact c(with) no visible drainage." A nursing note dated and timed 3/20/11 at 6:00am reads, "Dressing to R hip wound intact." The letter R has a letter L written over it, making it unclear if the writer means left or right. The nursing note	W9999		

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W9999	Continued From page 23	W9999		

dated and timed 3/23/11 at 6:00pm reads, "L hip wound measured, L 2cm W 1cm, D 0.2cm." The nursing noted dated and timed 3/25/11 at 6:00am reads, "Dressing to L hip wound intact, no drainage noted." The L has a letter R that was written first, with the letter L written over it, again making it unclear if the writer is talking about the left or the right hip. A nursing note for this same date at 5:00pm reads, "Dressing to L hip wound clean and intact, no drainage noted."

A nursing note dated and timed 3/21/11 at 12:20pm reads, in part, "IDT(Interdisciplinary Team) weekly skin note. (R3) has wound on R hip and presently non-healing. 2nd area is on L ear - pressure from cannula - now c(with) cushion added to cannula."

During an interview with E13(Assistant Director of Nursing) on 4/6/11 at 10:30am, E13 was asked how the decubitus to R3's hip broke open again. E13 stated that R3 likes to lie on one side of his body, and that if staff would have been more adamant about making R3 lie on his left side or back, then he would not have broken open with a decub on his right hip. E13 was asked if the wound was on his right hip or left hip, or right thigh, since nursing documentation is conflicting. E13 stated it is definitely on R3's right hip, because she remembers that he has opposite sites of breakdown, being his right hip and his left ear. E13 stated she will find out which nurse is charting that the breakdown is on R3's left hip/thigh, and make sure the charting is more accurate. E13 was asked how the breakdown occurred behind R3's left ear. E13 stated that the breakdown was from the oxygen cannula, that rests behind R3's ears. E13 stated

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W9999	Continued From page 24	W9999		

that now they have foam to prevent the pressure behind R3's ear from the cannula. E13 confirmed that R3's right hip decubitus has now progressed to a Stage 3, and that a wound center is following in the treatment and management of R3's hip and ear wounds.

2) R4, per review of undated face sheet, is a 54 year old male whose diagnoses include Profound Mental Retardation, and Convulsions, not otherwise specified.

The nursing note dated and timed 3/24/11 at 7:30am, reads, in part, "...Re-open wound to L(left) big toe noted. No bleeding or drainage noted....Alerted that L toe again with black scab on tip of L great toe. Called wound care center where resident previously went and was healed from their treatment. They recommended using adaptive cover with dry dressing and change qod(every other day). If no healing, then probably need to make another appointment with wound care center."

The Weekly Assessment of Skin Alteration Form for R4 was reviewed. The measurements for R4's L great toe for the date of 3/24/11 measures 1.5 x 2.0 x 0.1. Under stage, it is documented as unstageable. The entry for the date of 3/30/11 notes the measurements of 0.8 x 0.8 x 0.1, and documentation reads that the wound to the L great toe is now a Stage 2, as there is no scab left at this entry.

During an interview with E13(Assistant Director of Nursing) on 4/6/11 at 10:30am, E13 was asked how R4's L great toe re-opened, after it was originally healed. E13 explained that they

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had done a procedure, different from skin grafting on R4's ulcer, but that it only lasted about two weeks. E13 stated that R4 has toes that are long, and curl downward. E13 confirmed that the breakdown to R4's L great toe was from pressure from his shoes, and positioning. E13 stated that they are now more careful, and are floating his feet, by placing something under his calf, to raise his feet off of the wheelchair foot rests, and while he is lying down in bed.

3) R15, per review of Physician Order Sheet dated 3/16/11 - 4/15/11, is a 49 year old female whose diagnoses include Severe Mental Retardation, Seizure Disorder, Cerebral Palsy, Anxiety, Psychosis, and Muscle Spasms.

