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F 425	Continued From page 43 coming in at around 2:00 AM. Still the supplies should have come sooner than 10:00 AM. The facility can always call and check if they feel they are not getting their supplies fast enough. I was aware that the facility had discontinued some of their stock medications as not necessary to keep on hand. However, most facilities do keep Ativan IM, on hand. I am not sure of all the medications the facility has discontinued, and will have to discuss with the administrator a more appropriate list for emergency stock medications." On 1/6/12, the facility pharmacy policy was provided and reviewed. The policy failed to document any information on calls for Emergency nutrition supplies, or what to do when they do not arrive timely. On 1/6/12, at 11:00 AM, E1, Administrator stated, "I don't think I know for sure if there is a policy for times for an E-run. I think once the call is made, they would come in 2 or 3 hours. I was not aware R2's supplies had taken that long (9 hours) to get here. I discontinued the stock Ativan this summer, thinking it would be ordered per resident, only as needed. I will have to review this with the pharmacist."	F 425		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300/610c)2) 300.1010h) 3001030a)1) 300.1030c) 300.1210b) 300.1210c) 300.1210d)2)3)	F9999		

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F9999	Continued From page 44 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	F9999		

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F9999	Continued From page 45 of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and	F9999		

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F9999	Continued From page 46 be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Based on interview and record review the facility failed to follow their policy for tracheostomy (trach) care and failed assess and identify a base line for the frequent suctioning of R2's trach, failed to notify the physician of increased suctioning of R2's trach from once per hour to every 30 to 45 minutes, and failed to alert the physician of R2's, 02sats repeatedly dropping below 90% prior to suctioning for 1 of 2 residents (R2) reviewed for tracheostomy care in the sample of 4. R2 became non-responsive and died.	F9999		

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Findings included:

1. A review of E7's, Licensed Practical Nurse (LPN), nurses notes dated 12/26/11 at 10:40 PM, documented R2 was admitted to the facility with a diagnoses of; Tracheostomy (Trach), Gastrostomy Tube (G-tube), Myotonic Muscular Dystrophy, Malnutrition, Pneumonia, and Neuromuscular Dysphagia. The nurses notes document R2 had Oxygen 4.5 Liters at 35% humidified air delivered via the trach. R2 was to receive Glucerna 1.5 at 45 ml per hour continuous via G-tube. E7's, 10:40 PM nurses note documented R2's Oxygen Saturation (O2-sat) level was 93% - 94% upon admission.

A review of the Emergency Medical Services Patient Care Report dated 12/26/11 at 2237 (10:37 PM) documented the following in part;
Subjective Data - 23 year old man admitted to hospital on 12/11/11 for voluntary trach placement due to poor swallow and aspiration of saliva. Per RN (Register Nurse) (at hospital) requires frequent suctioning. Able to express when he does need suctioned. Patient with catheter, has Peripheral Inserted Central Catheter Line from Right bicep. Keeping foley in. Oxygen Saturation 97%. "LPN at SNF (skilled nursing facility) states she is not sure how trach equipment is supplied to nursing home."
Objective data - 23:00 (11:00 PM) - On 35% high humidity with ventri mask. Report given to LPN at nursing home. Informed LPN that I am not trained on nursing home equipment. Waited at nursing home while LPN contacted someone to let her know how the equipment works.

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On 1/6/12 at 3:15PM, E7 stated, " R2 arrived around 10:45PM. I have suctioned people before, but was not familiar with the machine used for humidified air. I called E3, LPN to come in and help me get R2's oxygen set up. E3 arrived about 11:00 PM, and she then called the pharmacy to get instructions on how to set up the humidified air machine. The ambulance left around 11:30 PM, after R2 was set up and stable. R2 would turn on his light when he felt short of breath, and point to his chest. I suctioned R2 5 or 6 times during the night. R2's, Oxygen Saturation (02-sats) stayed in the low 90's through out the shift. There was not a lot of fluid when I suctioned him. R2 slept off and on during the night when not being suctioned. He did not appear to be in distress when I cared for him. I documented the care in the nurses notes. We do not have a form for suctioning, it is just written in the nurses notes."

