STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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 INCIDENT REPORT INVESTIGATION INCIDENT OF 08/06/11/IL 54872	W 000		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to implement policy and procedures governing life saving measures as evidenced by: 1) Direct Care staff failed to start CPR (Cardio Pulmonary Resuscitation) for 1 of 1 individual in the sample (R1) after discovering that she (R1) was unresponsive and was not breathing while doing bed checks on 08/06/11 at 3:50 A.M.; 2) The facility's failure to ensure that all staff were retrained regarding life sustaining measures after the 08/06/11 incident, affecting 15 of 15 individuals of the facility (R2 - R16); and 3) The facility's failure to ensure that third shift staff are capable of transferring an unresponsive individual from the bed to the floor to perform CPR when working alone, affecting 15 of 15 individuals of the facility who do not have "Do Not Resuscitate" orders (R2-R16). These failures resulted in an Immediate Jeopardy. Findings include: On 10/20/11 at 1:00 PM, an Immediate Jeopardy	W 318		12/1/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 318	Continued From page 1 was identified to have begun on 08/06/11 when staff of the facility found R1 in bed, unresponsive at 3:50 A.M. Staff did not check to ensure that R1 was breathing and/or had a pulse. Staff did not transfer R1 to the floor from the bed as per the facility's training on CPR to provide life sustaining treatment. CPR was not started as per the facility's policy and as recommended by the American Heart Association Guidelines for 2010. R1 was pronounced at the facility by the Coroner (Z1) at 4:20 A.M. on 08/06/11. Her death certificate with an issue date of 08/17/11 identifies that the immediate cause of death was Cardiac Arrest. R1 was not receiving Hospice Services, nor did she have "Do No Resuscitate" orders at the time of her death. After this incident, the facility did not retrain staff on CPR and/or transferring an unresponsive individual from the bed to the floor to provide life sustaining treatment. The facility also has not ensured that third shift staff are capable of transferring an unresponsive individual from the bed to the floor to perform CPR when working alone. E1 (Administrator), E2 (RSD-Resident Services Director) and E3 (Executive Director) were notified of the Immediate Jeopardy on 10/20/11 at 1:08 P.M. Refer to deficiency cited at: W331 - The facility must provide clients with nursing services in accordance with their needs.	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331		12/1/11

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W 331	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policy and procedures governing life saving measures as evidenced by: 1) Direct Care staff failed to start CPR (Cardio Pulmonary Resuscitation) for 1 of 1 individual in the sample (R1) after discovering that she (R1) was unresponsive and was not breathing while doing bed checks on 08/06/11; 2) The facility's failure to ensure that all staff were retrained regarding life sustaining measures after the 08/06/11 incident, affecting 15 of 15 individuals of the facility (R2 - R16); and 3) The facility's failure to ensure that third shift staff are capable of transferring an unresponsive individual from the bed to the floor to perform CPR when working alone, affecting 15 of 15 individuals of the facility who do not have "Do Not Resuscitate" orders (R2-R16). These failures resulted in an Immediate Jeopardy. Findings include: On 10/20/11 at 1:00 PM, an Immediate Jeopardy was identified to have begun on 08/06/11 when staff of the facility found R1 in bed, unresponsive at 3:50 A.M. Staff did not check to ensure that R1 was breathing and/or had a pulse. Staff did not transfer R1 to the floor from the bed as per the facility's training on CPR to provide life sustaining treatment. CPR was not started as per the facility's policy and as recommended by the American Heart Association Guidelines for 2010. R1 was pronounced at the facility by the Coroner (Z1) at 4:20 A.M. on 08/06/11. Her death	W 331		

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W 331	Continued From page 3	W 331		

certificate with an issue date of 08/17/11 identifies that the immediate cause of death was Cardiac Arrest. R1 was not receiving Hospice Services, nor did she have "Do No Resuscitate" orders at the time of her death. After this incident, the facility did not retrain staff on CPR and/or transferring an unresponsive individual from the bed to the floor to provide life sustaining treatment. The facility also has not ensured that third shift staff are capable of transferring an unresponsive individual from the bed to the floor to perform CPR when working alone. E1 (Administrator), E2 (RSD-Resident Services Director) and E3 (Executive Director) were notified of the Immediate Jeopardy on 10/20/11 at 1:08 P.M.

