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(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 336	Continued From page 65 10/22/11. Per further review of resident records, in all 6 Houses, it was determined that all the residents in House 3 and 7 (R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R11, R46, R47, R16, R87, R88, R89, R90, R91, R92, R93, R94, R95, R96, R97, R98, R99, R100, and R101) health status reviews are being completed on a 4 month and not the required 3 month interval. The Director of Nurses, E12, during 11/8/11 3:38PM interview, stated that E14, LPN (License Practical Nurse) and E15, LPN are doing their quarterly assessments every 4th month instead of every 3rd month. E12 confirmed that the individuals (R1, R2, R10, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R11, R46, R47, R16, R87, R88, R89, R90, R91, R92, R93, R94, R95, R96, R97, R98, R99, R100, and R101) who reside in House 3 and House 7 are being assessed every 4th month. E12 further stated that she does not know why this is occurring except that LPN, E15 trained LPN, E14.	W 336		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230b)6)7) 350.1230d)2) 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	W9999		

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W9999	Continued From page 66 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 b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, nursing services failed to coordinate the	W9999		

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W9999	Continued From page 67 Individual Program Plan with hospice services for 1 of 1 individual (R11) recently discharged from the hospital with foot ulcers, and assessed to be in need of hospice care. This lack of coordination of Individual Program Plan has the potential to negatively affect an additional 6 individuals (R52, R53, R65, R15, R72 and R98) currently provided hospice care. Findings Include: 1) The 11/16/10 Individual Program Plan (IPP) identifies R11 as a 79 year old verbal male who ambulates with a four wheel walker, gait belt and staff assistance. According to this IPP, R11 is his own guardian and has the diagnoses of Mild Mental Retardation, Osteoarthritis, Vascular Dementia, and Peripheral Neuropathy. This IPP further states that "R11's overall health has been stable with no major illnesses or injuries." Per surveyor team coordinator's request for a "List of residents with current decubs/skin breakdown, wounds, blisters, etc.," the facility, on 11/7/11, identified R11 as having a current "open area." The 10/23/11 "NURSE'S NOTES" by Licensed Practical Nurse (LPN), E6, state that R11 was sent to a local hospital, per physician orders, for the evaluation and treatment of his left lower extremity, which was painful, warm to touch, had 3+ pitting edema, redness with weeping. This Nurse"s Notes further states R11 was admitted to the hospital with a diagnosis of cellulitis. LPN, E6, during 11/8/11 8:30AM interview, stated that R11 was upset, kicked his walker stubbing	W9999		

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his big toe and a cellulitis started on the lower left leg. E6 further stated that R1 was sent to the hospital on 10/23/11 and returned from the hospital on 10/31/11 with open areas to his left foot. E6 stated prior to this hospitalization R1 was ambulatory.

According to the Nurse"s Note"s dated 10/17/11, by LPN, E6, the staff reported client became agitated while getting ready for supper and kicked his walker without shoes on resulting in a cut on his left great toe.

Per 11/8/11 8:24 AM observation of Specialized Wound Management Nurse Practitioner, Z4's initial assessment of R11's left outer ankle ulcers, R11 had a 2 cm by 7cm black area with deep necrosis, with a peri-wound 5 1/2cm by 7 1/2cm distal and a yellow area 1cm by 2cm with deep necrosis proximal. Z4 stated, per 11/8/11 8:24AM interview, that at this time the present treatment was skin prep around the open areas and Betadine to the open areas to dry them out. Z4 further stated that she will order an arterial doppler, if one has not been previously ordered, to determine future treatment need (i.e. debridement) based on whether or not R11 has fair or poor circulation to the affected areas.

The Administrative staff, E13, on 11/9/11 at approximately 10:00AM, provided the surveyor with a color copy of two photographs of R11's left foot open areas she had taken on 11/1/11. E13 stated that she took the pictures because the nursing staff was unfamiliar with the camera.

At 3:52PM, on 11/8/11 in House 3, while waiting to observe a survey protocol medication pass,