E7's nurses notes dated 12/27/11, from 1:00 AM to 6:00 AM, failed to evidence documentation that R2 was suctioned "5 or 6 times" during the night as E7 had reported. E7 made two entries on 12/27/11 at 3:05 AM and 4:30 AM, and both document "suctioned small amount of mucous". R2's O2-sats are recorded once on 12/27/11, at 3:05 AM, as 93% to 94%. There is no documented information in R2's nurses notes on the other (4) times R2 was suctioned during the night on 12/27/11, or, his behaviors of turning on the light and pointing to his chest when feeling short of breath. On 12/27/11, no documentation was evidenced in the nurses notes by E7, regarding R2's vital signs, quality of respirations, bilateral breath sounds, type of secretions, condition of trach/stoma site, cough, or

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ascultation of R2.

On 1/5/12 at 1:00 PM, E9, Certified Nurses Aide, CNA, stated " I cared for R2 during the night of 12/27/11, and he did sleep off and on. R2 put his light on several times, I think at least 4 times, to have the nurse come and check his trach and suction him.

On 1/18/12 at 10:00 AM, in a telephone interview, E12, LPN, stated, "I came in at 6:00 AM. E7, suctioned R2 before she left, about 6:30 AM, and he was asleep till around 8:00 AM. I suctioned R2 at 8:00 AM, and removed a large amount of whitish secretions at that time. I was told in report that R2 had to be suctioned frequently. After 8:00 AM, E3, LPN, came in, and was responsible for the care of R2. I did come and help E3 several times during the day with R2's suctioning. R2 would turn on his light and point to his chest when he felt short of breath. His 02-sat's would go down to around 88%, and his heart rate would go up to around 115 or so. After suctioning, his O2-sat's would go back up to the lower 90's, and his heart rate would go down below 100. We were suctioning him throughout the day about every 45 minutes or so. R2 usually had a lot of fluid when I suctioned him. I did not discuss with E3, about calling the doctor about his needing to be suctioned so often, as we were told R2 needed frequent suctioning. R2's 02-sats would be stable after he was suctioned."

A review of R2's nurses notes failed to show documentation by E12 that she had cared for or suctioned R2 on 12/27/11. The nurses notes contain no documentation on how often R2's O2-sats had fallen into the 88% range between suctioning as described by E12, and had no

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information on secretions, amounts and type, results of E12's suctioning and no information regarding the stoma site, or R2's behaviors.

On 1/5/12 at 10:00 AM, E3, LPN, stated, "E7 called me on 12/26/11 at around 10:45 PM, to come and help her set up R2's humidified oxygen because E7, was not familiar with the equipment. I came in around 11:00PM. I called the pharmacy where the equipment came from, and got directions on how to set up the machine for humidified air. When R2 was set up I stayed to help get R2's doctors orders written and get information faxed to the pharmacy for his medications. I left at around 12:30 AM. At 8:00 AM, I returned to work and was in charge of R2's care. E12 helped me with R2's suctioning during the day. I suctioned R2 at 8:30 AM, and his 02-sat's at that time were around 92%. R2 used his call light to let us know when he needed to be suctioned. It seemed that we (E12 and E3) suctioned R2 about every 30 to 45 minutes. I thought this was not a problem, because I was told R2 needed to be suctioned frequently. R2 was gotten up in a geriatric chair at 12:00 PM for one hour and tolerated this well. R2 had visitors at one point during the day and he seemed calmer then also. After 1:00 PM, I noticed more than once that prior to suctioning his 02-sat's would drop to 88% or 89%. After suctioning they would go back up to 90% or 92%. R2's secretions were white and and I did not get a lot of fluid when I suctioned him. During these times, R2 did not seem in distress, just very anxious. He would point to his chest to show he was short of breath. He put on his call light a lot, and seemed like he did not want to be left alone in his room. I have taken care of other residents

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with trach's in previous jobs, and did not feel uncomfortable caring for R2."

A review of E3's nurses notes dated 12/27/11, documents she suctioned R2 at 8:15 AM, 10:15 AM, 1:00 PM and 1:30 PM. The notes document that each time R2 had moderate amounts of white phlegm, but fail to document O2-sats, consistency of secretions, condition of R2's trach site, or any of the behaviors of anxiousness that E3 described of R2 during the day. At 2:30 PM, E3 documented, "DuoNeb done. Spo2 (O2-sats) 90-92%, suctioned large amount of phlegm. No other information is documented regarding R2's, O2-sats being in the upper 88% - 89%'s prior to suctioning, or the condition of R2's trach. At 3:30 PM, E3 did document R2's 02-sat's were 89% and he was suctioned for a moderate amount of white phlegm.