The nursing note dated and timed 4/10/11 at 1:15pm for R15 was reviewed. It reads, "Reported by staff that resident has wound on her sacral area, assessment done, noted c(with) wound on sacral area measuring 0.8 x 4.0 x 0.5cm(centimeters), c minimal serous non-foul drainage."

The Weekly Assessment of Skin Alteration Form for R15 dated 4/10/11 was reviewed. Measurements are documented at 0.8 x 4.0 x 0.1cm, and is documented as a Stage 2. The entry dated 4/13/11 notes measurements of 1.0 x 3.2 x 0.2cm, and is documented as a Stage 2.

The Physician Order Sheet for R15 has an entry noted for 4/10/11 at 1:25pm, which reads, "Apply Exuderm Odor Shield to sacral wound q(every) 3 days, and PRN(as needed) p(after) NSS(normal saline) cleanse till healed." An entry is also noted for the date of 3/18/11 at 10:00am, which

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W9999	Continued From page 26 reads, "Dietary recommendations, D/C(discontinue) beneprotein (wound healed)." The Facility Summary and Conclusion for R15 was reviewed. The document reads, in part, "....Investigation was initiated to find out cause of new sacral wound. Staff interviews were completed....R15 is at moderate risk for developing skin breakdown due to limited sensory perception, degree to which skin is exposed to moisture, degree of physical activity, limited mobility and potential risk for friction and shearing due to poor bed mobility. Facility was able to identify that she was at risk for skin breakdown, and so prevention plan was put into place. R15 had a history of pressure ulcers, and just recently healed a coccyx pressure ulcer last month. ...Based on staff interview, it has been identified that on April 10, 2011, 6am-2pm shift aide(E14) was unable to check resident's skin on buttocks area, and perform incontinence care during morning routine care. Aide(E14) felt rushed to bring resident to dining room for breakfast. When aide changed her(R15), incontinent brief at around 1:15pm, she noticed a wound on her sacrum, and reported to nurse. Upon investigation, it was determined that aide failed to check and change resident at the start of shift and every two hours as scheduled. Aide stated that she turned resident without a draw sheet and removed incontinent brief. Aide added that it could be a possibility that her actions contributed to the cause of injury....A disciplinary action was given to aide who worked on 4/10/11 6am-2pm shift." During an interview with E1(Administrator) on 4/19/11 at 12:45pm, E1 was asked whether	W9999		

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W9999	Continued From page 27 E14's lack of hygiene could have lead to the skin breakdown on R15's recently healed sacral decubitus. E1 confirmed that R15's wound could have opened when E14 did not reposition and change R15 as she should have. E1 stated that they did conduct a house wide in-service, after R15 re-opened her sacral wound. 4) R7, per his Physician's Order Sheet dated March/April, 2011 is a 16 year old male whose diagnoses includes Profound Mental Retardation, Cerebral Palsy and Seizure Disorder. R7's record was reviewed. A nurses' note dated 3/11/11 at 9:30pm was noted to include, "....left great toe wound noted with serosanguinous drainage, cleaned, treatment provided and covered with dry dressing..." A weekly assessment of skin alteration form (WASA), dated 3/11/11, was reviewed. It includes; Ulcer: unstageable, unable to stage due to eschar..." E13, Assistant Director of Nursing (ADON) was interviewed on 4/6/11 at 10:30am. E13 stated, "This is the second time R7 has a pressure sore on his toe. The first time we thought it was too tight shoes, so once it's healed we got a bigger shoe, but then he got this again. Further observations noted that it's the way his toe is curved that hit his shoes." E3, Director of Nursing, was interviewed on 4/5/11 at 1:25pm. E3 stated, "The cause of the pressure sore is the shoes." Surveyor asked if R7's pressure sore is preventable. E3 answered, "As long as we keep him out of his shoes, it's	W9999		

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preventable." E3 then verified that R7 is non ambulatory.

5) R14, per review of Physician Order Sheet, is an 11 year old female whose diagnoses include Profound Mental Retardation, Joubert Disease, Dandy Walker Syndrome, Failure to Thrive, History of Apnea, and Seizure Disorder.