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W9999	Continued From page 69 R11 sat in the living area, in a tilt and recline positioning chair (hospice provided), with his legs down and not elevated to prevent edema due to questionable circulation. The surveyor, during 11/8/11 4:10PM interview, questioned the Day Shift Lead Worker in House 3, E5, as to why R11 was up in a chair without his feet and legs being elevated. E5 stated that the nurse did not "give any definite answers to when (R11's) legs are to be elevated." We were just told that when he is "lying down to elevate (left) foot." E5 further stated that "we have no instructions anywhere on when he should be out of his chair" or any other repositioning directives. LPN, E6, at 4:15PM on 11/8/11, stated we "keep (R11's) feet elevated as much as possible." E6 confirmed that there has been no team meeting or plan of care for R11. The Qualify Support Person (QSP), E7, at 4:18PM on 11/8/11, stated, "We had no special staffing on him (R11) since his return from the hospital." E7 further stated that we have an (annual) IDT (interdisciplinary team) meeting scheduled on Thursday (11/10) where R11's care will be discussed in general. E7 continued to state that "We have had no special staffing because he's been put on hospice and they attend to his needs. He has hospice every morning." According to E12, the Director of Nursing (DON), during 11/9/11 9:00AM interview, R11 has a hospice CNA (Certified Nursing Assistant) 5 days a week Monday through Friday for approximately an hour daily and a nurse usually comes to see	W9999		

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him every day to assess his status. E12 further stated that the admission meeting with hospice just involves the nurses. There is no special IDT meeting that occurs. We only have a monthly IDT meeting on the residents that includes the Department heads, QSPs, Dietary and DT (Day Training) QSPs.

E12 further stated the following: "Hospice is reporting off to the DSPs (Direct Support Staff) on what to do. Everybody should have a shift lead. There is no Health Care Plan when an individual has a change in status. (R11s) health status has definitely changed. I can see where it would be beneficial to have a meeting."

At 9:37AM on 11/9/11, DON E12 informed the surveyor that she had spoken with the Administrator, E1, and the facility will have an IDT meeting on R11's care today and add an addendum to his IPP.

At 11:12AM on 11/9/11, the DON E12 and the Assistant Director of Nursing (ADON) E2 informed the surveyor that the hospice nurse had a care plan for R11 and was bringing it with her for the meeting.

The DON E12, on 11/9/11 at 1:05PM, gave the surveyor a copy of the facility's "POLICY AND PROCEDURE FOR CLIENT RE-ADMISSION OR RE-ENTER TO THE FACILITY FROM THE HOSPITAL," last revised 10/2010. This policy and procedure, per review, did not include a specific procedure on when the IDT would meet to assess and plan care . This policy does not address the special IPP staffing needs of individuals with a change in health status such as

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W9999	Continued From page 71 a readmission to the facility from a hospital etc. The hospice LPN, Z3, during 11/9/11 1:40PM interview, stated the following: a) R11 was placed on hospice with a non specific diagnosis of debility on 11/1/11; b) R11 is seen Monday through Friday by the CNA. It is approximately a 2 hour visit; c) The CNA gets R11 out of bed 5 days a week, showers him 2 days a week, assesses him and his vitals 3 times a week; d) R11 has 2 visits a week by the hospice LPN; e) Z3, just met with the facility and developed a more specific plan of care for R11, that integrates the hospice and facility plan of care; d) The facility and hospice will re-evaluate the plan every two weeks or as needed; e) The coordination of hospice and facility plans is new, and did not previously occur; f) R52, R53, R65, R15, R72 and R98 who are also receiving hospice care will also have their care plans coordinated with their IPP . (A) 350.620a) 350.1210 350.1230d)2)3) 350.1235a)4) 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	W9999		

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W9999	Continued From page 72 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. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by:	W9999		

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W9999	Continued From page 73 Based on record review and interview the facility failed to provide nursing services to meet the needs of 1 of 1 individual (R12) who was unconscious and having respiratory distress when the facility failed to promptly contact 911. R12 was transported to local hospital and expired from unsuccessful Cardiopulmonary Resuscitation. Findings include: Physician's Orders/POS (dated 6/1/11- 6/30/11) identify R12 as a 77 year old individual who functioned at the mild range of Mental Retardation with additional diagnoses of Hyperlipidemia, Alzheimer's and Dementia. Facility's investigation report titled, "Follow Up Report" (undated) states, "At approximately 7:15 AM E19(DSP/Direct Support Person) heard E17(LPN/Licensed Practical Nurse) call R12's name. R12 was on the floor. E17 had noted that R12 had been sitting in the chair approximately 5 minutes before. E19/ DSP reported that she did not hear R12 fall from the chair. E19 told E20/DSP to call the AOD (Administrator on Duty), E21/AOD and E22/AOD, and the other nurse, E18/ LPN, to the house 5 STAT. E18 did not hear the initial page. Staff paged E18 to the house 5 STAT and to bring oxygen. R12 was breathing although it was labored. E18 got the crash cart from the nursing office. When E18 returned E17/LPN was checking her pulse. E17 could not find her pulse. CPR (Cardiopulmonary Resuscitation) was started by both nurses after a mouth check that was negative. 911 was called" (typed as written). Further review of facility's	W9999		

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report states that the EMT/Emergency Medical Technicians arrived at approximately 7:30 AM and that R12 was transported to local hospital. The report further states, "R12's diagnosis at the time of her death was unsuccessful CPR." The Follow Up report states that R12 had a Cerebral Vascular Accident in the past and that R12 was hospitalized on 5/7/11 due to having a heart attack.