On 1/5/12 at 1:30 PM, E3 stated, "I did not think he was being suctioned too often. I had been told by E7, that the hospital reported R2 was being suctioned frequently, and he was on an antibiotic for pneumonia. I did not think to ask the doctor or his nurse if suctioning R2 every 30 to 45 minutes was too much. I did not call the hospital to verify how frequently R2 had been suctioned when there. I documented everything in the nursing notes. There were no other forms to be filled out regarding R2's trach or suctioning. Z3, Nurse Practitioner also came and saw R2, the morning of 12/27/11, and she did not say he looked unstable. At 3:00 PM, E5, LPN, came in and took over R2's care. E5 did tell me that she thought R2 should be sent to the Emergency Room, because he needed so much suctioning, but I did not agree. I told E5, R2 looked stable to me, and was only anxious when he needed to be suctioned. I gave her the DuoNeb medication

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and told her do his breathing treatment, and recheck him. I gave E5 the medication cart keys and left the floor to do paperwork at 3:30 PM."

In a telephone interview on 1/19/12 at 10:15 AM, E3 stated, "On 12/27/11, I do not think R2 changed his behavior from morning to afternoon. He was putting on his light every 15 - 20 minutes throughout the day. He was being suctioned every 30 to 45 minutes. It was after lunch I noticed 02-sat's would go down to 88% or 89%, but after suctioning they would go back up in the lower 90%'s and R2 would be calmer. I feel he was stable on my shift. None of the CNA staff told me they thought R2 should go to the hospital."

On 1/5/12 at 11:00 AM, E5, stated, "I came in to work at 3:00 PM, was given report on R2, and saw him at 3:15 PM. I have have had training and cared for and suctioned trach patients in a previous job. At 3:15 PM, R2 looked uncomfortable and needy. I told E3, shouldn't R2 be sent out if he needed to be suctioned, so often. E3 did not agree and handed me R2's nebulizer medicine and told me to give the treatment to give R2. R2's 02-sat's were 88%, his pulse was over 100 and he appeared anxious and distressed. He was pointing at his trach site repeatedly. After the nebulizer treatment his Ps02 was 93%, and he did calm a little. R2, was on the call light about every 15 - 20 minutes, was very anxious, and seemed to need someone in the room with him to reassure him. I had E10, CNA, stay with him off and on and this helped him calm down. At 4:30 PM, I suctioned R2, he was teary, and after suctioning his 02-sat's were 90%. I spoke with him, he seemed easily consoled and calmer. At 5:00 PM, I suctioned R2, his 02-sat's was 87% and pulse was over 100

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and he was again very anxious, so I suctioned R2 and then called the physician's office to discuss R2's being so anxious. At 5:15 PM, Z2, Nurse Practitioner (NP), returned my call. I told her R2 seemed very anxious. Z2 ordered Ativan 1mg IM / Now, to be given. I (E5) was not able to give the Ativan as there was none in the stock supply in the building. I called and faxed the order to the pharmacy to have Ativan sent out for R2. I did not call Z2 back and tell her we had no IM Ativan. At 5:30 PM, I (E5) saw R2 and he was resting in bed, gave him a stuffed animal to hold, I checked his tube feeding, he was resting, he nodded and opened his eyes when I spoke to him."

E5's nurses notes dated 12/27/11 at 3:15 PM, documented "Upon entering room, resident (R2) appeared to be in distress. Sp02 (O2-sats) @ 88%. Neb treatment given, resident denies pain with nod of head, wheezing noted in upper and lower bilateral lobes. No distress noted, will continue to monitor." At 4:30 PM, E5's notes documented, "Resident in room, teary eyed, continues to deny pain with nod of head, pointing to trach. Suctioned with small amount phlegm extracted. Sp02 at 90%." At 5:00 PM, E5 documented "resident appears anxious, Sp02 at 90%, writer called to Dr's (physician)exchange, awaiting call back. At 5:15 PM, E5's notes documented that Z2, returned the call and ordered Ativan 1mg for Anxiety. A review of the physician's order sheet dated 12/27/11 documents "Give 1mg Ativan, Now."

