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W9999	Continued From page 43 LICENSURE VIOLATIONS 350.620a) 350.1210b) 350.1220j) 350.1230d)2)3) 350.1235a)3)4) 350.1420a) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or	W9999		

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W9999	Continued From page 44 welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.1235 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; Section 350.1420 Compliance with Licensed Prescriber's Orders	W9999		

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W9999	Continued From page 45 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 350.1610. 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 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) These Requirements were not met as evidenced by: A) Based on interview and record review, the facility failed to implement policy and procedures governing life saving measures as evidenced by staff's failure to start CPR (Cardio Pulmonary Resuscitation) for 1 of 1 individual (R9) who was found unresponsive without pulse and/or heart beat and who expired at the facility on 07/02/10, having the potential to affect 35 of 41 individuals of the facility who do not have "Do Not Resuscitate" orders (R1-R3, R6-R8, R1-R18, R20-R26, R27-R39, R42-R45). *In House Day Training staff failed to demonstrate trained CPR skills by failing to start CPR upon finding R9 unresponsive without pulse and/or heart beat;	W9999		

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W9999	Continued From page 46 *Nursing staff failued to do chest compressions as part of the resuscitation attempts as recommended by the American Heart Association (AHA) and as per facility policy; *Staff failed to call 911 or other emergency medical services upon finding R9 unresponsive; and *Nursing staff failured to continue resuscitation measures as recommended by the AHA and maintain current CPR certification. B) In addition, nursing staff failed to implement nursing protocol for "Charting and Documentation" when they failed to document a complete accounting of changes in the individual's health status for 1 of 1 individual outside the sample (R10) who received forty five doses of PRN (as needed) cough medication, and failed to timely notify R10's physician of these changes. R10 expired at the hospital on 02/20/11 after being admitted with "Healthcare Associated Pneumonia". Nursing staff failed to: *Document on the Medication Administration Record (MAR) the reason for the administering forty five doses of PRN cough medication from 01/27/11 to 02/8/11 and document R10's response to the medication; *Follow the Physician's Standing Orders to notify the physician if a cough persist over twenty four hours; * Notify the physician of the continued use of the PRN cough medication coupled with R10's onset	W9999		

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of edema to his legs and hands; and

* Document vitals and assess R10's breathing and/or lung sounds while receiving the forty five doses of the PRN cough medication.

C) In addition, the facility failed to monitor the health status of 7 of 7 individuals outside the sample (R11-R17) who did not receive their prescribed medications as the physician ordered for the promotion of bowel movements, when they failed to:

* Monitor the health status of the seven individuals who did not receive their Senna Plus tablets as physician ordered, inclusive of monitoring the bowel movement log(s); and

* Implement Standing Orders for Constipation as physician ordered.

Findings include:

A) The facility failed to implement policy and procedures governing life saving measures as evidenced by staff's failure to start CPR.

On 07/02/10 when In House Day Training staff found R9 in bed, unresponsive. In House Day Training staff were the first to arrive at the scene and failed to check that R9 was breathing and/or had a pulse. The In House Day Training staff did not call for emergency medical services, nor start CPR. The facility's nursing staff arrived to the scene and found R9 to be non-responsive without heart beat or pulse. Nursing staff did not start chest compressions, but rather started using a hand held bag valve mask device to provide

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W9999	Continued From page 48 positive pressure ventilation. While utilizing the bag valve device for breaths, nursing staff did not use chest compressions as recommended by the American Heart Association Guidelines for 2010. Life saving measures were stopped by E2 (Administrator/Registered Nurse). E2 documented that she called the physician and was told to cease further resuscitation. 911 was not called. R9 was not receiving Hospice services, nor did she have "Do Not Resuscitate" orders at the time of her death. The Medical Examination/Coroner Certificate of Death report with an issue date of 04/21/11 identifies that R9 was a 51 year old female at the time of her death on 07/02/10, This report states that the immediate cause of death was a Myocardial Infarction (heart attack). The facility's (undated) policy and procedures for "Cardiac Arrest" states, "This urgent condition is demonstrated by the following signs: Loss of respiration; Loss of arterial pressure, no pulse in carotid or femoral area; No heart sounds, pupils are dilated. Prompt re-establishment of adequate oxygenation and circulation are essential to avoid irreversible brain damage in 3-5 minutes by implementing cardiopulmonary resuscitation, by: Air way opened; Breathing restored by artificial ventilation; Circulation restored by external cardiac massage." This policy also states, "Continue cardiopulmonary resuscitation until spontaneous	W9999		

