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W 331	Continued From page 20 01/14/11 at 12:30 p.m., the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1230b)3)6)7) 350.1230d)1)2)3) 350.3240a) 350.3750 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical,	W9999		

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W9999	Continued From page 21 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. Section 350.3240 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) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on interviews and record review the facility failed to ensure development and implementation of a plan of care for the monitoring and treatment of recent seizures on 11/02/10 for 1 of 1 individual (R1) in the facility who was found dead in his bed on 11/05/10 with a cause of death	W9999		

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listed as Grand Mal Seizure. The facility also failed to ensure that direct care staff have the knowledge of how to remove a person from bed to a firm surface and initiate CPR (Cardio-Pulmonary Resuscitation) in the event of recurrence. (R2 through R16)

Findings Include:

Upon review of R1's physician's order sheet dated 11/01/10 through 11/30/10, R1 is a 30 year old male who functions at a Profound level of mental retardation. R1's only other diagnoses listed on this physician's order sheet are a history of Seizures and Chronic Constipation. R1 is not prescribed any anti-seizure medication.

During interview with E1 (Administrator) on 01/06/11 at 10:15 a.m., E1 said that although R1 has a history of seizures, he is not taking any medication for seizures and prior to 11/02/10 she cannot remember him ever having a seizure since being admitted to this facility.

According to R1's IDT (Interdisciplinary Team) Report dated 03/18/10, R1 was admitted to this facility on 03/06/96. R1's IDT on this date continues to say that R1, "...Is unable to communicate verbally to express his needs or desires."

Per review of R1's Annual Risk Assessment Bed Check Frequency form dated 03/18/10, documentation states that R1 is to have nightly bed checks at 11 p.m., 2 a.m. and 4 a.m.

During interview with E1 on 01/06/11 at 10:15 a.m., E1 stated there is no documentation to

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provide evidence that bed checks were done according to R1's Annual Risk Assessment Bed Check Frequency form.

Per documentation (no title to documentation page), dated 11/02/10 and signed by E2 (Residential Service Director), documentation states, "It was reported to me by my staff (E6, E7 and E8) (Direct Support Persons) that approximately 6:10 a.m. while staff were drying (R1) off after his shower, he slumped over on staff (E7), his eyes rolled back; stumbling; sweating and was incontinent and disoriented. This lasted approximately one and one-half minutes. He was not injured. He appeared to be his normal self by smiling afterward. Then at around 7 a.m., he appeared to be sucking and chewing on his tongue. He ate breakfast as normal and was smiling...." Documentation continues to say that R1 was then taken to day training and that Z1 (R1's) physician was notified of the incident at approximately 7:55 a.m. on 11/02/10.

The 11/02/10 documentation continues to say that at 11:25 a.m., "(E2) called the (name of local day training) for (R1). (E2) spoke with (Z2) (Day Training Program Coordinator/Qualified Mental Retardation Professional). She (Z2) said that she was just getting ready to call us. She (Z2) said that (R1) had been fine then he bugged his eyes out and started hitting himself on the arm. I told (Z2) that (R1) often does that here at (name of facility). She (Z2) said that staff thought it was strange because he does not do that there."

Review of R1's physician's visits documentation shows that R1 was seen by Z1 (R1's physician)

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on 11/02/10 and received orders for: Complete Blood Count with differential and Platelet Count; Comprehensive Metabolic Panel; and Thyroid Stimulating Hormone and Serum Magnesium. Diagnoses listed for this visit are listed as: "Epilepsy, Tonic-Clonic, (Without) Status (new onset); Profound Mental Retardation; Other Malaise and Fatigue."

Upon review of R1's laboratory results, documentation shows that the lab tests were drawn on 11/03/10 with normal results. Documentation continues to show that R1's lab results were faxed to Z1 (R1's physician) on 11/04/10 by E2 (Residential Service Director) with no orders received from Z1.

During interview with E1 on 01/06/11 at 10:15 a.m., E1 said that she was not aware of anything put in place to monitor R1's health and/or neurological status after his seizure on 11/02/10.

The facility was unable to provide evidence that R1's vital signs and neurological status was monitored after the 11/02/10 seizure. The facility was also unable to provide evidence that direct care staff were instructed on how to monitor R1 and were aware of what to look for regarding R1 having potential seizure activity.

There is no evidence that the facility put systems in place to monitor R1's health and/or neurological status after the 11/02/10 incident and the physician's diagnosis of new onset of Epilepsy, Tonic-Clonic, (Without) Status.

