STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G277	A. BUILDING _____ B. WING _____	09/06/2011

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CHESTNUT MANOR	1404 SOUTH 14TH STREET HERRIN, IL 62948

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS ANNUAL CERTIFICATION SURVEY - FULL - W102, W104, W137, W122, W149, W249, W331, W368, W369, W406, W441 and W446 LICENSURE SURVEY INSPECTION OF CARE - IOC COMPLAINT INVETIGATION SURVEY COMPLAINT #1152290/IL53869 - W104 and W149 INCIDENT REPORT INVESTIGATION INCIDENT OF 05/02/11/IL 53773 - W149	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility's governing body has failed to provide operating direction over the facility to ensure the health and safety of the 15 of 15 individuals of the facility (R1-R15) as evidenced by their failure to: A) Implement policy and procedures regarding proper use of oxygen. This failure jeopardizes the safety of 1 of 1 individual (R2) in the sample of 4 requiring continuous oxygen and potentially affecting 14 other individuals of the facility (R1, R3-R15).	W 102		10/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 102	Continued From page 1 1) The facility failed to provide necessary monitoring and supervision to prevent R2 from removing his oxygen with the oxygen concentrator running; and 2) The facility failed to develop a program plan and provide necessary monitoring and supervision to prevent R2 from attempting to sneak and smoke cigarettes while using continuous oxygen. This failure resulted in an Immediate Jeopardy. B) Implement policy and procedures to assure that 1 of 1 individual in the facility requiring continuous oxygen (R2) can be safely evacuated out of the facility in the event of an actual emergency. This failure jeopardizes the safety of all 15 of 15 individuals of the facility (R1 - R15). 1) The facility failed to ensure that all staff are trained to actually evacuate R2 who requires continuous oxygen and the other 14 individuals (R1, R3 - R15) out of the facility during the first shift (12 A.M. - 8:00 A.M.) when the individuals are asleep. 2) The facility failed to develop and implement a plan for evacuating R2 who requires continuous oxygen per concentrator out of the facility in the event of an actual fire which potentially affects 14 additional individuals (R1, R3 - R14) of the facility. This failure resulted in an Immediate Jeopardy. C) Direct care staff failed to implement the facility's policy and procedures regarding handling	W 102		

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W 102	Continued From page 2 soiled linens to reduce the prevcntion of transmission of infections and odors in the facility as observed. D) The facility's staff failed to implement policy and procedures regarding oxygen storage. Findings include: Refer to deficiencies cited at: W104 - The governing body must exercise general policy, budget, and operating direction over the facility. W122 - Condition of Participation of Client Protections W406 - Condition of Participation of Physical Environment	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's governing body has failed to provide operating direction over the facility to ensure the health and safety of the 15 of 15 individuals of the facility (R1-R15) when they failed to: A) Implements policies and procedures regarding oxygen usage, storage or supervision of the individual who utilzes the oxygen. This failure	W 104		10/13/11

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W 104	Continued From page 3	W 104		

jeopardizes the safety of 1 of 1 individual (R2) in the sample of 4 requiring continuous oxygen with the potential to affect 14 other individuals of the facility (R1, R3-R15).

B) Develop and implement policies and procedures to ensure safe evacuation of an individual requiring continuous oxygen in the event of an actual emergency. This failure jeopardizes the safety of all 15 of 15 individuals of the facility (R1 - R15).

C) Ensure that direct care staff implements the facility's policy and procedures regarding handling soiled linens to reduce the prevention of transmission of infections and odors in the facility.

Findings include:

A) The facility failed to implement policy and procedures regarding oxygen usage, storage and supervision which jeopardizes the safety of all individuals of the facility (R1- R15).

The facility's undated policy and procedures, "For the use, storage and transportation of Oxygen used for medical purposes" states, "Cylinders must be laid down or secured upright to prevent them from falling over when stored. Empty cylinders must be stored with the valve closed, and attached with a label marked empty."

During observation on 07/21/11 at 4:05 P.M., eight small oxygen canisters were noted sitting upright in a cardboard sectioned box in the QMRP's office. When the cardboard box was

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W 104	Continued From page 4	W 104		

moved, the surveyor noted that the canisters shifted and tilted within the box. The canisters were not secured upright to prevent them from falling over within the box onto the floor. One large oxygen canister and one small oxygen canister sat directly on the floor. E1 (QMRP) was present during this observation and stated that the canisters sitting on the floor were empty. These two canisters were not marked as empty as per the facility's policy.

On 07/19/11 at 3:40 P.M., R2 was standing at the north men's wing door of the facility wearing his portable oxygen. R2 continually opened the door and peeked out the door. A cigarette receptacle is located fifteen to sixteen feet from this door. R2 continued peeking out the door until receiving his nebulizer treatment at 4:25 P.M..

During the interview with E1 (QMRP) on 07/21/11 at 4:45 P.M., she stated that R2 tries to sneak and smoke discarded cigarette butts.

Further review of the facility's undated policy, "For the use, storage, and transportation of Oxygen used for medical purposes" states within the procedures section that, "Smoking and the use of oxygen are incompatible and if a client (or others) smokes while using oxygen they put themselves, their surroundings, the property, and others in any of these areas at great risk..."

On 07/19/11 at 3:40 P.M., R2 was standing at the north men's wing door of the facility wearing his portable oxygen. R2 continually opened the door and peeked out the door. A cigarette receptacle is located fifteen to sixteen feet from this door. R2 continued peeking out the door until receiving

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W 104	Continued From page 5 his nebulizer treatment at 4:25 P.M.. On 07/22/11 at 3:50 P.M., R2 was observed opening the north men's wing door of the facility using his oxygen via his nasal cannula. R2 started outside the door in the direction of the cigarette receptacle until he noticed that the surveyor was in the parking lot area. R2 immediately turned around and reentered the north door. Within seconds, R2 peeked out of the door and looked in the direction of the surveyor. When seeing the surveyor, he immediately closed the door. During the interview with E1 (QMRP) on 07/21/11 at 4:45 P.M., she stated that R2 tries to sneak and smoke discarded cigarette butts. R2's Individual Program Plan (IPP) dated 08/18/10 does not specify the level of monitoring and supervision needed to prevent him attempting to sneak and smoke while using continuous oxygen. Refer to deficiency cited at W122 - The facility must ensure that specific client protections requirements are met. B) The facility failed to develop and implement policies and procedures to assure that R2 who requires continuous oxygen (R2) can be safely evacuated out of the facility in the event of an actual emergency, which potentially affects all individuals of the facility (R1- R15). Refer to deficiency cited at W406 - The facility must ensure that specific physical environment	W 104		