The facility's undated policy entitled Health Care Services: Life Sustaining Treatments states, "It is the policy of the facility to provide life sustaining treatment in any medical emergency. Life sustaining treatment include first aid and cardiopulmonary resuscitation (CPR)..."

In review of the memo sent to the Illinois Department of Public Health dated 08/26/11, this memo states,

"This fax is to report the death of a resident of this facility. R1 is a 49 year old lady who lived at O*r P***e (name of the facility) for 10 years. She functioned in the profound level ... (On) 08/06/11 between 3:30 A.M. bed check and 3:50 AM discovery, R1 passed away. (Staff completed bed checks according to the recommended schedule of every 30 minutes.) R1 had no noted changes in functioning, health status, etc immediately prior to this incident. Cause of death is pending

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	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

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W 331	Continued From page 4 receipt of report by the Deputy Coroner (Z1)..." The facility's Inservice records dated 01/07/11 identifies that staff of the facility participated in training on this date for, "CPR and Transfer of (an) Unresponsive Body". Further review of the content of this inservice report identifies, "CPR Steps - When you find a person unresponsive - run and call 911 or tell a co-worker to do this... Go back to the person. The person must be on a firm surface. If in a bed or in a chair or sofa, move them to the floor. Move the feet first and then the shoulders to the floor- protecting the head. In bed you can drag the sheet under them to move them to the edge of the bed and lower to the floor, protecting the head." This inservice record goes on to describe CPR steps to be used once the individual is lowered to the floor. The facility's Incident Report dated 08/06/11 regarding R1's death identifies that direct care staff (E4) did not implement trained skills for transferring an unresponsive body from the bed to the floor, nor did she perform CPR. This incident report states, "Facts: Shift began 12 A (A.M.) - 8 A bed checks for above resident (R1) are conducted on a 30 minute basis. R1's room mate R2 got up and used the toilet at 2 AM. She had wet on floor. I cleaned up the floor (mopped it). Then completed a bed check. (At bed checks I turn on the over head light and look at the residents - watching for movement, signs of breathing, listening for snoring.) At 2 AM check - R1 was fine, under the covers as she normally sleeps. At 2:30 AM check	W 331		

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W 331	Continued From page 5 - same - R1 was in bed, moved when light was turned on. At 3:00 AM check - same - R1 was in bed, moved when light was turned on. At 3:30 AM check - R1 was the same, lying slightly on her side, breathing. At 3:50 AM - R3 got up to smoke. I (E4) proceeded to men's end to complete bed checks on that end. Returned to women's end and began with R1 and R2's room. I (E4) turned on the light and stood in the door way. I looked in the room for a long time. R1 did not seem "right" I walked up to the bed. R1 was laying on her left side, facing out toward the center of the room. She was under the covers. R1's face was pale and her lips were slightly blue. I touched her arm and her thigh and called her name. She did not respond. She looked gone. I went to (the) office and called 911. The operator told me to check her mouth. The first responder arrived, Officer (Z2). He came in and looked at R1 and confirmed he thought she was gone. He said there was nothing I could have done. The paramedics arrived and they confirmed that R1 was gone. The coroner was called. I called my supervisor (E2) to notify her of the situation. She told me (E4) she (E2) was on her way." E4 (Direct Care Staff) was interviewed on 10/20/11 at 11:10 AM and stated, "I have worked at the facility since April of 2010 and have been trained in CPR. When I found R1, I called her name. She didn't look alive. I touched her and I got no response. I called 911 and they told me to check her mouth." When E4 was asked what is the facility's policy for CPR, she stated, "We are to do CPR on the floor if they are in bed." When E4 was asked if she did CPR on R1 on 08/06/11,	W 331		

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W 331	Continued From page 6	W 331		

she (E4) stated, "No, I couldn't do CPR because she was too heavy and I couldn't pull her off the bed." During this interview, E4 stated that she has not received further training in CPR and or transferring an unresponsive individual from the bed to the floor after finding R1 unresponsive in bed on 08/06/11.