On 1/5/12 at 2:50 PM, E5 stated "At 6:00 PM, E6, LPN, came on duty and I gave him report. I informed him of R2's status. During the report, between 6:10 PM and 6:20 PM, the pharmacy called back and said the Ativan had not been

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approved and needed the doctors signature. At about 6:30 PM, E6, called me to R2's room and told me R2 didn't look right. I attempted to locate an apical and radial pulse and found none. R2's eyes were fixed. E6 said to call 911 and he started CPR with E13, CNA. The Emergency Medical Technicians (EMT) / Ambulance was here within 10 minutes, and they continued CPR and left the building at about 6:50 PM."

A nurses note dated 12/27/11, 6:45 PM, by E5, documented in part, "Writer summoned to residents room, resident lying on back, eyes affixed, unable to obtain apical pulse, no respirations, requested crash cart, CPR started, 911 called, CPR continued. Ambulance here and 2 EMT's, continued CPR out of building."

On 1/6/12 at 2:37 in a telephone interview, E6, LPN, confirmed that he had only seen R2 for the first time on 12/27/11 at 6:30 PM, when he was found non-responsive. E6 stated he called E5 for help, and CPR was started and 911 called for assist. E6 stated that E13 did help with CPR.

On 1/19/12, at 4:00 PM in a telephone interview with E13, she stated that she was assigned to care for R2 on 12/27/11. E13 stated that she arrived at 6:00 PM, and immediately went to the dining room to help feed other residents, and did not see R2 until called by E6, to assist with CPR on R2.

On 1/6/12 at 2:37 PM in a telephone interview, E6, stated that he arrived at work at 6:00 PM, and received report on R2, from E5. E6 stated that at about 6:15 PM the pharmacy called and reported R2's Ativan order had not been approved and needed the physician's signature. E6 stated he

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went to do rounds and at 6:30 PM he entered R2's room and found him unresponsive. R2 was lying in bed with no palpable pulse and eyes fixed. E6 stated he started CPR with E13, while E5, called for an ambulance. E6 stated the R2 had no vitals when he (R2)left the building.

In additional interviews done on 1/5/12, with E8 and E10, both CNA's, they both verified on 12/27/11, R2 used his call light every 30 minutes or so to get the nurse to suction him. When he was short of breath he would point to his chest, and he seemed anxious, but was more calm when staff were in the room.

On 1/6/12 at 2:00 PM, E11 CNA, stated, "I helped to care for R2 on 12/27/11 during the day shift. I came at 6:00 AM. R2 would put on his light every 20 or 30 minutes. He either put on his light or would bang his hand on the wall to get someone to come to him. The nurses were in his room every 30 minutes or so to suction him. R2, seemed scared to me and I did ask once if E3, thought he should be sent to the emergency room. E3 told me R2 was stable.

On 1/19/12, at 9:40 AM, in a telephone interview E1, Administrator, stated " I did pop in and check on R2 at various times during the day. R2 did seem nervous to be in the facility, I thought it ws because he was no longer in the hospital. On 12/27/11, no day staff approached me about R2's or said that R2 needed to go to the hospital. On 12/27/11, at about 5:00 PM, E5, did voice concern about R2 needing to be suctioned so often and told me, "I'm probably going to send him (R2) out." I told E5, if you feel you need to send any resident out, that is your call. E1, stated she left

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at around 5:00 PM, and saw R2 before she left. At that time R2 was laying quietly in his bed and smiled when she spoke to him." E1, stated that on 12/26/11 and 12/27/11, no DON or RN staff on were on duty that day to assess the status of R2, his tracheostomy, or level of care needed.

On 1/24/12, at 10:00 AM, in an telephone interview with E1, she stated "Prior to this incident, the facility had not provided the nurses any training in tracheostomy in the past year. I asked all the nurses if they had previous trach training or experience, and they E3, E5, E6, E7, and E12, told me they had been trained and had done suctioning in previous jobs, and were comfortable with doing suctioning."