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W 104	Continued From page 6 requirements are met. C) Direct care staff failed to implement the facility's policy and procedures regarding handling soiled linens to reduce the prevention of transmission of infections and odors in the facility. The facility's undated policy and procedures of soiled linen states, "*Heavily soiled linen should be rolled or folder to contain the heaviest soiled in the center of the bundle. *Soiled linen should be bagged at the site of collection." On 07/22/11, the surveyor entered the facility at 8:15 A.M.. A strong bowel movement (BM) odor was evident when entering the front door. An attempt to mask the odor with air freshener could be smelled. An air purifier was on in the living room to assist in reducing the smell. At 9:15 A.M., R4's room was checked for personal items. A strong urine odor was present in the hall way between his room and the bathroom. Wet, soiled bedding was observed sitting in his laundry hamper and a strong BM and urine smell was noted. R4's bedding was not bagged. When the surveyor exited R4's bedroom, wet, soiled linens were laying on the floor in the hall near the laundry room door. These items were not bagged. E1 (QMRP) was interviewed on 07/22/11 at 10:05 A.M. and stated, "There was a personal problem with a staff member (unidentified) this morning and she had to be sent home. E4 (Direct care staff) will be in at 11:30 A.M. and start the laundry." At this time the surveyor asked E1 for the facility's policy and procedures for	W 104		

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W 104	Continued From page 7 Housekeeping and/or for Soiled Linen(s). After reviewing the policy on Soiled Linens with E1, she stated, "Staff should be bagging the soiled linens and not placing them on the floor or in the individual's laundry baskets."	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: A) Based on observation, interview and record review, the facility failed to implement policy and procedures regarding proper use of oxygen which jeopardizes the safety of 1 of 1 individual (R2) in the sample of 4 requiring continuous oxygen which may potentially affect 14 other individuals of the facility (R1, R3-R15). The facility failed to: 1) Provide necessary monitoring and supervision to prevent R2 from removing his oxygen and leaving his cannula on his bed with the oxygen concentrator running; and 2) Develop a program plan and provide necessary monitoring and supervision to prevent R2 from attempting to sneak and smoke cigarettes while using continuous oxygen. This failure resulted in an Immediate Jeopardy. The Administrator (E2) and the QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M. The Immediate Jeopary was removed on 08/22/11 at 3:10 P.M.	W 122		9/1/11

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W 122	Continued From page 8 Findings include: Refer to deficiency cited at: W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 122		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that individuals have the right to retain and use personal possessions for 1 of 1 individual in the sample of 4 (R4) whose guardian requested that the facility purchase personal possessions for his use. Findings include: Per telephone interview with Z4 (R4's guardian) on 07/22/11 at 9:00 A.M., Z3 stated, "The facility was to take out $500.00 from R4's Trust fund and purchase him a new television, clothing, personal activities and baseball items for his room and/or tickets to see a baseball game." R4's bedroom was observed at 9:30 A.M. on 07/22/11. R4 had a large older looking model television on his dresser. No personal items were noted on his bedroom walls or on his bed. The	W 137		10/5/11

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W 137	Continued From page 9 surveyor did not observe a new television, activity items and or baseball decorations in his room. E1 (Qualified Mental Retardation Professional/QMRP) on 07/22/11 at 9:45 A.M. and stated, "I'm not sure if any new items were bought for R4 because E3 (prior QMRP) would have taken care of that. R4 hasn't received a new television or activity supplies. I will talk with Z3 and purchase him (R4) some items for his bedroom."	W 137		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: A) Based on observation, interview and record review the facility failed to implement policy and procedures regarding proper use of oxygen which potentially jeopardizes the safety of 1 of 1 individual (R2) in the sample of 4 requiring continuous oxygen via nasal cannula and potentially affects 14 other individuals of the facility (R1, R3-R15). The facility failed to: 1) Provide necessary monitoring and supervision to prevent R2 from removing his oxygen with the oxygen concentrator running; and 2) Develop a program plan and provide necessary monitoring and supervision to prevent R2 from attempting to sneak and smoke cigarettes while using continuous oxygen.	W 149		10/10/11

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W 149	Continued From page 10 This failure resulted in an Immediate Jeopardy. B) Based on observation, interview and record review, the facility failed to implement policy and procedures regarding injuries of unknown origin when they failed to implement a system of corrective action as per the facility's policy for 2 of 3 individuals sustaining fractures of the right pinky finger of unknown origin within the past six months (R4 and R 10). Findings include: A) The facility failed to implement policy and procedures regarding oxygen usage. An Immediate Jeopardy was identified to have begun on 08/18/10 when R2's Interdisciplinary Team failed to ensure that a risk assessment was completed and included within his Individual Program Plan (IPP) as identified per the facility's policy and procedures. R2 was observed not wearing his oxygen and had laid his nasal cannula and tubing on his bed covers while attached to the oxygen concentrator and the machine still on. Staff were not observed to intervene and or monitor R2 for removing his oxygen. R2 was also observed peeking out the northend door of the facility, watching a cigarette receptacle while wearing his oxygen. The Qualified Mental Retardation Professional (QMRP) states that he tries to sneak and smoke discarded cigarette butts. Staff were not observed to intervene and or redirect this behavior and no plan has been developed to address this behavior which places the safety of all individuals of the facility at risk. The Administrator (E2) and the QMRP (E1) were notified of the Immediate	W 149		

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W 149	Continued From page 11 Jeopardy on 07/22/11 at 4:15 P.M. The facility's undated roster states that R2 is a 54 year old male who functions at a moderate level of mental retardation. The Physician's Orders sheet dated 07/31/11 states that R2 has diagnoses which includes Chronic Respiratory COPD (Chronic Obstructive Pulmonary Disease) and requires continuous oxygen of 2 to 3 L (liters) per minute per concentrator. The facility's undated policy and procedures for Proper Use and Care of Oxygen Concentrators states, "Only use and store oxygen in a well ventilated area. Keep internal doors open while the oxygen cylinder or concentrator is in use. *Ensure clients or others never leave their cannula or mask on the bed or in the chair when the oxygen is being supplied. *Ensure the oxygen supply is turned off when not in use. " On 07/21/11, R2 was observed at 3:55 P.M. standing in his bedroom in front of the television. He did not have his oxygen on by nasal cannula. R2's portable backpack was observed sitting upright next to the entrance of the doorway. The tubing connected to the oxygen concentrator machine was lying on the bed. A hissing sound was heard when the tubing was moved from the covers of the bedding. R2 stated that his oxygen was still on. When asked why he had his oxygen off, R2 stated that he was getting ready for his bath.	W 149		