In reviewing the statements contained within the facility's Resident Death Investigation dated 08/06/11, the Residential Services Director's (E2) statement dated 08/06/11 states, "Due to the passing of R1, I reviewed all employee files to ensure that all were current in CPR and First Aid. It was concluded that they were. Also the In-Service training that was completed on 01/07/2011 includes the staff on duty (E4) and current staff. I feel that all current DSP (Direct Support Person) staff are adequately trained in CPR and First Aid. (E5) (prior) Administrator conducted the CPR and First Aid training, which included primarily the Transfer of (an) unresponsive body."

E2 (RSD) was interviewed on 10/20/11 at 11:30 A.M. and stated, "When E4 called me that day (08/06/11), I told her she needed to do CPR." When E2 was asked if E4 had performed CPR on R1, E2 stated, "No". When E2 was asked if E4 and or any other staff of the facility had been retrained since 08/06/11 on CPR and transferring individuals from bed to the floor when working alone at nights with the other fifteen individuals of the facility, she stated, "No." When E2 was asked if R1 was Hospice and/or had orders for Do Not Resuscitate, she stated, "No."

On 10/20/11 at 1:08 P.M. E3 (Executive Director)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

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W 331	Continued From page 7	W 331		

stated, "After 08/06/11 we placed two staff on midnight shifts for one month." During this interview, E3 stated that as of this date (10/20/11) the facility had only one staff working alone on the midnight shift. When the surveyor asked if staff had been retrained on CPR since 08/06/11, E1(Administer), E2 (RSD) and E3 (Executive Director) all stated, "No." When the surveyor asked if staff had been retrained since 08/06/11 on transferring an unresponsive individual from the bed to the floor when working alone at nights with the other fifteen individuals of the facility, E1(Administer), E2 (RSD) and E3 (Executive Director) all stated, "No."

The Medical Certificate of Death with an issue date of 08/17/11 identifies that R1 was 49 years of age at the time of her death. R1 was pronounced at the facility by the Coroner (Z1) at 4:20 A.M. on 08/06/11. This certificate identifies that the immediate cause of her death was a result of, "CARDIAC ARREST." R1 was not receiving Hospice services, nor did she have "Do No Resuscitate" orders at the time of her death. The facility's investigation dated 08/06/11 regarding R1's death does not identify that staff (E4) did not complete CPR after finding R1 unresponsive in bed the morning of 08/06/11 at 3:50 AM. This investigation also does not address any type of recommendations and or corrective action taken by the facility in retraining staff on CPR and/or transferring an unresponsive individual from the bed to the floor when working alone at nights with the other fifteen individuals of the facility. These failures resulted in an Immediate Jeopardy.

E1(Administer), E2 (RSD) and E3 (Executive

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W 331	Continued From page 8 Director) were notified of the Immediate Jeopardy on 10/20/11 at 1:08 P.M. The Immediate Jeopardy was removed on 11/03/11 at 1:25 P.M. when the facility submitted an acceptable plan which includes: 1) The facility will ensure that all staff are trained on the Life Sustaining Measures Policy and that staff will complete CPR on any individual found non responsive until emergency medical services arrives. Staff have signed a statement acknowledging this policy by 10/23/11. Training of this policy will be included in new employee's orientation on an ongoing basis. The Administrator (E1) will monitor for compliance on an ongoing basis. 2) The facility will ensure that all staff are retrained in CPR to include the removal of an unresponsive individual from a bed to the floor to initiate CPR and the use of a CPR board by 10/23/11. This training will be included in all new employee's orientation on an ongoing basis. The Administrator (E1) will monitor for compliance on an ongoing basis. Although the Immediate Jeopardy was removed, noncompliance continues at the time of the Exit Conference since the facility has not had an opportunity to evaluate the effectiveness of their plan.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