A review of the facility's Monthly Staffing Schedule for the month of December 2011, indicated the facility did not have RN coverage for for 21 of 31 days in December 2011. This included 12/26 and 12/27/11. E1 confirmed there was no RN coverage in an interaview on 1/5/12 at 11:00AM. E1, also confirmed the facility did not have a Director of Nursing from the end of November 2011 through December 2011.

The facility provided a policy, Tracheal Suctioning 03/05, and a policy, Suctioning Tracheostomy 03/04. Both policies document reasons for and procedures to follow when suctioning a trach patient. However, both policies fail to document how to assess the status of a tracheostomy resident, or to determine if suctioning is effective, or how frequently to suction. Both policies advise nurses to note the nature of secretions as to if they are thin, tenacious, bloody, foul odor, color and volume. The policy Tracheal Suctioning Policy does

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F9999	Continued From page 57 document #25 - Document in nurses notes the results of Suctioning. On 1/5/12 at 2:00 PM, in a telephone interview with Z2, Nurse Practitioner, she stated, "On 1/27/11, at dinner time, E5 did call me about R2. E5 told me he was a new trach patient, and he was very anxious. I asked if the facility had IM-Ativan available in the building, if so, give him 1mg / IM. If it helped his anxiety, I was thinking to make it a PRN order. It is not unusual for newer trach patients to feel anxious about their ability to breath. If R2 was requiring suctioning every 30 to 45 minutes, I should have been called much sooner. When E5 called, she did not tell me that R2 was requiring suctioning so frequently. Knowing this, I and may not have ordered the Ativan, and probably would have ordered him sent out to the Emergency Room to be sure he was stable. I was not notified that he had gone to the ER or that he had passed away. On 1/5/12 at 3:00 PM, in a telephone interview with Z1, R2's physician, he stated; "Typically when you increase suctioning, it increases secretions. The question is, is this frequent suctioning the norm for R2. If staff had called and given this information about needing suctioning so often, we might have done something different, as Ativan can slow down the respirations. I believe they (facility) should have called sooner. As R2, was new to my service, I would probably have sent him to the hospital to be sure he was stable." On 1/5/12 at 4:00 PM, in a telephone interview with Z3, Nurse Practitioner, she stated, "I was in the building on 12/27/11, and did see R2,	F9999		

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between 10:00 AM and 11:00 AM. At that time he had just been suctioned, his lungs sounded okay, and his color was good. He was not demanding. After I saw R2, I moved to the other side of the building and was there till about 4:00 PM. At no time did any staff come to me and tell me they were suctioning R2 every 30 to 45 minutes. I should have been told or at least asked, about R2 having to be suctioned so frequently. No one came and asked me anything, or I would have looked at him.

On 1/24/12 at 11:10 AM, a telephone interview was done with Z5, RN (Registered Nurse)-CCU (Critical Care Unit) Nurse Manager, and Z6-RN, responsible for the transfer of R2 to the nursing home.

Z6 stated, "On 12/26/11, when transferred, R2 was stable, meaning his vital signs were within normal parameters, and he was responding well to his trach. Prior to transfer, I told the nursing home nurse, that R2 was being suctioned frequently, about every 2 hours. At the hospital, he did have a lot of secretions that did cause his 02-sats to go down into the upper 80's and his pulse would go up to around 116 - 120. When suctioned this would reverse. He had his trach about 6 days. When he first got the trach he needed suctioning more frequently, but at the time of discharge he was being suctioned about every 2 hours. I put the phone number to the CCU unit on the transfer information so the facility could call with any questions they might have about R2. No one called that night to me to ask anything about R2."

E5 stated, I believe R2 was being suctioned

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about every 2 hours at time of discharge. Depending on the person some people produce more secretions, and the amount can vary depending on the time of the day. However, more frequent suctioning every 30 to 45 minutes can sometimes produce more secretions. When people have pneumonia, they have thicker secretions, and this can be auscultated. None of my staff have reported, being contacted by the nursing home regarding R2. Being suctioned every 30 to 45 minutes would not be normal for a stable trach patient. If this happened while on the unit we would be calling the doctor to have the patient assessed."

A review of Z7's hospital discharge note dated 12/27/11, documented in part, "patient was trached during hospitalization and trach was done for persistent atelectasis secondary to mucous plug. Patient's condition improved gradually, but he still is repeat suction almost every 2 hours. Fever resolved. Leukocytoses improved. Diabetes is being well controlled. Aspiration pneumonia improved with IV Antibiotics. He has otherwise remained stable on the day of discharge."