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W 149	Continued From page 12 Per continued observation, R2 was observed at 4:15 P.M. still standing in front of his television in his bedroom. His oxygen tubing remained on the bed and the hissing noise continued. R2 informed the surveyor that his oxygen was on when asked if the surveyor could check his oxygen concentrator. No staff were present in the area and staff were not observed to monitor R2 to ensure that he does not leave his cannula on the bed when the oxygen is being supplied as per the facility's policy. E1 (Qualified Mental Retardation Professional/QMRP) was interviewed on 07/21/11 at 4:45 P.M. and stated, "R2 knows better than to leave his oxygen on the bed. He also tries to sneak and smoke discarded cigarette butts. The oxygen supplier has stated that if he didn't try to sneak and smoke he could keep his oxygen supply in his room. We will have to start monitoring him more closely." Further review of the facility's undated policy, "For the use, storage, and transportation of Oxygen used for medical purposes" states within the procedures section that, "Smoking and the use of oxygen are incompatible and if a client (or others) smokes while using oxygen they put themselves, their surroundings, the property, and others in any of these areas at great risk..." On 07/19/11 at 3:40 P.M., R2 was standing at the north men's wing door of the facility wearing his portable oxygen. R2 continually opened the door and peeked out the door. A cigarette receptacle is located fifteen to sixteen feet from this door. R2 continued peeking out the door until receiving	W 149		

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W 149	Continued From page 13 his nebulizer treatment at 4:25 P.M.. On 07/22/11 at 3:50 P.M., R2 was observed opening the north men's wing door of the facility using his oxygen via his nasal cannula. R2 started outside the door in the direction of the cigarette receptacle until he noticed that the surveyor was in the parking lot area. R2 immediately turned around and reentered the north door. Within seconds, R2 peeked out of the door and looked in the direction of the surveyor. When seeing the surveyor, he immediately closed the door. During the interview with E1 (QMRP) on 07/21/11 at 4:45 P.M., she stated that R2 tries to sneak and smoke discarded cigarette butts. R2's Individual Program Plan (IPP) dated 08/18/10 does not specify the level of monitoring and supervision needed to prevent him from removing his oxygen and leaving his cannula on his bed with the oxygen concentrator running. No risk assessment is included within this plan to ensure safe practice in case of a fire and or other emergencies as identified per the facility's policy and procedures. Further review of R2's IPP does not identify that a program plan has been developed to address his behavior of attempting to sneak and smoke while using continuous oxygen.. R2's IPP does not specify the level of monitoring and supervision needed to prevent him from sneaking to smoke a cigarette while using continuous oxygen. During the Daily Status Meeting on 07/21/11 at 4:15 P.M., E1 (QMRP) confirmed that R2's IPP does not address the level of monitoring and or	W 149		

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CHESTNUT MANOR	1404 SOUTH 14TH STREET HERRIN, IL 62948

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 14 supervision needed for safety while using continuous oxygen. E1 also confirmed that no plan has been developed to address his behavior of attempting to sneak and smoke cigarettes while using continuous oxygen. The Administrator (E2) and the QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M. . The Immediate Jeopary was removed on 08/22/11 at 3:10 P.M. when the surveyor confirmed a plan which includes: 1) The Cigarette receptacles were moved out of R2's line of vision and placed away from the northend door on 07/23/11. 2) A program was written on 08/02/11 to train R2 on oxygen safety. Staff were trained on this program on 08/10/11. All new staff will be trained upon hire on an ongoing basis. 3) Staff were in serviced on 08/10/11 on how to monitor R2's safe oxygen use. Staff will encourage R2 to participate in activities. When he is not actively participating in an activity or program, staff will know his whereabouts and check every ten minutes to ensure that he is wearing his oxygen. All new staff will be trained upon hire on an ongoing basis. 4) The Administrator purchased R2 an electric cigarette so that if he choses to smoke, he can do so safely. 5) The facility will develop a risk assessment by 09/01/11 to address R2's safe oxygen use. 6) The Administrator (E2) and the QMRP (E1) will	W 149		

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W 149	Continued From page 15 monitor for compliance. While the Immediate Jeopardy was removed on 07/22/11, the facility remains out of compliance since they have not had the opportunity to fully implement and evaluate the effectiveness of this plan. B) The facility failed to implement policy and procedures regarding injuries of unknown origin when they failed to implement a system of corrective action as per their facility policy. The Facility's Abuse Prevention Program, Option 6: Injuries of Unknown Origin policy states, 1) Once it is noted that a resident has sustained an injury the Administrator, RN Consultant and the Resident Service Director must be notified immediately. 2) An Incident Accident Report must be completed. The resident's family or guardian must be immediately notified. The Primary Physician must also be notified. This policy goes on to states that the Incident/Accident Report must include, any corrective action taken and follow up information. 1) The facility's undated roster states that R10 is a 48 year old male who functions at a profound level of mental retardation. On 07/19/11 at 3:30 P.M., R10 was observed at the facility sitting on the couch in the living room. He was observed wearing brown gloves to both of his hands. At 4:50 P.M., R13 was observed	W 149		

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W 149	Continued From page 16	W 149		

pulling at R10's gloves and removed his glove from his right hand without intervention until brought to the attention of E2 (Administrator) who was present in the living room area. R10 remained in the living room wearing his gloves until the evening meal at 5:25 P.M. R10 is nonverbal and was unable to verbally answer questions asked to him by the surveyor.

An undated Medical Care Plan identifies that R10 has Raynaud's Phenomenon which requires that he wear mittens to both of his hands. This plan staff that the mittens are to be removed every two hours for ten minutes and when awakened for toileting at night. R10's mittens are also to be removed for fifteen to thirty minutes during meals.

An Incident/Accident Report dated 03/13/11 states that R10 was found to have, "swelling and bruising to his right hand" and "bruising noted (to the) 4th and 5th finger" after breakfast. This report also states that the time, nature of the incident and how the injury occurred were unknown.

In review of the facility's investigation dated 03/14/11, it is noted that R10 sustained a fracture to his right proximal phalanx (pinky finger). Within this investigation, the facility concluded that R10's injury, "was self inflicted".

R10's The Behavior Development Program dated 11/17/10 states that he has behaviors of PICA (eating inedible items). This program does not identify that he has behaviors of or history of demonstrating other self injurious behaviors.