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W9999	Continued From page 49 respirations occur, a pulse is detectable or the victim is pronounced dead." In reviewing R9's Nurse's Notes on the day she expired (07/02/10), the following nursing entries were noted: "7 AM In process of being fed by DT (Day Training) staff appetitive poor, took 45%, took meds in applesauce. Color pale pink, skin warm and dry, in no distress. Sat in her wheelchair but is lethargic today. 8:45 A.M. Skin care and repositioning done. 9:30 A.M. Positioned in bed with rails up Color pale pink, (her usual), skin warm and dry in no distress, resting comfort (comfortably) 10:30 A (A.M.) LPN (Licensed Practical Nurse E5) check (ed) R9, asleep and in no distress 10:45 A (A.M.) Staff (unidentified In House Day Training staff) summoned writer (E2) to R9's room #22 bed 1. R9 was non-responsive skin warm, apneic and in asystole, pupils non-responsive. No BP (blood pressure) palpated, lower extremities beginning to mottle, nailbeds cyanotic and circumaural cyanosis apparent right hand positioned near sternum as if she had experienced chest pain. Resuscitation attempted with "A**u" (trade name) bag with no response. Phoned physician and gave order to cease. Patient pronounced deceased at 10:50 AM..." There is no documentation within the 07/02/10 nursing entries identifying that chest compressions were started by staff during the minutes that they attempted to resuscitate R9. It is not documented that staff continued resuscitation efforts while notifying the physician.	W9999		

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W9999	Continued From page 50 Further review of this documentation does not identify that 911 or other emergency medical services were called after staff found R9. On 04/19/11, E2 (Administrator/RN) was interviewed at 2:15 P.M. regarding the names of the In House Day Training staff that were identified in the facility's nursing entries for 07/02/10. E2 stated that she thought Z4 had been there and a new female staff, but that she could not remember her name. Z4 (In House Day Training Coordinator) was interviewed on 04/20/11 at 8:58 A.M. and confirmed that he was present and on duty on 07/02/10. Z4 stated, "Yes, I was here on the day R9 died. She (R9) wasn't feeling well. One of my staff (Z8) checked on her and she wasn't responsive. My staff (Z8) called (out) for help. E5 (Licensed Practical Nurse/LPN) responded. The facility staff (E5 and E2, Administrator/Registered Nurse-RN) took over." During this interview Z4 stated that the In House Day Training staff receive CPR training annually by Z5 (Day Training QMRP/Qualified Mental Retardation Professional). When Z4 was asked if the In House Day Training staff had called 911 after finding R9 unresponsive, Z4 stated, "No." Z8 (In-House Day Training Staff) was interviewed on 04/26/11 at 1:20 P.M. and stated, "I went to get R9 up. I noticed that the side of her face was a little blue. When I was lifting her up (in the bed) she took a big breath. I thought something was wrong and I ran and got the nurse (E5). E5 took over and I left the room. When Z8 was asked if R9 was breathing when she found her, Z8 stated, "I'm not sure. I thought she took a big breath."	W9999		

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Z8 stated, "No" when asked if she checked to see if R9 continued breathing or if she had a pulse. Z8 stated that R9 did not say anything nor did she open her eyes while she (Z8) was in her bedroom. During this interview, Z8 stated that she was CPR certified. When Z8 was asked if she assessed R9 and started CPR, Z8 stated, "No."