The nursing notes for R14 were reviewed. The entry noted for 3/23/11 at 6:00am was reviewed. It reads, but is not limited to, "...PRN(as needed) Tylenol given for temp 101.5 and cold compress applied. Temp dropped to 99.0. Will continue to monitor." An entry noted for 3/23/11 at 11:00pm, reads, in part, "Had a temp of 101.5 at 9:50pm. PRN Tylenol given. Temp down at 11:00pm to 98.5. Mom called. Will continue to monitor." An entry dated and timed for 3/24/11 at 7:20am, reads, in part, "Received pt(patient) in wheelchair. T-100.2. given tylenol at 7:30am. Asked CNA(Certified Nursing Assistant) to give a sponge bath to help alleviate temperature." The entry noted for 3/24/11 at 7:40pm, reads, but is not limited to, "Temp 100.9 at 6:30pm. Administered Tylenol 7ml(milliliters) PRN as ordered." The entry dated and timed 3/25/11 at 1:30am, reads, in part, "Resident's condition with on and off temp. E16(Physician) ordered Biaxin." This is the first entry where the physician was notified since running a temperature on 3/23/11. The nursing note dated and timed 1:30am on 3/26/11, reads, but is not limited to, "Resident noted to be having a low grade fever of 99.7. Cold compress applied, and tylenol given." The nursing note dated and timed 3/27/11 at 2:00am reads, in part, "Temp at 12:15am was 101.8. Tylenol 7ml PRN

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given PGT(per g-tube). Ice packs placed on different parts of body." The nursing note dated and timed 3/28/11 at 6:00am reads, in part, "...@(at) 12:30am, T= 100.7. Tylenol 7ml given PRN PGT. Ice packs placed on axillary areas." The nursing note dated and timed 3/29/11 at 1:00am, reads, in part, "Resident had fever 103.7 @ 12:30am. Emergency 911 called. Resident transferred to hospital at 12:40am. Notation reads at 8:00am on 3/29/11, "Resident admitted to hospital Dx.(diagnosis): pneumonia." On 3/30/11 at 11:00am, the nursing note reads, but is not limited to, "Resident returned from hospital D/T(due to) Aspiration Pneumonia. Returned with one new order for antibiotic. Order faxed to Pharmacy. Awaiting the prescription to come in. Dr's order to start prescription as soon as it comes in." On 4/1/11 at 6:00am, the nursing note reads, in part, "Remains stable with ABT(antibiotic therapy) Augmentin for pneumonia in progress." Per review of MAR(Medication Administration Record, this is the first time R14 received her antibiotic since her return to the facility on 3/30/11 at 11:00am. No return call was made to the physician from 8:00pm on 3/30/11 to let the physician know that the antibiotic still was not received, and that R14 did not start her antibiotic for 43 hours since her arrival to the facility.

The Convenience Box Contents document was reviewed. Augmentin was part of the facility's convenience medications, and it was carried in both liquid and tablet form, yet the facility did not use the Augmentin out of the convenience box when the pharmacy could not obtain the dose until 4/1/11, after it was originally ordered on 3/30/11 by R14's physician.

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W9999	Continued From page 30 During an interview with E17(Licensed Practical Nurse) on 4/8/11 at 2:15pm, E17 confirmed that the first dose of Augmentin that R14 received was on 4/1/11 at 6:00am. During an interview with E1(Administrator) on 4/15/11 at 1:00pm, E1 was asked why the staff never called the physician back after 8:00pm on 3/30/11 to let him know that they still had not received the Augmentin from the pharmacy for R14. E1 stated that they should have called him back on the 31st just to see if it was still ok to wait for the Augmentin to come in, or see if he wanted them to start a different antibiotic. E1 was asked if all staff are aware of the convenience box, and the medications that are contained in them. E1 stated that all staff are aware, and that the nursing staff should have checked to see if Augmentin was contained in their convenience box since pharmacy could not fill the prescription immediately. E1 was asked why the nursing staff did not let the physician know right away, when R14 started running elevated temperatures. E1 stated she does not know why the nursing staff did not call sooner. E1 also did not know why the nursing staff waited to let the physician know that after being placed on Biaxin, R14 still continued to run a temperature. 6) R16, per her Medication Administration Record (MAR) dated 2/16/09 through 3/15/09, was a 14 year old female whose diagnoses includes Profound Mental Retardation, Anoxic Brain Injury, Pneumonia and Spastic Quadriparesis. R16 died on 3/31/09 at 10:50am, R16 was pronounced dead by the paramedics	W9999		