E4 (Direct Care Staff) was interviewed on

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W 149	Continued From page 17 07/21/11 at 2:40 P.M. and stated, R10 is not self injurious. I'm not sure how he got his pinky broken, but I don't think that he injured it himself. During this interview E4 confirmed that R10 is nonverbal and would not be able to inform someone if he had been abused. The facility's investigation dated 03/14/11 does not identify that corrective action was taken by the facility to prevent further incidents of injuries of this nature as identified per the facility's policy. 2) The Psychological Report dated 05/12/11 states that R4 is a 59 year old male who functions at profound level of mental retardation. This report also states that R4 is non verbal and that he has a behaviors of pacing and chewing his thumb which have been present since adolescence. The facility's investigation dated 06/14/11 states that E3 (prior RSD/Resident Services Director) received a call on 06/07/11 from Z1 (Case Manager) stating that the nurse (Z2 Registered Nurse/RN) noted discoloration and bruising to R4's right pinky and right ring finger. No Incident/Accident Report was contained within the facility's investigation as per the facility's policy. A Diagnostic Imaging Report dated 06/07/11 states, "There is a comminuted fracture through the distal aspect of the fifth metacarpal with radial and volar side displacement manor distal fracture fragment... Impression: Displaced fifth metacarpal fracture..."	W 149		

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W 149	Continued From page 18 Within the facility's investigation it is concluded that R4's injury was "self inflicted". It also states, "All staff have been instructed to monitor R4 closer when he is going in and out of doors (facility, bus, day training or out in the community)". R4 was observed on 07/19/11 pacing back and forth and going in and out of the facility's back patio door from 3:30 to 5:20 P.M.. Staff did not intervene and or redirect him to another activity. During this observation, staff were not observed to closely monitor R4 when he was, "going in and out of the doors" at the facility. During the Daily Status Meeting on 07/21/11 at 4:50 P.M., E2 (Administrator) stated, "We had talked about getting R4 some hand/arm guards to protect his hands and arms. We think that he fractured his finger when he bumped his finger going in and out of the doors." When E2 was asked what corrective action had been taken to prevent further injury after R10 and R4 sustained fracture to their right pinky fingers, she stated, "Well we told staff to watch them more closely." E1 (QMRP) was also present during this meeting and stated, "No" when asked if the facility had reproducible evidence showing that action had been taken by the facility after R10 and R4 sustained fractures of unknown origin to their right pinky finger.	W 149		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number	W 249		10/13/11

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W 249	Continued From page 19 and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to implement and/or reinforce self medication training objective(s) and/or self medication skills training for 6 of 6 individuals (R1, R2, R3, R5, R6 and R7) observed during the 4:00 P.M. medication administration pass on 07/20/11. Findings include: The medication administration was observed on 07/20/11 from 4:25 P.M. to 5:20 P.M. E3 (Direct Care Staff) was observed administering all the medications to all of the individuals (for R1, R2, R3, R5, R6 and R7) without evidence of training and or reinforcement of skills. E3 was observed to obtain all of the individual's medications from the medication cabinet, push out the medications and put the medications in a cup for all of the individuals. At 4:25 P.M., R5 was given his Ativan 0.5 mg tablet without evidence of training. R6 then entered the medication room and was administered Cranberry Capsule 250 mg., Oyster Shell 500 + D and Ativan 0.5 mg. without evidence of training. At 4:40 P.M., R2 entered the medication room.	W 249		

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W 249	Continued From page 20 E3 took his medication from the medication drawer, punched out the medications into a cup and handed the cup to R2. R2 took two tablets of Mucinex 600 mg., Oyst Cal D 500 mg, Metformin 1000 mg and one teaspoon of Antacid Plus per review of the bubble packs. E3 then took R2 to his room to start his nebulizer treatment with Buedsonide 0.25 mg. At 5:00 P.M. R7 entered the medication room and took two puff of Flovent HFA AER MCG. R7 was given Ranitidine 150 mg, Senna 8.6 - 50 mg., Risperidone 1 mg., Risperidone 1 mg, Sodium Chloride 1 gm., Folic Acid 1 mg. and Vitamin B-1 100 mg . No self medication training was provided to R7 during this observation. At 5:15 P.M. R1 took Tarazosin 1 mg, Calcium 600 + D and Potassium Chloride 10 med ER without evidence of training and or reinforcement of medication skills training. On 07/20/11 at 5:19 P.M. E3 informed the surveyor that R3 was refusing to come into the medication room to take her medication. He then took R3's medication from the medication drawer, punched out her medication and mixed the medication into a small cup of yogurt. In reviewing R3's medication bubble packs, she took Potassium Chloride 10 meq, Senna S tablet 8.6 - 50 mg. Sodium Chloride, Ativan 1 mg., Haloperidol 2 mg, Oysco 500 mg. and Carbamazepi Chew 100 mg. E3 left the medication room and gave R3 her medication while she was sitting on the couch in the living room of the facility. In reviewing the Monthly Reviews dated May	W 249		

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W 249	Continued From page 21 2011, R1, R2 and R3, all have self medication objectives which were not implemented and or reinforced during the 07/20/11 4:00 P.M. medication administration pass. a) R1 has a self medication objective to identify what her Benadryl is taken for with 40% accuracy. She was not asked to identify any of her medications and/or asked what the medications were for when observed at the 4:00 P.M. medication pass on 07/20/11. b) R2 has a self medication objective to identify what his Metformin is taken for with 90% accuracy. He was observed to take Metformin 1000 mg during the 4:00 P.M. medication pass on 07/20/11 and staff did not ask him to identify what this medication is taken for. c) R3 has a self medication objective to point to her container for her medications at medication pass time with 50 % accuracy allowing 4 verbal prompts and physical guidance. She was not allowed the opportunity to point to her container of her medication during the 4:00 P.M. medication pass on 07/20/11. E3 was interviewed on 07/20/11 at 5:20 P.M. and stated, "No, I did not run any self medication programs" when asked by the surveyor if he had implemented R1's, R2's, R3's, R5's, R6's or R7's self medication objectives. When asked why he did not implement and or reinforce self medication skills training during the medication administration, he stated, "I was running short on time".	W 249		
W 331	483.460(c) NURSING SERVICES	W 331		10/13/11

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W 331	Continued From page 22 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 4 of 4 individuals in the sample (R1, R2, R3 and R4) are provided with nursing services in accordance with their needs when nursing failed to: 1) Ensure that staff are provided with the necessary equipment to monitor oxygen saturation and ensure that staff monitor and report signs and symptoms of swelling of the legs as identified within the nursing plan for 1 of 1 individual in the sample of 4 who has diagnosis of Chronic Obstructive Pulmonary Disease (COPD), requiring continuous oxygen (R2). 2) Develop and implement a plan for monitoring signs and symptoms of Gastrointestinal (GI) bleeding for 1 of 1 individual in the sample of 4 receiving Celebrex and Aspirin concomitantly which increases her risk of gastrointestinal ulceration (R3). 3) Ensure that staff implemented the nursing plan for constipation for 1 of 1 individual in the sample of 4 who has diagnosis of Constipation (R4) after he went ten days without a documented bowel movement on any shift in July 2011. a) Staff failed to administer the as needed medication to R4 after documenting that he went three days without a bowel movement. b) Staff failed to notify the physician after	W 331		