On 1/27/12 at 11:15 AM, E14, Respiratory Therapist, stated, "I was not at the facility at the time R2 was there. However, because of the frequency of R2's suctioning being every 30 to 45 minutes, if asked, I would have advised the facility to contact R2's physician and update him as to what was going on. With R2's 02sats going down to 88% and then back up repeatedly, in a supposedly stable trach patient, staff should alert the physician and make sure no other interventions are wanted, or see if the doctor may

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F9999	Continued From page 60 want the resident sent out to the ER for an evaluation." R2's Certificate of Death, dated 12/28/11 documented the cause of death was Aspiration Pneumonia and Tracheostomy. (A) LICENSURE FINDINGS 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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F9999	Continued From page 61 practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Based on interview and record review the facility neglected to follow their policy for tracheostomy (trach) care and neglected to assess and identify	F9999		

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F9999	Continued From page 62 a base line for the frequent suctioning of R2's trach, neglected to notify the physician of increased suctioning of R2's trach from once per hour to every 30 to 45 minutes, and neglected to alert the physician of R2's, 02sats repeatedly dropping below 90% prior to suctioning for 1 of 2 residents (R2) reviewed for tracheostomy care in the sample of 4. R2 became non-responsive and died. Findings include: 1. A review of E7's, Licensed Practical Nurse (LPN), nurses notes dated 12/26/11 at 10:40 PM, documented R2 was admitted to the facility with a diagnoses of; Tracheostomy (Trach), Gastrostomy Tube (G-tube), Myotonic Muscular Dystrophy, Malnutrition, Pneumonia, and Neuromuscular Dysphagia. The nurses notes document R2 had Oxygen 4.5 Liters at 35% humidified air delivered via the trach. R2 was to receive Glucerna 1.5 at 45 ml per minute continuous via G-tube. E7's, 10:40 PM nurses note documented R2's Oxygen Saturation (O2-sat) level was 93% - 94% upon admission. On 1/6/12 at 3:15PM, E7 stated, " R2 arrived around 10:45PM. I have suctioned people before, but was not familiar with the machine used for humidified air. I called E3, LPN to come in and help me get R2's oxygen set up. E3 arrived about 11:00 PM, and she then called the pharmacy to get instructions on how to set up the humidified air machine. The ambulance left around 11:30 PM, after R2 was set up and stable. R2 would turn on his light when he felt short of breath, and point to his chest. I suctioned R2	F9999		

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about 5 or 6 times during the night. R2's, Oxygen Saturation (02-sats) stayed in the low 90's through out the shift. There was not a lot of fluid when I suctioned him. R2 slept off and on during the night when not being suctioned. He did not appear to be in distress when I cared for him. I documented the care in the nurses notes. We do not have a form for suctioning, it is just written in the nurses notes."

E7's nurses notes dated 12/27/11, from 1:00 AM to 6:00 AM, failed to evidence documentation that R2 was suctioned "5 or 6 times" during the night as E7 had reported. E7 made two entries on 12/27/11 at 3:05 AM and 4:30 AM, and both document "suctioned small amount of mucous". R2's O2-sats are recorded once on 12/27/11, at 3:05 AM, as 93% to 94%. There is no documented information in R2's nurses notes on the other (4) times R2 was suctioned during the night on 12/27/11, or, his behaviors of turning on the light and pointing to his chest when feeling short of breath. On 12/27/11, no documentation was evidenced in the nurses notes by E7, regarding R2's vital signs, quality of respirations, bilateral breath sounds, type of secretions, condition of trach/stoma site, cough, or ascultation of R2.