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W9999	Continued From page 31 while they were in the facility prior to transporting R16 to the nearest hospital. R16's record was reviewed. A hospital discharge medication list dated 3/14/09 was reviewed. It includes an order for Amikacin 400mg every 8 hours (explicit times) for 4 days, last given 3:00pm. The discharge summary dated 3/14/09 was reviewed. Under hospital course it includes, "....Patient was placed on Amikacin since the ID was Pseudomonas and it was highly resistant to numerous antibiotics (including Zosyn- which patient had recently been on at nursing home for 1 week)...." R16's Nurses' Progress Notes were reviewed. The following notes are noted as follows: "3/14/09 4 - 5pm: 14 yr (year) ... female readmitted from (hospital) via (ambulance)..... 3/14/09 6pm : Resident on ABT (antibiotic) Amikacin x 4 days. Pharmacy called to inform that the medication is not available. MD (medical doctor) called for the substitute. MD asked to call back the hospital. 3/14/09 7pm : The hospital called ....she gave 2 substitutes...but patient is allergic to them. Called MD back to inform him of situation. 3/15/09 3:20pm: ....On IV ABT yet to be started followed up with pharmacy. 3/16/09 5am: ...On IVPB (intravenous piggyback) started this am x 4 days..." E1, Administrator, was interviewed on 4/15/11 at 1:40pm. E1 was asked how the facility will obtain	W9999		

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medications if the pharmacy does not have it. E1 stated that currently staff are to call the MD for further instructions. Surveyor explained to E1 that in R16's case, the nurse called the MD. MD gave orders to call the hospital, which staff did and got alternative antibiotics which R16 is allergic to. Nurse than called MD and informed MD of what is going on. E1 then verified that staff did not pursue other alternatives after this incident.

R16's Nurses' Progress Notes continued:

"3/16/09 1:30pm: No distress noted on shift...MD (medical doctor) paged for fluctuations in heart rate..."

3/16/09 3:00pm: Still awaiting MD to call back."

Further review of nurses notes showed no documentation if MD called back regarding R16's fluctuating heart rate until MD was called again on 3/18/09 at 10:30am and MD called back at 11:00am.

E1, Administrator was interviewed on 4/15/11 at 1:40pm. E1 verified that during that time period there were incidents when the physician does not answer pages quickly.

7) R17, per her Physician's Order Sheet dated 12/16/09 through 01/15/10, was an 18 year old female whose diagnoses included Altered Mental Status and Seizure Disorder. R17, per the nurses' notes dated 1/2/10 at 7:25am, "expired due to cardiac arrest at 7:18am."

The facility's hospitalization notification, completed by E23 (former Administrator), dated

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1/6/10 was reviewed. Under Summary of incident it includes, "On 1/2/10, resident began having seizure activity. MD (medical doctor) was paged and resident was transferred by ambulance to the (nearest hospital) emergency room. Report received from hospital that resident expired due to cardiac arrest. Investigation immediately initiated. Based on investigation and staff statements, resident did not exhibit any signs or symptoms of distress prior to the incident. Investigation has shown that the staff response to the resident's seizure activity was appropriate and timely...."