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W 331	Continued From page 23 documenting that R4 went one week without a bowel movement. 4) Complete weekly skin assessments as identified in the nursing care plan for 1 of 1 individual in the sample of 4 with history of decubitus ulcers (R1). Findings include: 1) Nursing failed to ensure that staff are provided with the necessary equipment to monitor oxygen saturation and ensure that staff monitor and report signs and symptoms of swelling of the legs as identified within the nursing plan The facility's undated roster states that R2 is a 54 year old male who functions at a moderate level of mental retardation. The Physician's Orders sheet dated 07/31/11 states that R2 has diagnoses which includes Chronic Obstructive Pulmonary Disease (COPD) and requires continuous oxygen of 2 to 3 L (liters) per minute per concentrator. In reviewing the 08/18/10 Interdisciplinary Team Meeting reports, R2 has a care plan for his nursing diagnosis of Impaired Gas Exchange. a) Nursing failed to ensure that staff are able to monitor the oxygen saturation for R2 as identified within his nursing plan. Within the therapeutic interventions of R2's nursing plan for Impaired Gas Exchange, it is noted that staff are to, "Maintain oxygen administration device as ordered, attempting to maintain oxygen saturation at 90% or greater.	W 331		

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W 331	Continued From page 24 This provides for adequate oxygenation." In reviewing the facility's progress notes, no documentation is noted to identify that staff are maintaining R2's oxygen saturation at 90% or greater. E4 (Direct Care staff) was interviewed on 07/22/11 at 2:50 P.M. and stated, "I know that he requires continuous oxygen, but I don't know how we are to maintain his oxygen saturation at 90% or greater." When E4 was asked if the facility had a pulse oximeter, she stated, "No". b) Nursing failed to ensure that staff monitor and report signs and symptoms of swelling of the legs as identified with his nursing plan. R2's nursing plan for Impaired Gas Exchange identifies therapeutic interventions which includes that staff are to, "Report signs and symptoms of swelling of his legs (Most notable around the sock band, ankles, and tops of the feet) to the MD (Medical Director) or RN (Registered Nurse). In reviewing the R2's progress notes and program documentation, no documentation is noted identifying that staff are monitoring and documenting that they are checking R2's legs for swelling. E4 (Direct Care staff) was interviewed on 07/22/11 at 2:50 P.M. and stated, "No we do not have a sheet to show that we are checking his (R2's) legs for swelling." When E4 was asked if staff check R2's legs for swelling, she stated, "We do daily skin checks, but we don't check him specifically for swelling of his legs."	W 331		

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W 331	Continued From page 25	W 331		

2) The facility failed to develop a plan to monitor for signs and symptoms of Gastrointestinal (GI) bleeding while taking Celebrex and aspirin.

The facility's undated roster identifies that R3 is a 67 year old female who functions at a severe level of mental retardation. The Physician's Orders sheet dated 07/31/11 states that R3 has diagnoses of Defuse Osteoporosis, Epilepsy, Cerebellum Degeneration, Dehydration, Anemia and Edema. R3 also has a diagnosis of Peptic Ulcer Disease (PUD) which is a stomach disorder marked by corrosion of the stomach lining due to the acid in the digestive juices. The Physician's Orders also states that she receives Aspirin 81 mg (milligrams) and Celebrex 200 mg daily.

In reviewing the Physician's Desk Reference (PDR) 65th Edition, 2011, the following Black Box warning for Celebrex notes:

"Drug Interactions:
Celebrex can be used with low-dose aspirin. However concomitant administration of aspirin with Celebrex increases the rate of GI (Gastrointestinal) ulceration or other complications compared to use of Celebrex alone...

Gastrointestinal Risk
* NSAIDs (Non Sterodal Anti-inflammatory Drugs) including Celebrex cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration and perforation of the stomach or intestines which can be fatal. These events can occur at any time during use and

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W 331	Continued From page 26 without warning symptoms... (See WARNINGS) Warnings and Precautions ...Other factors that increase the risk for GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, use of alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients and therefore, special care should be taken in treating this population... Physicians and patients should remain alert for signs and symptoms of GI ulceration and bleeding during Celebrex therapy and promptly initiate additional evaluation and treatment if a serious GI adverse event is suspected. This should include discontinuation of the NSAID until a serious GI adverse event is ruled out..." Z1 (Pharmacist) was interviewed by telephone on 08/17/11 at 9:25 A.M. and stated, "R3 has orders for CBC (Complete Blood Count) every 6 months. Staff should be monitoring for black, tarry stools and or blood in her stools." R4's CBC results dated 02/08/11 identifies that her HGB (Hemoglobin) level was low at 12.2 (reference range 12.3 -15.5). These results were signed off by the Registered Nurse (RN) Consultant/Z2. The CBC results dated 08/05/11 identifies that R4's HCT (Hematocrit) level was low at 34.9 (reference range 36.8 - 44.9) and that her HGB level was low at 12.1. These results were signed off by the RN Consultant/Z3. There is no documentation that the physician was notified of R3's abnormal results by either of the RN Consultants (Z2 or Z3).	W 331		

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W 331	Continued From page 27 In reviewing R3's Interdisciplinary Team (IDT) meeting report dated 11/19/10, no plan has been developed to address her increased risk for GI ulceration while taking Celebrex and aspirin. No documentation is noted within the IDT report to monitor R3 for black, tarry stools and/or blood in her stools. Per record review, no bowel movement records were noted for R3. E1 (QMRP) was interviewed by telephone on 08/17/11 at 9:50 A.M. and stated that direct care staff do not maintain a bowel movement record for R3. E1 also stated, "I called Z5 (Medical Director) and he is sending over a medical plan for monitoring R3 while she is taking Celebrex and aspirin." 3) Nursing staff failed to ensure that direct care staff implemented R4's nursing plan for constipation. The facility's undated roster states that R4 is a 58 year old male who functions at a profound level of mental retardation. R4's Medication Administration Record (MAR) dated July 2011 states that he has diagnosis of Constipation and receives Senna S tablets 8.6 -50 mg (milligrams) daily and Docusil 100 mg twice daily. Further review of the MAR identifies that he has a PRN (as needed) order for Milk of Magnesia (MOM) 60 ml (milliliters) for 72 hours. A Medical Care Plan for R4 for Bowel Movements dated 05/12/11 states:	W 331		