Z5 (Day Training QMRP) was interviewed on 04/26/11 at 1:10 P.M. and stated, "I am a certified CPR instructor through the American Red Cross. I train all of the day training staff in first aid, CPR and AED (Automated Electronic Defibrillator)." Z5 then showed the surveyor her credentials certifying her as an instructor until 12/31/11. Z5 then stated that Z8 had been certified in CPR on 05/18/10 and recertified in April, 2011. When Z5 was asked what should staff do when they find an unresponsive individual, she stated, "They should check for breaths, watch for the chest rising and falling and check for a pulse. If the staff person is by themselves and finds someone who is not breathing and there is no pulse, staff should call for help from another staff and have them call 911. Then staff should return to the person and immediately start CPR. During this interview, Z5 confirmed that Z8 should have immediately started CPR after calling for help.

E5 (LPN - Licensed Practical Nurse) was interviewed by telephone on 05/12/11 at 12:30 P.M. and stated, "Z4 hollered at me. I do not recall what I was doing. I went to R9's room. She had no pulse and was not breathing, Her skin was mottled and gray. I ran to get the crash cart. When I got back to the room E2

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(Administrator/RN) was there and I left the room." When E5 was asked if she immediately started CPR after assessing that R9 had no pulse and was not breathing, E5 stated, "No, I ran to get the crash cart for the board to put her on because she was in the bed." When E5 was asked if anyone present (Z4 and Z8) in the room at this time started CPR while she went to get the crash cart, she stated, "No, I don't think so." E5 went on to state, "When I came back with the crash cart, E2 was already in the room. I left the room after that. I did not document my assessment because E2 took over. I don't know what happened after that."

E2 (Administrator/RN) was interviewed on 04/19/11 at 3:50 P.M. and stated, "When I was called down to R9's room, her pupils were fixed and dilated, and she was unresponsive. I did a sternal rub and then a thump (to the chest) and there was no response. I tried to establish an airway and started the "A**u" (trade name) bag." When E2 was asked if she or any staff present had started chest compressions as per the American Heart Association Guidelines and as per the facility's policy on Cardiac Arrest, E2 stated, "No." When E2 was asked if 911 or other emergency medical services were called, she stated, "No."

E2 (Administrator/RN) was interviewed on 04/26/11 at 10:00 A.M. and stated, "I called Z9 (facility's Medical Director) and told him what had happened. He gave me orders to cease resuscitation." When E2 was asked if anyone continued resuscitation while she phoned the physician, E2 stated, "No." During this interview E2 confirmed that the facility did not continue

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resuscitation measures until R9 was pronounced as per the facility's policy and procedures on "Cardiac Arrest."

Z9 (facility's Medical Director) was interviewed by telephone on 05/12/11 at 1:10 P.M. and stated, "I did not pronounce her (R9). Are you sure it was not the PA (Physician Assistant/Z7)?" Z9 stated, "I would not have pronounced her without being there." When Z9 was asked if CPR should have been performed on R9 after she was found unresponsive without breaths or pulse, Z9 stated, "Yes, I would expect CPR to be started." When Z9 was asked if he would have expected chest compressions to be done as part of the resuscitation attempts, Z9 stated, "Yes, I would have expected them to do chest compressions." When Z9 was asked if staff should delay CPR to get the crash cart/board, Z9 stated, "No, sometimes you have to do what you have to do. They should not have delayed CPR to get the board."

After reviewing the list of staff who are currently certified in CPR it was noted that as of 04/22/11, the facility's Administrator (E2) and the Director of Nursing's (E3) CPR certification had expired on 02/21/11.