R17's Nurses' Notes were reviewed. The following notes were written by E24, nurse, and they are as follows:
"1/2/10 5:00am: ...E25, CNA (Certified Nursing Assistant) noticed that the patient having seizures and notified the nurse. Checked for vitals. Resident had seizure for two minutes then stopped. Checked vitals T (BP) 160/96; P 92; T 98.2; R 26; no distress noted. Bit her tongue on the side with minimal bleeding.

5:20am: Noticed that the resident having another seizure. Requested CNA to put back to bed. AM meds given per g-tube and called MD, E27. No return call from E27.

5:25am: Called E27 and E28, physicians. Resident still having some seizures. Notified E28 and received order to sent to hospital A (nearest hospital) or hospital B. Resident started having another seizure at 5:30am.

5:45am: Called ambulance service and hospital B and gave them report. ER (emergency

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room) nurse asked to send to hospital A.

5:50am: Called hospital A and gave report to nurse. E26, nurse assisted in sending to the hospital. Assisted with resident care and copies while I remained with the patient to monitor until the paramedic arrived. O2 (oxygen) started by respiratory therapist, E29 and continued to check pulse oximetry. Pulse oximetry above 70 and 97%. Resident had congestion so kept the head of the bed elevated.

6:15am: Ambulance crew arrived and took over. Checked vitals give O2 and checked on the patient. As they wanted to take to the nearest hospital. Transferred to hospital A by the transportation at 6:40am.

7:25am: Received report from hospital A that the patient expired due to cardiac arrest at 7:18am.."

R17's record was reviewed further. No seizure log can be found.

The Patient Care Report from the ambulance service dated 1/2/10 was reviewed. Under comments it includes, "Called for the active seizure. Crew found above patient seizing in bed. per staff patient has been seizing since 0500. No IV (intravenous) visible in room. Patient moved to ambulance, while hooking from IV with patient on 1.5L NSS (normal saline solution) patient stopped seizing and went pulseless and apneic. Crew started CPR (cardiopulmonary resuscitation)...."

E25, CNA, was interviewed via phone on 4/12/11

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at 4:05pm. E25 stated, "She (R17) was having a seizure. I called the nurse (E24). I left when the nurse got there. I didn't go back to her room."

E26, nurse, was interviewed via phone on 4/13/11 at 10:40am. E26 stated, "I was not the nurse (for R17). E24 was the nurse. E25 called the nurse. I looked out and saw and heard E25 saying R17 is having a seizure. I went there (R17's room) and saw R17 having a seizure. When E24 came, I left."

E24, nurse was interviewed via phone on 4/13/11 at 10:45am and again on 4/15/11 at 12:40pm. E24 stated, "She (R17) got the seizure at 5:00am. I checked her, took the vitals. She was on (her) wheelchair. E25, just transferred her. I told E25 to transfer her back to her bed. I then checked if she has been getting her seizure medications at the desk (nurses station). At 5:20am, she had seizures and in between she was shaking on and off." Surveyor asked whether E24 was with R17 the whole time. E24 answered, "I wasn't there the whole time. It's a busy time, nobody wants to waste time, because everybody has to be out by 7am." E24 added, "E25 was in and out of the room and E26 was passing meds (medications) in hallway and also helped. R17 had seizures on and off the whole time." E24 then added, "At 5:00am, seizure lasted 2 minutes. That first time after the seizure is over, I went out to get the E25 and asked him to put her back on bed. The first seizure, everybody left her (R17). I brought my cart right in front of her room and prepared my medications, that's the time I noticed the seizure, a small seizure." E26 clarified that "it was not a complete seizure (small seizure), just shaking a