During review of the facility's documentation (untitled), dated 11/05/10 and signed by E2,

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documentation states, "At approximately 2:45 a.m., (E4) (Direct Support Person) called me and said that she and (E3) (Direct Support Person) thought that (R1) a client, was dead. I told her to call 911.... ...When I arrived at the facility about 3:30 - 3:45 a.m., the EMTs (Emergency Medical Technician's) were wheeling (R1) on a stretcher into the emergency vehicle...." Documentation continues to say, "... (E4) said she was checking on (R1) and thinking he was not breathing and called (E3) in the room to check too. (E3) called 911 and they were attempting to turn his (R1's) body over since he was on his stomach and get him onto the floor to do CPR...." "...Due to his size and position, they said they had to struggle to turn him over and (E3) stayed on the phone with 911 during this time. They had turned him over on the bed when she (E4) said that the police officer and EMTs came in and they (E3 and E4) left the room...."

Per review of a statement written by E3 (no date) documentation states, "10 pm: Arrive at work and start laundry. 10:30 pm/10:45 (R1) walks into hallway/living room and then back to bathroom. I see him in bathroom and ask him if he wants to go back to bed. He walks to bedroom and I follow. He sits on the side of the bed and points to feet so I put his socks on. He then lays his head on pillow and lays down. I put covers on him and leave room. He was acting normal/smiling (at) me...."

E3's written statement continues to say, "...around 2:40 am: Staff (E4) does mens end bed checks. When she goes to check (R1), she screams my name. I go to find her in (R1's) room. She asks me to check him because she does not

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think he is breathing. I touch his back and call his name repeatedly. I then check his wrist for a pulse and felt nothing so I yelled to her to call 911. She runs to grab phone and hands it to me in (R1's) room. The 911 operator (female) tells me to try turning (R1) over and place on floor and begin C.P.R. (Cardio-Pulmonary Resuscitation). (R1) was laying face down, almost in between mattress and wall. I stay on phone with 911 lady, and try with one hand to turn him while staff (E4) assists. We manage to get him to his side and almost over when the first police officers arrive. They take over and 30 (seconds) later the ambulance arrives."

E4's written statement of the 11/05/10 events dated 11/09/10 states that she started her shift at 12:00 a.m. on 11/05/10. Documentation continues to say, "...I looked up and it was almost 2:30 a.m. so I went down and got (R3) to check his sugar. When I was done with him I went and got (R2) and took him to the bathroom. I had to change him because he had a (bowel movement). I then went in to check on (R1) and (R4). I noticed blood on (R1's) pillow. I thought he had a nose bleed so I turned around and turned on his light because only the hall light was on. When the light came on I noticed he was face down on the bed towards the wall. I went over and shook him. He didn't respond. So I shook him again and said his name. He didn't respond. I yelled for (E3) my co-worker. She came in and I told her to check him. She tried to wake him but couldn't. She then checked his pulse. She yelled call 911. I ran and got the phone. I handed her the phone. I tried to turn (R1) over but he was so heavy. I tried at his shoulders, stomach, and hips to pull him over. (E3) helped me get him over...."

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W9999	Continued From page 27 Upon review of the ambulance report dated 11/05/10, the ambulance was called at 2:51 a.m. and arrived at the facility at 2:57 a.m. Documentation within the ambulance report states, "Called for a (possible) DOA (dead on arrival) UOA (upon arrival) we found (patient) laying in bed. Staff stated they rolled him over because he was laying face down with his head between the wall (and) the mattress edge. CPR was not started due to the last time the (patient) was checked was four (and) half hours ago (and) (patient) was very cool to the touch other then where he had blankets on him (and) (patient) already lost bladder and bowel control. Cardiac monitor showed asystole in 2 leads...." "...The coroner came out to the scene." Documentation within the ambulance report continues to say that R1 was already deceased when the ambulance arrived at the facility. Per review of the Coroner's Field Investigation Report dated 11/05/10, documentation states that the Assistant Coroner arrived at the facility on 11/05/10 at 3:20 a.m.. Documentation continues to say that R1 was laying face up in bed and that he had a bloody nose and mouth and that there was blood on his pillow. Per interview with E2 (Residential Service Director) on 01/06/11 at 9:45 a.m., when asked how much blood was found on R1's pillow, E2 stated that she did not know and that she did not think that E3 or E4 had specified how much blood there had been on R1's pillow. During interview with E1 (Administrator) on 01/06/11 at 10:15 a.m., E1 stated that she did not	W9999		

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know how much blood was on R1's pillow at the time of his death because staff had already washed the sheets by the time she arrived at the facility.

During interview with E1 on 01/07/11 at 12:10 p.m., E1 said that E3 and E4's documentation (dated 11/09/10) did not thoroughly describe the 11/05/10 incident regarding R1's death by not documenting the amount of blood on R1's pillow, the amount of blood, where the blood came from, the consistency of the blood or whether the blood was wet or dry. E1 also stated that there was not thorough documentation of the condition of R1's skin (color, temperature) at the time he was found unresponsive.