The Nurse's Notes for 07/02/10 at 10:45 AM states that R9 was non-responsive with her right hand positioned near sternum as if she had experienced chest pain. These notes do not state that either Z4, Z9, E5, or E2 started chest compressions when they found R9. After attempting to establish an airway, staff did not do chest compressions, nor continue resuscitation efforts on R9. Neither 911 nor other emergency

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W9999	Continued From page 54 medical services were called. R9's Medical Examination/Coroner Certificate of Death report with an issue date of 04/21/11 states that the immediate cause of death was a Myocardial Infarction (heart attack). R9 was not receiving Hospice services, nor did she have "Do Not Resuscitate" orders at the time of her death. B) Nursing staff failed to implement nursing protocol for "Charting and Documentation" when they failed to document a complete accounting of changes in R10's health status. The Medical Certificate of Death dated 02/20/11 states that R10 was a 62 year old male at the time of his death. This Certificate identifies the immediate Cause of Death as Pneumonia. In reviewing the facility's undated nursing protocol for Rules for Charting and Documentation it states, "The purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. 2. Guidance to the physician in prescribing appropriate medications and treatments. 4. Nursing service personnel with a record of the physical and mental status of the resident. 5. Assistance in the development of Plan of Care for each resident. 6. The elements of quality medical nursing care..." This protocol also states that nursing are to,	W9999		

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W9999	Continued From page 55 "Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc. (etcetera), as well as routine observations..." In reviewing the facility's Nurse's Notes and the Medication Administration Records for R10 from 01/01 - 02/13/11, nursing staff failed to document a complete account of R10's care while requiring cough medicine from 01/27/11 - 02/08/11. January 2011 R10's Nurse's Notes from 01/01 - 01/31/11 were reviewed. No documentation is noted regarding R10 experiencing any coughing or need for Robitussin medication until nursing documented on 01/31/11. This nursing entry states that R10 was in, "some distress with coughing" and was given Robitussin for cough. In reviewing the January 2011 Medication Administration Record (MAR) for 01/01/11 - 01/31/11, R10 received two teaspoons of Robitussin four times daily on 01/27, 01/28. 01/29, 01/30 and 01/31/11. The back of this MAR does not identify that nursing staff completed the reason and the results for the Robitussin medication given to R10 received on these dates (01/27, 01/28. 01/29, 01/30 and 01/31/11). The facility's undated Standing Orders for "Cough" states: "a) Benylin, Robitussin 2 teaspoons every four hours PRN (as needed) unless contraindicated. b) Notify physician if cough persist over 24 hours or if breath sounds are abnormal or if sputum is present or if the resident has a temperature	W9999		

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W9999	Continued From page 56 (101)." In review of the Nurse's Notes from 01/27 - 01/31/11, there is no documentation stating that the physician was notified of R10 requiring Robitussin four times a day for five consecutive days. There are no vital signs, including monitoring for temperatures and/or respiratory assessment, including monitoring of lungs sounds are noted with these entries. R10's response to the medication is not documented. February 2011 In reviewing the February Medication Administration Record (MAR) for 02/01/11 through 02/09/11, R10 continued to receive Tussin (one teaspoon) as needed, three times daily (at 6:00 A.M., 10:30 A.M. and 3:30 P.M.) on 02/01/11 - 02/06/11 and on 02/08/11. R10 received Tussin twice on 02/07/11 and 02/09/11 at 6:00 A.M. and 10:30 A.M.. The back of this MAR does not identify that nursing staff documented the reason and the results of the Tussin medication for any of the dates that R10 received this medication. In reviewing R10's Nurses Notes and MAR for February 2011, the following is noted: 02/01 R10, "has a productive cough. No temperature. Tussin given per orders." There are no vital signs, including monitoring for temperatures and/or respiratory assessment, including monitoring of lungs sounds are noted with these entries. R10's response to the medication is not documented.	W9999		