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W9999	Continued From page 36 little bit." Surveyor asked why the ER nurse from hospital B asked that R17 be transported to hospital A. E24 answered, "She was supposed to go to hospital B but because I told the ER nurse it was seizures, she said to send to the closest hospital (hospital A)." Surveyor asked if she thought it was an emergency. E24 answered, "it was not very serious. It was small seizures. If it was continuous seizures, call 911." Surveyor asked whether E24 thought about calling 911 after hospital B ER nurse told her to transport R17 to the nearest hospital. E24 answered, "We already called the ambulance service." E24 added, "She (R17) had the twitching and that's what concerned me. R17 still had twitching even after her seizure medication." E29, Respiratory Therapist, was interviewed via phone on 4/19/11 at 12:40pm. E29 stated, "They called me to evaluate R17 for O2. I took her pulse ox. I can't remember what it was but it was low. I started her on oxygen. She was still seizing and was foaming in the mouth. I remembered I asked E24 what they are going to do and they said they called the ambulance. I can't remember what time I was called." Surveyor asked if the ambulance crew arrived a few minutes after E29 got to R17's bedside. E29 answered, "it was a while after (she got there). Mostly client was still seizing. There were times it stopped for a second or two and started again." E29 added, "They told me they called 911, it was regular ambulance that arrived." Surveyor asked if E29 felt that 911 should have been called for R17. E29 answered, "Yes, R17 had respiratory distress and wasn't responsive." E29 added, "It was really like seizures and she was in respiratory distress."	W9999		

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8) R18, per his Physician's Order Sheet (POS) dated 2/16/09 through 3/15/09, was a 36 year old male whose diagnoses includes Profound Mental Retardation, Cerebral Palsy and Seizure Disorder. Per the facility investigation dated 4/26/09, "facility ws informed that R18 expired at the hospital on 4/25/09."

R18's nurses' notes were reviewed. The following notes were noted:

"2/23/09 12noon: At about 10:45am, resident was brought back from (day training program) by day training staff that resident not doing fine. T:98, P:100, R:24, BP:110/90, Pulse ox:92%. Start O2 2L per n/c (nasal cannula), pulse ox now reading 98-99%. E27, Medical Doctor, paged. Awaiting return call.

2/23/09 3pm: Resident in bed with HOB (head of bed) elevated. He seems resting comfortably. No s/s (signs and symptoms) of SOB (shortness of breath) noted. Continue on O2 2L per n/c.....

2/24/09 4am: E31, CNA (Certified Nursing Assistant) 2:00am, did temperature and reported a temp of 99.5. I went to give him 20ml of Acetaminophen and do an assessment his HR (heart rate) was 150, RR (respiratory rate) 28-30, BP 130/82 with decrease breath sounds. I called respiratory therapist, she also assessed him, same result: decrease breath sounds and increase heart rate. Paged E27 and E28 (physician) , no call back....transfer resident to hospital at 4:15am..."

R18's POS was reviewed and under Oxygen it includes an order for, "O2 sats (saturation) q shift

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W9999	Continued From page 38 (every shift) and PRN (as needed)." R18's history and physical dated 3/9/09 at the hospital includes, "...being admitted to the hospital on 2/24/09 because of fever, tachycardia and tachypnea and was found to have a left lower lobe pneumonia, respiratory acidosis in which he was intubated and transferred to ICU (intensive care unit)...." E1, Administrator was interviewed on 4/15/11 at 1:40pm. E1 verified that during that time period there were incidents when the physician does not answer pages quickly. E1 also verified that the nurses notes do not include O2 sats for the second shift for R18 on 2/24/09. E1 also verified that the nurses notes do not clearly document what was wrong with R18 and why R18 was brought back from the day training site by staff. 9) R13, per review of Physician Order Sheet dated December of 2008, was a 49 year old male whose diagnoses included Cerebral Palsy, Aggressive Behavior, Depression, Seizures, and Chronic Small Bowel. The nursing notes for R13 were reviewed. The following dates and times read, in part, "1/23/09-Resident scheduled to GI(Gastrointestinal) consult ...on 2/5/09." "2/5/09 10am- Resident went on appt. at hospital." "2/5/09 6pm- Resident returned from appt. vomiting. Feeding stopped. vitals taken."(no md update). "2/6/09 6am-..called the nurses attention that he vomited 1x...pls(please) continue to monitor."(no md update.	W9999		