On 01/06/11 at 10:15 a.m., when asked if she has investigated why 2 direct support persons were unable to turn R1 over and get him onto the floor to begin CPR, E1 said, "I assumed it was because he was so heavy and was really tall. They should have grabbed the sheet and lowered him to the floor." E1 stated that she has not provided any training to direct support persons in regards to moving a resident from the bed to the floor should a similar incident occur.

Upon review of R1's Nutritional Assessment dated 03/12/10, R1 is 5 feet 6 inches tall and weighs 160 pounds. R1's ideal body weight is 142 pounds.

According to the facility's Nutritional Assessments the facility has 14 other residents who are documented to be either above their ideal body weight and/or the approximate height as R1:

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W9999	Continued From page 29 R3 - Nutritional Assessment dated 06/28/10 - 41 year old male - height 5 feet 0 inches - weight 125 pounds. R4 - Nutritional Assessment dated 09/17/10 - 38 year old male - height 5 feet 9 inches - weight 163 pounds. R5 - Nutritional Assessment dated 01/20/10 - 30 year old female - height 5 feet 5 inches - weight 150 pounds. R6 - Nutritional Assessment dated 05/05/10 - 37 year old male - height 5 feet 8 inches - weight 190 pounds. R7 - Nutritional Assessment dated 06/28/10 - 49 year old female - 5 feet 2 inches - weight 220 pounds. R8 - Nutritional Assessment dated 06/28/10 - 62 year old male - 5 feet 8 inches - weight 172 pounds. R9 - Nutritional Assessment dated 08/20/10 - 43 year old female - 5 feet 5 inches - weight 218 pounds. R10 - Nutritional Assessment dated 09/17/10 - 57 year old male - 5 feet 5 inches - weight 180 pounds. R11 - Nutritional Assessment dated 09/17/10 - 31 year old female - 5 feet 2 inches - weight 195 pounds. R12 - Nutritional Assessment dated 05/05/10 - 49	W9999		

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W9999	Continued From page 30 year old male - height 5 feet 0 inches - weight 153 pounds. R13 - Nutritional Assessment dated 10/21/10 - 57 year old female - height 4 feet 11 inched - weight 170 pounds. R14 - Nutritional Assessment dated 04/20/10 - 49 year old female - height 4 feet 9 inches - weight 150 pounds. R15 - Nutritional Assessment dated 02/19/10 - 40 year old female - height 5 feet 2 inches - weight 158 pounds. R16 - Nutritional Assessment dated 12/08/10 - 32 year old female - height 5 feet 7 inches - weight 181 pounds. The facility was unable to provide evidence that all staff are currently certified in CPR (Cardio Pulmonary Resuscitation) and have basic knowledge of moving a person from the bed onto the floor and initiating CPR. Nurse's Notes for R1 dated 10/30/10 state, "(Z1) (R1's physician) rounds 10/06/10 - Doing OK - No changes - (R1) doing well on my visit today - up (and) about. Very pleasant (no complaints). Documentation is signed by E5 (Registered Nurse Consultant)." There is no evidence that nursing provided recommendations to the direct care staff in how to assess an individual who is having a seizure, what vital signs should be monitored after a seizure and how to ensure an individual having a seizure should be monitored.	W9999		

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W9999	Continued From page 31 There is no additional entry in R1's Nurse's Notes until 11/27/10 when documentation says, "On 11-2-10 (E2) (Residential Service Director) notified me that (R1) had a seizure (at) 6:10 (a.m.) lasting 1 1/2 (minutes) - afterward he was smiling and acting like himself - she notified (Z1) - Labs were ordered and done 11/3/10 (with) (Z1) made aware of abnormals. No further seizure (activity) had been noted. 11-3-10 Podiatrist was here - Nails were trimmed - (No new orders) - (R1) had no other seizure activity noted by staff (and) his behavior was normal - On 11-5-10 I was notified by (E1) (Administrator) that (R1) had expired." Upon interview with E5 (Registered Nurse Consultant) on 02/15/11 at 8:45 a.m., E5 said that she had not assessed R1 after his initial seizure on 11/02/10 and that she did not put systems in place for R1 to be monitored regarding his health and/or neurological status. E5 continued to say that she was not sure if the direct support staff were certified in CPR or not. E5 said that she does not train direct support staff in CPR or basic first aid. E5 said that after R1's death on 11/05/10, she reviewed R1's chart and lab work. When asked if she had investigated how much blood was on R1's pillow or from where the blood had come, E5 said that she had not. E5 stated that the facility had initiated more frequent bed checks after R1's death and, "That was basically it." The facility was unable to provide evidence that all staff are currently certified in CPR (Cardio-Pulmonary Resuscitation) and have basic knowledge of moving a person from the	W9999		