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OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 9 350.1230d)2)3) 350.1235a) 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. 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. 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

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OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 10 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement policy and procedures governing life saving measures as evidenced by: 1) Direct Care staff failed to start CPR (Cardio Pulmonary Resuscitation) for 1 of 1 individual in the sample (R1) after discovering that she (R1) was unresponsive and was not breathing while doing bed checks on 08/06/11; 2) The facility's failure to ensure that all staff were retrained regarding life sustaining measures after the 08/06/11 incident, affecting 15 of 15 individuals of the facility (R2 - R16); and 3) The facility's failure to ensure that third shift staff are capable of transferring an unresponsive individual from the bed to the floor to perform CPR when working alone, affecting 15 of 15 individuals of the facility who do not have "Do Not Resuscitate" orders (R2-R16). Findings include: The facility's undated policy entitled Health Care Services: Life Sustaining Treatments states, "It is the policy of the facility to provide life sustaining treatment in any medical emergency. Life sustaining treatment include first aid and cardiopulmonary resuscitation (CPR)..." In review of the memo sent to the Illinois	W9999		

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OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 11	W9999		

Department of Public Health dated 08/26/11, this memo states,

"This fax is to report the death of a resident of this facility. R1 is a 49 year old lady who lived at O*r P***e (name of the facility) for 10 years. She functioned in the profound level ... (On) 08/06/11 between 3:30 A.M. bed check and 3:50 AM discovery, R1 passed away. (Staff completed bed checks according to the recommended schedule of every 30 minutes.) R1 had no noted changes in functioning, health status, etc immediately prior to this incident. Cause of death is pending receipt of report by the Deputy Coroner (Z1)...."

The facility's Inservice records dated 01/07/11 identify that staff of the facility participated in training on this date for, "CPR and Transfer of (an) Unresponsive Body." Further review of the content of this inservice report identifies,

"CPR Steps - When you find a person unresponsive - run and call 911 or tell a co-worker to do this... Go back to the person. The person must be on a firm surface. If in a bed or in a chair or sofa, move them to the floor. Move the feet first and then the shoulders to the floor- protecting the head. In bed you can drag the sheet under them to move them to the edge of the bed and lower to the floor, protecting the head." This inservice record goes on to describe CPR steps to be used once the individual is lowered to the floor.

The facility's Incident Report dated 08/06/11 regarding R1's death identifies that direct care staff (E4) did not implement trained skills for transferring an unresponsive body from the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

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W9999	Continued From page 12	W9999		

to the floor, nor did she perform CPR. This incident report states,

"Facts: Shift began 12 A (A.M.) - 8 A bed checks for above resident (R1) are conducted on a 30 minute basis. R1's room mate R2 got up and used the toilet at 2 AM. She had wet on floor. I cleaned up the floor (mopped it). Then completed a bed check. (At bed checks I turn on the over head light and look at the residents - watching for movement, signs of breathing, listening for snoring.) At 2 AM check - R1 was fine, under the covers as she normally sleeps. At 2:30 AM check - same - R1 was in bed, moved when light was turned on. At 3:00 AM check - same - R1 was in bed, moved when light was turned on. At 3:30 AM check - R1 was the same, lying slightly on her side, breathing.