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W9999	Continued From page 39 "2/6/09 7:40am-...refused breakfast b/c(because) of loss of appetite and vomiting at this time. Monitored closely."(no md update). 2/6/09 8:30am-c/o(complaints of) abdominal pain with nausea. Vomited 2x watery like content. MD paged(E27). Awaiting MD response." 2/6/09 8:45am-MD paged 2x. Awaiting response." 2/6/09 9:15am- Spoke with E27 c(with) order to send resident to hospital for evaluation." 2/6/09- 10:30am -No further vomiting episode noted but resident still c/o nausea, and abdominal discomfort. Awaiting for ambulance." 2/6/09 11:15am -Resident picked up by the ambulance service crew. En-route to hospital for evaluation. 2/6/09 6:15pm- Verified resident status at hospital ER. Spoke with nurse who stated resident is admitted with Dx(diagnosis) of early small bowel obstruction." 2/26/09 9am- Call placed to hospital regarding resident's status. Staff from record office told nurse resident expired on the 2/23/09. Refused to say the cause of death." The Physician Order Sheet for R13 was reviewed. The entry noted on 2/6/09 reads, "Send to hospital ER for evaluation." The Emergency Transfer form dated 2/6/09 for R13 was reviewed. Under diagnosis it reads, "Chronic Small Bowel." Under reason for transfer it reads, "c/o abdominal pain, nausea and vomiting. A second Emergency Transfer form for R13 dated 12/20/08 was reviewed. Under diagnosis, it reads, "Chronic small bowel obstruction."	W9999		

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Under reason for transfer, it reads, "c/o abdominal discomfort, x1 emesis, with history of small bowel volvulus."

A consultation report for R13 dated 12/21/08 was reviewed. It reads, in part, "The patient is a 48 year old seen in consultation for seizures, history of cerebral palsy. He has a G-tube(Gastrostomy tube)....Other problems include chronic small bowel obstruction."

The patient Information and transfer form from the hospital, back to the facility on 12/22/08 for R13 was reviewed. Under major diagnoses, it reads, "Sm(small) bowel obstruction."

The Death Notification to Public Health for R13, dated 2/27/09, reads, in part, "Resident was admitted to hospital on 2/6/09 with small bowel obstruction. Facility was made aware of resident's death on 2/26/09. Resident died on 2/23/09 of Myocardial Infraction(Infarction)."

No documentation was available indicating the facility completed an investigation after the death of R13. Documentation was present, indicating the facility completed paper work to obtain the hospital file for R13 for his admission from 2/6/09 - 2/23/09 with the purpose of the request, which reads, "to conduct internal state required report," but no such report was presented to this surveyor.

During an interview with E1(Administrator) on 4/15/11 at 1:00pm, E1 was asked if a formal report/investigation was completed after the death of R13. E1 stated that she does remember requesting in writing to the hospital copies of

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W9999	Continued From page 41 R13's hospital stay, but E1 stated that at this time she was not the Administrator of the facility, and if a formal investigation would have been completed, it would have been completed by E30(Former Administrator). E1 confirmed that she has presented to this surveyor all the information she could locate, and that no formal investigation has been completed by the former Administrator. E1 stated that she does remember this client, and stated that the facility was made aware that R13 had expired by R13's father. E1 explained that R13's father called to let them know that R13 had expired, so he could let us know what he wanted to do with R13's belongings. E1 stated that she remembered that R13 had surgery for his small bowel obstruction, and expired during surgery. E1 stated that she does not know why the nursing staff did not contact the physician more timely once R13 started vomiting and complaining of abdominal pain on 2/5/09 and 2/6/09, which was a time frame of 14 hours, and 30 minutes, especially since R13 had a known diagnosis of chronic small bowel obstruction. E1 also did not know if the facility had been following R13's bowel pattern. E1 stated that if there was no bowel documentation present in the files, then there probably was no management of R13's bowel pattern. E1 confirmed that a thorough investigation should have been completed regarding both calling the physician more timely, and determining if a bowel pattern was monitored while R13 was under the care of their facility. (A)	W9999		