E17/ LPN's witness statement, dated 7/24/11, states, "At 7:15 AM I noted client (R12) had fallen to floor, lying on R (right) side. Skin is very cool and slightly clammy. Her eyes are open and taking widely- spaced breaths. Turned to back, pillow placed (under) head. Does not respond to name, pale. Unable to obtain radial or apical pulse. O2 (oxygen applied at 2 l (liter). Breathing becomes less frequent, 911 called, 2 man CPR initiated (myself and E18/LPN who had got O2 (oxygen) tank, crash cart)." (typed as written).

E18/LPN's witness statement (dated 7/24/11) states, "Called to house 5 STAT, brought oxygen tank to house. Client noted lying on R (right) side with knees bent next to activity table. High side nurse and AOD/Administrator on Duty already at client's side. Labored breathing and cyanosis to lips noted. O2 (oxygen) applied at 2 L/ NC (liters per nasal cannula) at this time. Client is unresponsive. This nurse directed staff to call 911 and ran to get crash cart."

Facility's notification (dated 7/24/11) states that R12 died on 7/24/11 at 8:04 AM at local hospital.

Prehospital Care Report Summary (services provided by local ambulance service) dated

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7/24/11 states that the facility placed the call to ambulance service on 7/24/11 at 7:22 AM stating that R12 was in Cardiac Arrest, Apnea and Respiratory Arrest. The report further states that the ambulance arrived on scene at 7:27 AM and noted in their initial assessment that R12 was apneic, color was cyanotic, temperature was cool, pupils were unreactive and that R12 was unconscious.

Facility's 911 Policy and Procedure (revised 4/10/10) states, "In the event a client is having difficulty breathing, loses consciousness, has loss of pulse or blood pressure, or is bleeding excessively, DSP's (Direct Support Persons) are to call 911 for immediate crisis intervention, then call STAT for the nurse." Under the Procedure the policy states:

1. DSP's are to call 911 for immediate crisis intervention.
2. The client should not be moved.
3. A DSP pages STAT to the House for the Nurse and AOD (Administrator on Duty).

Facility's Policy and Procedure for Emergency Treatment (revised 4/10/10) states, "Medical Emergencies include, but are not limited to, seizures, poisoning, hemorrhaging, fainting, or unconsciousness, choking, fractures, bruises, cardiac arrest." The policy further states, "4. In the event the client is having difficulty breathing, loss of pulse or blood pressure, bleeding excessively, call 911 for immediate crisis intervention."

Further review of the facility's 911 and Emergency Treatment Policies, the policies do not state who

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would be responsible to call 911 if a nurse is present upon finding an individual in a medical crisis situation. Both policies identified that if a resident is found having difficulty breathing and is unconscious that 911 would be called immediately.

Facility's policy and procedure for Mistreatment of Residents (Revised 4/2/10) states, "Neglect means a failure in a facility to provide adequate medical or personal care or maintenance and in which such failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition."

In an interview with E12(Director of Nursing/DON) on 11/8/11 at 10:49 AM, when asked whether R12 was in a medical crisis when found in the floor with labored breathing and unresponsive, E12 stated, "Yes." E12 confirmed that 911 was not called until after the second nurse arrived to the scene. E12 confirmed facility's 911 policy states that if a resident is found unresponsive and having difficulty breathing that staff are to call 911 immediately, then call STAT for additional Nursing assistance.

In an interview with E18 (LPN/Licensed Practical Nurse) on 11/9/11 at 4:14 PM, E18 confirmed that she arrived to the scene and that E17 was already at R12's side. E18 further stated, "She (R12) was blue around the mouth and having difficulty breathing, that's when I made the decision to call 911 and I told staff to call 911."

In an interview with E1/Administrator on 11/9/11 at 3:13 PM, when asked when and who called 911 in regards to the 7/24/11 report regarding

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W9999	Continued From page 77 R12, E1 stated, "It doesn't say specifically when or who called 911." E1 stated "Yes" when asked if nursing would be expected to follow the 911 policy if they found a resident in an emergency crisis. When asked if staff followed facility's 911 policy, E1 stated, "Unable to tell from report exactly what happened." E1 confirmed that R12 was in a crisis situation when found laying in the floor unconscious and having respiratory difficulties. When asked if the staff who first found R12 laying in the floor should have immediately called 911, E1 stated, "Yes." When asked if staff followed the facility's 911 policy, E1 stated, "No." (A)	W9999		