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W9999	Continued From page 57 02/02/10 There is no documentation regarding R10's cough contained within this nursing entry. The MAR identifies that R10 received three doses of Tussin on this date. There are no vital signs, including monitoring for temperatures and/or respiratory assessment, including monitoring of lungs sounds are noted with these entries. R10's response to the medication is not documented. There is no documentation identifying that the physician was notified of R10's continued need for cough medication. 02/03/10 There is no nursing entry for this date. The MAR identifies that R10 received three doses of Tussin on this date. There are no vital signs, including monitoring for temperatures and/or respiratory assessment, including monitoring of lungs sounds are noted with these entries. R10's response to the medication is not documented. 02/04/10 "Res (resident) has a productive cough... Will continue to monitor." The MAR identifies that R10 received three doses of Tussin on this date. There are no vital signs, including monitoring for temperatures and/or respiratory assessment (including monitoring of lungs sounds) noted within these entries. R10's response to the medication is not documented. From 02/05-02/07/11, there is no further nursing documentation regarding R10's cough, even though the MAR identifies that R10 received two to three doses of Tussin medication on these dates. There are no vital signs, including monitoring for temperatures and/or respiratory assessment (including monitoring of lungs sounds) that noted within these entries. R10's	W9999		

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response to the medication is not documented. There is no documentation identifying that the physician (Z9) was notified of R10's continued need for cough medication.

It is also noted in reviewing the MAR for February 2011 that R10 received Tylenol for an increased temperature of 99.5 axillary on 02/05/11 at 6:00 A.M. R10's Nurse's Notes do not reflect that he had an elevated temperature. No further documentation is noted showing that nursing monitored R10's temperature after 6:00 A.M. on 02/05/11.

On 02/07/11 nursing documented that R10 began experiencing shortness of breath and that edema was noted to his ankles and hand. Orders were received for Lasix 20 mg (milligrams). The MAR identifies that R10 received two doses of Tussin on this date. There are no vital signs, including monitoring for temperatures and/or respiratory assessment (including monitoring of lungs sounds) noted with these entries. R10's response to the medication is not documented within this nursing entry. There is no documentation that the physician (Z9) was notified that R10 had been receiving cough medication on an as needed basis for the past eleven days.

On 02/08/11, nursing documented that R10 had a "productive cough" and that Tussin was given. This entry states that nursing, "will continue to monitor." The MAR identifies that R10 received three doses of Tussin on this date. There are no vital signs (including monitoring for temperatures and/or respiratory assessment) including monitoring of lungs sounds noted with these

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entries. R10's response to the medication is not documented.

R10's Medication Administration record for February 2011 identifies that after 02/08/11, he did not receive any further doses of Robitussin medication.

On 02/09/11, nursing documented at 1:30 P.M. that edema was still noted to R10's feet and hands. Nursing also documented that R10 had a, "hacky cough and clear production" and that orders were received from Z7 (Physician's Assistant) to discontinue routine doses of Robitussin and make it a PRN (as needed) order. Nursing staff also received an order for Lasix 20 mg daily. Nursing did not notify Z7 that R10 was already receiving Robitussin on a PRN basis or that he had been receiving Robitussin/Tussin since 01/27/11.

On 02/10/11 nursing documented, "feet elevated due to edema... productive cough remains." The Nurse's Notes from 02/10 - 02/13/11 states that R10's edema remained in his feet. There is no documentation regarding R10's "hacky cough."

At 7:30 A.M. on 02/13/11, nursing documented in the Nurse's Notes that R10 sounded congested and was coughing up white phlegm. R10's temperature was noted to be 98.1 axillary and vitals could not be completed due to his jerking. His SPO2 (Specific Oxygen Saturation) was noted at 89%. At 8:00 A.M., nursing documented that R10's, "lung sounds slightly congested," however this entry was crossed out. Further nursing documentation for 02/13/11 states, "8:45 A.M. Notified E2 (Administrator/RN) of change in