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W 331	Continued From page 28 1. Assist client with consumption of constipation medication(s). 2. Staff will document each shift if a bowel movement is observed or if the client has not had a bowel movement during the shift. 3. The individual will receive prune juice daily as part of the morning meal. 4. If there is no record of a bowel movement after the 3rd day, prune juice will be given. If no bowel movement after 24 hours of receiving the prune juice, MOM should be given per prn orders. 5. If there is no result after 24 hours of receiving the MOM, the RN Consultant will be notified. 6. The Physician will be notified if the individual has not had a bowel movement after 1 week (7 days). In reviewing R4's BM Record for the month of July 2011, it was noted that from July 12th - July 21st, 2011, no bowel movements have been documented on any shift. The MARs for July 2011 does not identify that MOM was given on any date for the month. R4's Hab. (Habilitation) Notes from 07/07/03 - 07/21/11 does not identify that staff notified the RN consultant regarding R4's lack of bowel movements. E1 (QMRP) was interviewed on 07/26/11 at 11:50 A.M. and stated, "Staff are to document his (R4's) bowel movements on the BM Record." The surveyor reviewed R4's BM Record for the month of July 2011, R4's MAR for July 2011 and R4's nursing plan for constipation with E1. E1 then stated, "No staff did not implement R4's nursing	W 331		

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W 331	Continued From page 29 plan for constipation. I don't see that they gave him the MOM or contacted the RN Consultant." 4) Nursing staff failed to complete weekly skin assessments as identified in the nursing care plan for R1 who has history of decubitus ulcers. The Physician's Orders sheet dated 05/31/11 identifies that R1 is a 64 year old female who functions at a moderate level of mental retardation and has diagnosis of Cerebral Palsy. R1's Medical Care Plan dated 02/26/11 identifies that she has a problem of skin breakdown to her buttock area. Within this plan there is an approach for nursing to complete weekly skin assessments. R1 was observed on 07/26/11 in the bathroom of the facility with E5 (Direct Care Staff). R1 was noted to have a 0.5 x 0.3 centimeter closed, healed area on the inner aspects of her buttock. No redness was noted. R1 stated that her buttock area had healed and was not hurting anymore. The Hab. (Habilitation) Notes dated 04/19/11 states that R1 was found to have an open area on her peri/vaginal area. On 04/20/11 the Hab. Notes states, "area on buttock looks about the same." No documentation was noted within these notes and or on the Treatment Record to identify the actual site of the open area. The Nursing Skin assessment for 04/16/11 identifies that R1 has a reddened area at the top inner aspect of her buttock cheeks. On 04/21/11,	W 331		

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W 331	Continued From page 30 a Skin Assessment states that she has a 1.5 cm (centimeter) x 2.0 cm open area with .5+ tunneling to the right buttock. The Skin Assessments dated 04/29/11 and 05/07/11 identifies that R1 has a Stage II pressure ulcer. Documentation on the 05/07/11 assessment identifies, "Good epithelial regrowth". No further weekly nursing assessment is noted until seven weeks later on 06/30/11. The Skin Assessment dated 06/30/11 states, "Skin is clear". E1 (QMRP) was interviewed on 07/26/11 at 11:50 A.M. and stated, "No, there are no Skin Assessments for R1 between the dates of 05/07/11 through 06/30/11. E1 also stated that the Registered Nurse (RN) Consultant should have completed weekly skin assessments for R1 during the months of May and June 2011.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all medications are administered as ordered by the physician for 4 of 4 individuals who had their medications administered in error during the month of June 2011 (R3, R5, R9 and R11). Findings include: 1) The Medication Error Report dated 06/16/11 states that R11 did not receive his medications of	W 368		10/13/11

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Lorazepam, Risperidone, Loratadine and Ciprofloxacn . This report states that these medications were an "Omission" due to the fact that staff, "Had clients meds (medications) ready to go for client to take" and that R11, "Left on bus before able to take them." This medication error was attributed to, "Inexperienced staff", "Insufficient staff" and "Increased workload".

R11's Physician's Orders sheet dated June 2011 identifies that he is to receive Loratadine 10 mg, Lorazepam 1 mg, Risperidone 2 mg and Ciprofloxacn 250 mg during the 7:00 A.M. medication administration.

2) The Medical Error Report dated 06/14/11 states that R5 received the wrong dose of Lorazepam 0.5 mg at 7:00 A.M.. This form states that R5 punched out a tablet from the 7:00 A.M. blister pack. This medication error was attributed to, "Inexperienced staff".

E8 (Direct Care Staff) was interviewed on 07/21/11 at 1:05 P.M. and stated, "R5 took two Lorazepam 0.5 mg tablets at 7:00 A.M. on 06/14/11. I was doing weights with the medication pass and he pushed out a second Lorazepam tablet and took it before I could stop him."

R5's Physician's Orders sheet dated July 2011 states that he is to receive one tablet of Lorazepam 0.5 mg at the 7:00 A.M. mediation administration pass.

3) The Medication Error Report dated 06/19/11 states that R9's Lorazepam 1 mg was given at the wrong time. The time that this medication was given in error is not documented on the

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W 368	Continued From page 32 report. The medication error was attributed to, "Inexperienced staff". R9 had adverse outcome of sleepiness resulting from the medication error. R9's Physician's Orders sheet dated June 2011 identifies that she is to receive Clonazepam 1 mg at bedtime. 4) The Medication Error Report dated 06/15/11 states that R3's Fentanyl 50 mcg (microgram) patch was not administered as physician ordered. This report states, "Failed to administer medication" and attributed the error to, "Inexperienced staff". R3's Physician's Orders sheet for June 2011 states that she is to have her Fentanyl patch applied every third day of the month during the 4:00 P.M. medication administration.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that all drugs are administered without error for 2 of 6 individuals who did not receive their 4:00 P.M. medications within the 3:00 P.M. to 5:00 P.M. window on 07/20/11 (R1 and R3). Findings include: The medication administration pass was observed on 07/20/11 from 4:25 P.M. to 5:20	W 369		10/13/11

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W 369	Continued From page 33 P.M. At 5:15 P.M. R1 took Tarazosin 1 mg, Calcium 600 + D and Potassium Chloride 10 med ER. After administering R1's medication, E3 (Direct Care Staff) stated, "I need to call the nurse (no name specified) because I am over my time - 5:00 P.M.." E3 stated, "I got started late with the medication pass" when asked by the surveyor why the medication pass had ran late. The Medication Administration Record and the Physician's Order sheet for July 2011 identifies that R1 is ordered to receive Tarazosin 1 mg, Calcium 600 + D and Potassium Chloride 10 med ER daily at 4:00 P.M. Per continuing observation of the medication administration pass, at 5:19 P.M. E3 informed the surveyor that R3 was refusing to come into the medication room to take her medication. He then took R3's medication from the medication drawer, punched out her medication and mixed the medication into a small cup of yogurt. In reviewing R3's medication bubble packs, she took Potassium Chloride 10 meq, Senna S tablet 8.6 - 50 mg. Sodium Chloride, Ativan 1 mg., Haloperidol 2 mg, Oysco 500 mg. and Carbamazepi Chew 100 mg. E3 left the medication room and gave R3 her medication while she was sitting on the couch in the living room of the facility. The Medication Administration Record and the Physician's Order sheet for July 2011 identifies that R3 is ordered to receive Potassium Chloride	W 369		