At 3:50 AM - R3 got up to smoke. I (E4) proceeded to men's end to complete bed checks on that end. Returned to women's end and began with R1 and R2's room. I (E4) turned on the light and stood in the door way. I looked in the room for a long time. R1 did not seem "right" I walked up to the bed. R1 was laying on her left side, facing out toward the center of the room. She was under the covers. R1's face was pale and her lips were slightly blue. I touched her arm and her thigh and called her name. She did not respond. She looked gone. I went to (the) office and called 911. The operator told me to check her mouth. The first responder arrived, Officer (Z2). He came in and looked at R1 and confirmed he thought she was gone. He said there was nothing I could have done. The paramedics arrived and they confirmed that R1 was gone. The coroner was called. I called my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G137	A. BUILDING _____ B. WING _____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PLACE	**301 NORTH 13TH STREET MURPHYSBORO, IL 62966**

(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
W9999	Continued From page 13	W9999		

supervisor (E2) to notify her of the situation. She told me (E4) she (E2) was on her way."

E4 (Direct Care Staff) was interviewed on 10/20/11 at 11:10 AM and stated, "I have worked at the facility since April of 2010 and have been trained in CPR. When I found R1, I called her name. She didn't look alive. I touched her and I got no response. I called 911 and they told me to check her mouth." When E4 was asked what is the facility's policy for CPR, she stated, "We are to do CPR on the floor if they are in bed." When E4 was asked if she did CPR on R1 on 08/06/11, she (E4) stated, "No, I couldn't do CPR because she was too heavy and I couldn't pull her off the bed." During this interview, E4 stated that she has not received further training in CPR and or transferring an unresponsive individual from the bed to the floor after finding R1 unresponsive in bed on 08/06/11.

In reviewing the statements contained within the facility's Resident Death Investigation dated 08/06/11, the Residential Services Director's (E2) statement dated 08/06/11 states, "Due to the passing of R1, I reviewed all employee files to ensure that all were current in CPR and First Aid. It was concluded that they were. Also the In-Service training that was completed on 01/07/2011 includes the staff on duty (E4) and current staff. I feel that all current DSP (Direct Support Person) staff are adequately trained in CPR and First Aid. (E5) (prior) Administrator conducted the CPR and First Aid training, which included primarily the Transfer of (an) unresponsive body."

E2 (RSD) was interviewed on 10/20/11 at 11:30

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W9999	Continued From page 14	W9999		

A.M. and stated, "When E4 called me that day (08/06/11), I told her she needed to do CPR." When E2 was asked whether E4 had performed CPR on R1, E2 stated, "No." When E2 was asked whether E4 and/or any other staff of the facility had been retrained since 08/06/11 on CPR and transferring individuals from bed to the floor when working alone at nights with the other fifteen individuals of the facility, she stated, "No." When E2 was asked if R1 was Hospice and/or had orders for Do Not Resuscitate, she stated, "No."

On 10/20/11 at 1:08 P.M. E3 (Executive Director) stated, "After 08/06/11 we placed two staff on midnight shifts for one month." During this interview, E3 stated that as of this date (10/20/11) the facility had only one staff working alone on the midnight shift. When the surveyor asked if staff had been retrained on CPR since 08/06/11, E1(Administer), E2 (RSD) and E3 (Executive Director) all stated, "No." When the surveyor asked if staff had been retrained since 08/06/11 on transferring an unresponsive individual from the bed to the floor when working alone at nights with the other fifteen individuals of the facility, E1(Administer), E2 (RSD) and E3 (Executive Director) all stated, "No."

The Medical Certificate of Death with an issue date of 08/17/11 identifies that R1 was 49 years of age at the time of her death. R1 was pronounced at the facility by the Coroner (Z1) at 4:20 A.M. on 08/06/11. This certificate identifies that the immediate cause of her death was a result of, "CARDIAC ARREST." R1 was not receiving Hospice services, nor did she have "Do Not Resuscitate" orders at the time of her death.

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W9999	Continued From page 15 The facility's investigation dated 08/06/11 regarding R1's death does not identify that staff (E4) did not complete CPR after finding R1 unresponsive in bed the morning of 08/06/11 at 3:50 AM. This investigation also does not address any type of recommendations and or corrective action taken by the facility in retraining staff on CPR and/or transferring an unresponsive individual from the bed to the floor when working alone at nights with the other fifteen individuals of the facility. (A)	W9999		