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W9999	Continued From page 60 resident, said to send to "***" (name of) Hospital ER (Emergency Room) for evaluation. The narrative portion of the Illinois Emergency Medical Services (EMS) report dated 02/13/11, states, "... pt's (patient's) c/c (chief complaint) today is increased congestion and low 02 (oxygen) sat (saturation). Upon arrival to pt, he is found sitting upright in wheelchair @ (at) nurses station. pt has audible wheezes and has a wet productive cough. Nurse (unidentified) stated the pt has had clear sputum and was recently put on Robitussin cough medicine but stated he has just gotten progressively worse. Nurse stated that she was getting an 02 sat of 89%. pt is moved to cot, secured and moved to rig. Vitals were attempted several times but unable to get blood pressure due to pts convulsive disorder and joint deformity. 02 sat was obtained - 79% on room air. pt is placed on cardiac monitor, IV (intravenous) is attempted without success. pt is place on high flow 02 @ 15 LPM (liters per minute) NRB (non rebreather), but pt cannot tolerate mask. Albuterol treatment is given with neb (nebulizer) mask... ER (Emergency Room) is notified. pt is taken to ... ER Rm (room) 6 upon arrival. pts 02 sat was 80% after neb tx. (nebulizer treatment). pts lungs are congested in all fields..." The facility's Nurse's Notes for 02/13/11 at 6:00 P.M. states, "... admitted with diagnosis of Healthcare Associated Pneumonia..." The Hospital History and Physical form dated 02/13/11 states, "This is a 62 year old gentlemen with history of cerebral palsy, seizures, right lung collapse which was in December who presents to	W9999		

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the emergency room for congestion and per EMS note patient was noted in the emergency room to be very congested with productive cough. Patient was saturating on 4 liters of oxygen at 85%... Patient earlier was tachyphemic and saturations are 86% on 13 liters high flow. Patient is going to be on Bi-Pap (bilevel positive airway pressure). Patient has been given IV antibiotics of Levaquin and Zosyn. We will add Vancomycin. Will do blood culture, sputum culture and talk to pulmonologist... Currently patient is on continuous pulse ox (oxygen) checking waiting to be transferred to ICU (Intensive Care Unit)..."

The facility's Nurse's Note for 02/17/11 at 10:00 A.M. states, "Called for update on resident (R10), nurse (Z10) stated he is still in ICU, done Bronchoscopy, full of fluids. On Ventilator since 02/14/11. Dx (diagnosis) Pneumonia."

On 02/17/11, nursing documented, Z11 (R10's guardian) called stating that resident had (a) change in condition. not doing well..."

On 02/20/11 at 10:00 A.M. nursing documented that R10 had been transferred from ICU and that, "he was critical with comfort measures at this time." Nursing documented at 6:45 P.M. that Z11 called and stated that R10 had passed away at 6:15 P.M. with respiratory failure."

The hospital Discharge Summary dated 02/20/11 states,

Discharge Diagnoses:
1. Acute respiratory failure with multi organ failure.
2. Megacolon, status post bowel resection.

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W9999	Continued From page 62 3. Severe pneumonia likely nursing home acquired... Hospital Course: A 63 (62) year old gentlemen with extensive medical problems, history of cerebral palsy, seizures, history of right lung collapse due to elevation of his diaphragm coming to hospital for hypoxia and pneumonia. The patient being treated. The patient became in respiratory depressed, later became acute respiratory failure being intubated. The patient has been given IV antibiotics covering for nursing home acquired pneumonia... The patient also had bronch evaluation which revealed the patient has some yeast and candida from the respiratory culture being treated. Respiratory culture also revealed klebsiella pneumoniae, strep pneumoniae being treated with sensitive antibiotics, Vancomycin and Zosyn... During hospital process in ICU, the patient required intubation and life support, IV fluids and pressors. Per patient poor medical condition, the patient's family also withdrew the life support of ventilator. The patient expired on the day of 20th..." E2 (Administrator/RN) was interviewed on 04/19/11 at 3:50 P.M. and stated, "Yes" when asked by the surveyor if nursing staff should have taken vitals, monitored for temperatures. When asked if nursing should have assessed and documented respiratory assessments, including monitoring of breathing and lungs sounds, E2 stated, "Yes." When E2 was asked if R10's vitals and respiratory assessment would be charted in another place besides the Nurse's Notes, E2 stated, "No." When R10's nursing documentation as well as the hospital report for R10 were reviewed with E2, she stated, "They	W9999		

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(nursing staff) should have completed vitals as well as checked and documented lung sounds. They should have notified the physician after continuing to give R10 cough medicine for such a long time."