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W 369	Continued From page 34 10 meq, Senna S tablet 8.6 - 50 mg. Sodium Chloride, Ativan 1 mg., Haloperidol 2 mg, Oysco 500 mg. and Carbamazepi Chew 100 mg daily at 4:00 P.M.	W 369		
W 406	483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement policy and procedures to assure that 1 of 1 individual in the facility requiring continuous oxygen (R2) can be safely evacuated out of the facility in the event of an actual emergency. This failure potentially jeopardizes the safety of all 15 of 15 individuals of the facility (R1 - R15). 1) The facility failed to hold evacutation drills under varied conditions to ensure that all staff are trained to actually evacuate R2 who requires continuous oxygen and 14 additional individuals (R1, R3 - R15) out of the facility during the first shift (12 A.M. - 8:00 A.M.) when the individuals are asleep. 2) The facility failed to develop and implement a plan for evacuating R2 who requires continuous oxygen per concentrator out of the facility in the event of an actual fire which may affect 14 additional individuals (R1, R3 - R14) of the facility. This failure resulted in an Immediate Jeopardy. The Administrator (E2) and the Qualified Mental	W 406		10/13/11

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W 406	Continued From page 35 Retardation Professional/QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M. E1 (QMRP) was notified that the Immediate Jeopardy was removed on 08/16/11 at 4:00 P.M. Findings include: Refer to deficiencies cited at: W441 - The facility must hold evacuation drills under varied conditions. W446 - The facility must make special provisions for the evacuation of clients with physical disabilities.	W 406		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to hold evacutation drills under varied conditions to ensure that all staff are trained to actually evacuate 1 of 1 individual in the sample of 4 who requires continuous oxygen (R2) and 14 additional individuals (R1, R3 - R15) out of the facility during first shift (12 A.M. - 8:00 A.M.) when the individuals are asleep. Findings include: The facility's undated roster states that R2 is a 54 year old male who functions at a moderate level of mental retardation. The Physician's Orders	W 441		10/13/11

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sheet dated 07/31/11 states that R2 has diagnoses which includes Chronic Respiratory COPD (Chronic Obstructive Pulmonary Disease) and requires continuous oxygen of 2 to 3 L (liters) per minute per concentrator.

On 07/19/11 at 3:40 P.M., R2 was standing at the north men's wing door of the facility wearing his portable oxygen. At 5:30 P.M. R2 was observed using oxygen per nasal canula. R2's oxygen tubing was attached to a oxygen concentrator machine.

In review of the fire evacuation drill reports from 08/31/10 to 07/16/11 it was noted that the facility has not fully evacuated out of the facility on the first shift since 08/31/10. This evacuation drill was conducted by E6 and E7 (Direct Care Staff). There is no documentation contained within this report detailing how R2 was evacuated from the facility.

Further review of the fire evacuation drill reports identify that simulated drills were conducted by direct care staff to the exit door(s) of the facility during first shift (11 P.M. to 7:00 A.M.) on 02/04/11, 05/02/11 and 11/13/10. These drills were conducted by conducted by E12 and E7 on 02/04/11, E9 and E10 on 05/02/11 and by E7, E9 and E11 on 11/13/10. The evacuation drill reports for first shift does not identify that E9, E10, E11 and or E12 have been trained to fully evacuate all individuals from the facility in the event of an actual fire during the night time hours. No documentation is contained within any of these reports detailing how R2 is to be evacuated from the facility.

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W 441	Continued From page 37 E1 (Qualified Mental Retardation Professional/QMRP) was interviewed on 07/21/11 at 11:30 A.M. and stated, "I have only been here two and a half weeks. I'm not sure how staff evacuate R2 with his oxygen." After reviewing the fire drills from 08/30/10 to present with E1, she stated, "No, there haven't been any other actual night time evacuation drills since 08/30/10. All the first shift staff have not been trained to totally evacuate the individuals from the facility in the event of an actual fire."	W 441		
W 446	483.470(i)(2)(ii) EVACUATION DRILLS The facility must make special provisions for the evacuation of clients with physical disabilities. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop, implement and provide staff training on a plan for evacuating 1 of 1 individual in the sample of 4 who requires continuous oxygen per concentrator (R2), affecting 14 additional individuals (R1, R3 - R14) of the facility in the event of an actual emergency. This failure resulted in an Immediate Jeopardy. The Administrator (E2) and the Qualified Mental Retardation Professional/QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M. Findings include: An Immediate Jeopardy was identified to begun on 08/31/10 when the facility the facility failed to conduct additional evacuation drills out of the	W 446		10/13/11

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facility during the night time hours when individuals are asleep. The evacuation drill on 08/31/10 was conducted by E6 and E7 (Direct Care staff). After this date, no actual evacuation drills have been conducted during the night time hours to train other staff to safely evacuate R2 and the other fourteen individuals out of the facility in the event of an actual emergency. E5 (Direct Care staff) stated on 07/22/11 that during an evacuation drill, staff get R2's portable oxygen from the QMRP's office, unplug his oxygen machine and hook him up to his portable oxygen and evacuates him out of the building. Z6 (City Fire Chief) stated that the facility should not evacuate R2 with his oxygen, but rather turn off the oxygen and evacuate him without it. The facility does not have an evacuation plan to safely evacuate individuals out of the facility who use oxygen. The Administrator (E2) and the QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M.

The facility's undated policy and procedures, "For the use, storage, and transportation of Oxygen used for medical purposes" states, "There is well documented evidence that when oxygen is not used in accordance with recommended safety precautions; severe injuries, fires and fatalities have occurred. It is essential that the safety precautions are followed at all times.... A risk assessment must be in place for the establishment and or client's home to ensure safe practice is in place."

The facility's undated roster states that R2 is a 54 year old male who functions at a moderate level of mental retardation. The Physician's Orders sheet dated 07/31/11 states that R2 has

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diagnoses which includes Chronic Respiratory COPD (Chronic Obstructive Pulmonary Disease) and requires continuous oxygen of 2 to 3 L (liters) per minute per concentrator.

In review of the fire evacuation drill reports from 08/31/10 to 07/16/11 it was noted that the facility has not fully evacuated out of the facility on the first shift since 08/31/10. This evacuation drill was conducted by E6 and E7 (Direct Care Staff). There is no documentation contained within this report detailing how R2 was evacuated from the facility or how staff have been trained to evacuate R2 from the facility.

E1 (QMRP) was interviewed on 07/21/11 at 11:30 A.M. and stated, "I have only been here two and a half weeks. I'm not sure how staff evacuate R4 with his oxygen use."

E5 (Direct Care staff) was interview on 07/22/11 at 2:50 P.M. and stated, "When we have a drill and evacuate, we get R2's portable oxygen from the RSD's office, unplug his oxygen machine and hook him up to his portable oxygen and get him out of the building."

Z6 (City Fire Chief) was interviewed on 07/26/11 at 9:00 A.M. and stated, "The facility should not evacuate R2 while using his oxygen concentrator and/or portable oxygen. The concentrator should be shut off and staff should evacuate him from the facility without oxygen. If there is heavy smoke in the evacuating area, staff should leave R4 in his room or evacuate him through the window."

R2's Interdisciplinary Team Meeting report dated

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W 446	Continued From page 40 08/18/10 does not have a plan contained within his individual program plan (IPP) detailing how he is to be evacuated in the event of fire. No risk assessment is included within this plan to ensure safe practice in case of a fire and or other emergencies as identified per the facility's policy and procedures. This failure resulted in an Immediate Jeopardy. The Administrator (E2) and the Qualified Mental Retardation Professional/QMRP (E1) were notified of the Immediate Jeopardy on 07/22/11 at 4:15 P.M. E1 (QMRP) was notified that the Immediate Jeopardy was removed on 08/16/11 at 4:00 P.M. when the surveyor confirmed a plan which includes: 1. The City's Fire Department trained staff on 07/26/11 on evacuation routes, plans and how to safely evacuate a resident who uses oxygen. 2. The facility's evacuation policy was updated on 07/21/11 as based on the City's Fire Department recommendations. This policy includes how to simulate evacuating without oxygen as based on the City's Fire Department recommendations. 3. All staff were trained on the new evacuation policy on 07/27 and 08/10/11. 4. The facility conducted a complete evacuation drill including simulating evacuating without oxygen on 08/11/11 which was supervised by E1 and E2. 5. Training on evacuation drills and the facility's evacuation policy and procedures will be ongoing	W 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G277	A. BUILDING _____ B. WING _____	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 446	Continued From page 41 and given to all new staff. 6. The QMRP (E1) and the Administrator (E1) will monitor for compliance. While the Immediate Jeopardy was removed on 07/22/11, the facility remains out of compliance since they have not had the opportunity to fully implement and evaluate the effectiveness of this plan.	W 446		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.	W9999		

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W9999	Continued From page 42 These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to implement policy and procedures regarding proper use of oxygen which potentially jeopardizes the safety of 1 of 1 individual (R2) in the sample of 4 requiring continuous oxygen via nasal cannula and potentially affects 14 other individuals of the facility (R1, R3-R15). The facility failed to: 1) Provide necessary monitoring and supervision to prevent R2 from removing his oxygen with the oxygen concentrator running; and 2) Develop a program plan and provide necessary monitoring and supervision to prevent R2 from attempting to sneak and smoke cigarettes while using continuous oxygen. Findings include: The facility's undated roster states that R2 is a 54 year old male who functions at a moderate level of mental retardation. The Physician's Orders sheet dated 07/31/11 states that R2 has diagnoses which includes Chronic Respiratory COPD (Chronic Obstructive Pulmonary Disease) and requires continuous oxygen of 2 to 3 L (liters) per minute per concentrator. The facility's undated policy and procedures for Proper Use and Care of Oxygen Concentrators states, "Only use and store oxygen in a well ventilated area. Keep internal doors open while the oxygen	W9999		

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W9999	Continued From page 43 cylinder or concentrator is in use. *Ensure clients or others never leave their cannula or mask on the bed or in the chair when the oxygen is being supplied. *Ensure the oxygen supply is turned off when not in use." On 07/21/11, R2 was observed at 3:55 P.M. standing in his bedroom in front of the television. He did not have his oxygen on by nasal cannula. R2's portable backpack was observed sitting upright next to the entrance of the doorway. The tubing connected to the oxygen concentrator machine was lying on the bed. A hissing sound was heard when the tubing was moved from the covers of the bedding. R2 stated that his oxygen was still on. When asked why he had his oxygen off, R2 stated that he was getting ready for his bath. Per continued observation, R2 was observed at 4:15 P.M. still standing in front of his television in his bedroom. His oxygen tubing remained on the bed and the hissing noise continued. R2 informed the surveyor that his oxygen was on when asked if the surveyor could check his oxygen concentrator. No staff were present in the area and staff were not observed to monitor R2 to ensure that he does not leave his cannula on the bed when the oxygen is being supplied as per the facility's policy. E1 (Qualified Mental Retardation Professional/QMRP) was interviewed on 07/21/11 at 4:45 P.M. and stated, "R2 knows better than to leave his oxygen on the bed. He also tries to	W9999		

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W9999	Continued From page 44	W9999		

sneak and smoke discarded cigarette butts. The oxygen supplier has stated that if he didn't try to sneak and smoke he could keep his oxygen supply in his room. We will have to start monitoring him more closely."

Further review of the facility's undated policy, "For the use, storage, and transportation of Oxygen used for medical purposes" states within the procedures section that, "Smoking and the use of oxygen are incompatible and if a client (or others) smokes while using oxygen they put themselves, their surroundings, the property, and others in any of these areas at great risk..."

On 07/19/11 at 3:40 P.M., R2 was standing at the north men's wing door of the facility wearing his portable oxygen. R2 continually opened the door and peeked out the door. A cigarette receptacle is located fifteen to sixteen feet from this door. R2 continued peeking out the door until receiving his nebulizer treatment at 4:25 P.M.

On 07/22/11 at 3:50 P.M., R2 was observed opening the north men's wing door of the facility using his oxygen via his nasal cannula. R2 started outside the door in the direction of the cigarette receptacle until he noticed that the surveyor was in the parking lot area. R2 immediately turned around and reentered the north door. Within seconds, R2 peeked out of the door and looked in the direction of the surveyor. When seeing the surveyor, he immediately closed the door.

During the interview with E1 (QMRP) on 07/21/11 at 4:45 P.M., she stated that R2 tries to sneak and smoke discarded cigarette butts.

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W9999	Continued From page 45 R2's Individual Program Plan (IPP) dated 08/18/10 does not specify the level of monitoring and supervision needed to prevent him from removing his oxygen and leaving his cannula on his bed with the oxygen concentrator running. No risk assessment is included within this plan to ensure safe practice in case of a fire and or other emergencies as identified per the facility's policy and procedures. Further review of R2's IPP does not identify that a program plan has been developed to address his behavior of attempting to sneak and smoke while using continuous oxygen. R2's IPP does not specify the level of monitoring and supervision needed to prevent him from sneaking to smoke a cigarette while using continuous oxygen. During the Daily Status Meeting on 07/21/11 at 4:15 P.M., E1 (QMRP) confirmed that R2's IPP does not address the level of monitoring and or supervision needed for safety while using continuous oxygen. E1 also confirmed that no plan has been developed to address his behavior of attempting to sneak and smoke cigarettes while using continuous oxygen. (A)	W9999		