Z9 (facility's Medical Director) was interviewed by telephone on 05/12/11 at 1:10 P.M. and stated, "I was not aware that R10 had been on cough medication for an extended period of time. I would have expected the facility to notify me of the extended usage." When Z9 was asked if he would have expected nursing to assess R10's breath and/or lung sounds and document these assessments, Z9 stated, "Yes." When Z9 was asked if he would have expected nursing to notify him of the extended use of the cough medication with the onset of edema in his (R10's) legs and hands, Z9 stated, "Yes, they should have notified me, he needed to be seen."

The Medical Certificate of Death dated 02/20/11 states R10's immediate Cause of Death as Pneumonia.

C) The facility failed to monitor the health status of individuals who did not receive their prescribed medications as the physician ordered for the promotion of bowel movements.

1) The Physician's Order Sheet (POS), dated 03/02/11, identified R13 as a 40 year old individual who functions at a Profound level of Mental Retardation. R13'S POS further includes the additional diagnosis of constipation, Functional Chron (chronic). The Medication Administration Record (MAR), for 04/11, states R13 is scheduled to receive Senna Plus, take (2)

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tablets by mouth three times a day at 7:00 am, 5:00 pm, and 9:00 pm. The MAR for 04/11 further states R13 did not receive this medication as ordered on 04/18/11 at 7:00 am, at 5:00 pm, 9:00 pm, or on 04/19/11 at 7:00 am.

The BM (bowel movement) Record Sheet for 04/11 shows that R13 had no recorded bowel movement from 04/08/11 until 04/11/11 and from 04/12/11 to 04/20/11.

R13's Physician Standing Orders for Constipation states:

a) Milk of Magnesia (MOM) 2 tablespoons in evening as needed, or alternative of resident's choice/
b) Dulcolax suppository------if no results give #c.
c) Soapsuds enema unless contraindicated.
d) Manual removal of fecal impaction by nurse.

Further review of R13's Medication Administration Record (MAR) for the month of April 2011 did not identify that any Standing Order (as needed) medications were given for constipation when R13 had no recorded bowel movements from 04/08 - 04/11/11 and from 04/12/11 - 04/19/11.

2) The Physician's Order Sheet , dated 03/02/11, identifies R11 as a 37 year old individual who functions at Profound level of Mental Retardation.

R11's Medication Administration Record (MAR) for April 2011 identifies that R11 is scheduled to receive two tablets of Senna Plus twice daily for promotion of bowel movements. Further review

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W9999	Continued From page 65 of this document identifies that R1 did not receive this medication as scheduled on 04/18 at 7:00 A.M. and at 5:00 P.M. or on 04/19/11 at 7:00 A.M. Nursing notes from 04/18/11 (at 7:00 A.M. at the time of the first medication ordered and not administered) to 04/21/11 did not include a nursing assessment related to missed Senna Plus tablets that were not administered. Further review of these notes does not identify that nursing implemented the Standing Orders for constipation. On 04/21/11, during an interview with E3, Licensed Practical Nurse (LPN), E3 stated that R11, R12, R13, R14, R15, R16 and R17 did not receive their Senna Plus medication as ordered by the physician on 04/18/11 and the AM dose on 04/19/11. On 04/21/11 at 8:33 am, E2 Administrator stated that as needed medications for constipation should be administered after three days without a bowel movement and that nursing staff are to monitor the bowel movement records. On 04/22/11 at 10:43 A.M., E2 confirmed that R11, R12, R13, R14, R15, R16 and R17 did not receive any standing order medications for bowel movements from 04/11 - 04/19/11. (A)	W9999		