On 1/18/12 at 10:00 AM, in a telephone interview, E12, LPN, stated, "I came in at 6:00 AM. E7, suctioned R2 before she left, about 6:30 AM, and he was asleep till around 8:00 AM. I suctioned R2 at 8:00 AM, and removed a large amount of whitish secretions at that time. I was told in report that R2 had to be suctioned frequently. After 8:00 AM, E3, LPN, came in, and was responsible for the care of R2. I did come and help E3 several times during the day with

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R2's suctioning. R2 would turn on his light and point to his chest when he felt short of breath. His 02-sat's would go down to around 88%, and his heart rate would go up to around 115 or so. After suctioning, his O2-sat's would go back up to the lower 90's, and his heart rate would go down below 100. We were suctioning him throughout the day about every 45 minutes or so. R2 usually had a lot of fluid when I suctioned him. I did not discuss with E3, calling the doctor about his needing to be suctioned so often as we were told R2 needed frequent suctioning. R2's 02-sats would be stable after he was suctioned."

A review of R2's nurses notes failed to show documentation by E12 that she had cared for or suctioned R2 on 12/27/11. The nurses notes contain no documentation on how often R2's O2-sats had fallen into the 88% range between suctioning as described by E12, and had no information on secretions, amounts and type, results of E12's suctioning and no information regarding the stoma site, or R2's behaviors.

On 1/5/12 at 10:00 AM, E3, LPN, stated, "E7 called me on 12/26/11 at around 10:45 PM, to come and help her set up R2's humidified oxygen because E7, was not familiar with the equipment. I came in around 11:00PM. I called the pharmacy where the equipment came from, and got directions on how to set up the machine for humidified air. When R2 was set up I stayed to help get R2's doctors orders written and get information faxed to the pharmacy for his medications. I left at around 12:30 AM. At 8:00 AM, I returned to work and was in charge of R2's care. E12 helped me with R2's suctioning during the day. I suctioned R2 at 8:30 AM, and his 02-sat's at that time were around 92%. R2 used

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his call light to let us know when he needed to be suctioned. It seemed that we (E12 and E3) suctioned R2 about every 30 to 45 minutes. I thought this was not a problem, because I was told R2 needed to be suctioned frequently. R2 was gotten up in a geriatric chair at 12:00 PM for one hour and tolerated this well. R2 had visitors at one point during the day and he seemed calmer then also. After 1:00 PM, I noticed more than once that prior to suctioning his 02-sat's would drop to 88% or 89%. After suctioning they would go back up to 90% or 92%. R2's secretions were white and and I did not get a lot of fluid when I suctioned him. During these times, R2 did not seem in distress, just very anxious. He would point to his chest to show he was short of breath. He put on his call light a lot, and seemed like he did not want to be left alone in his room. I have taken care of other residents with trach's in previous jobs, and did not feel uncomfortable caring for R2."

A review of E3's nurses notes dated 12/27/11, documents she suctioned R2 at 8:15 AM, 10:15 AM, 1:00 PM, 1:30 PM and 3:30 PM. The notes document that each time R2 had moderate amounts of white phlegm, but fail to document O2-sats, consistency of secretions, condition of R2's trach site, or any of the behaviors of anxiousness that E3 described of R2 during the day. At 2:30 PM, E3 documented, "DuoNeb done. Spo2 (O2-sats) 90-92%, suctioned large amount of phlegm. No other information is documented regarding R2's, O2-sats being in the upper 88% - 89%'s prior to suctioning, or the condition of R2's trach. At 3:30 PM, E3 did document R2's 02-sat's were 89% and he was suctioned for a moderate amount of white phlegm.

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On 1/5/12 at 1:30 PM, E3 stated, "I did not think R2 was being suctioned too often. I had been told by E7, that the hospital reported R2 was being suctioned frequently, and he was on an antibiotic for pneumonia. I did not think to ask the doctor or his nurse if suctioning R2 every 30 to 45 minutes was too much. I did not call the hospital to verify how frequently R2 had been suctioned when there. I documented everything in the nursing notes. There were no other forms to be filled out regarding R2's trach or suctioning. Z3, Nurse Practitioner also came and saw R2, the morning of 12/27/11, and she did not say he looked unstable. At 3:00 PM, E5, LPN, came in and took over R2's care. E5 did tell me that she thought R2 should be sent to the Emergency Room, because he needed so much suctioning, but I did not agree. I told E5, R2 looked stable to me, and was only anxious when he needed to be suctioned. I gave her the DuoNeb medication and told her do his breathing treatment, and recheck him. I gave E5 the medication cart keys and left the floor to do paperwork at 3:30 PM."

In a telephone interview on 1/19/12 at 10:15 AM, E3 stated, "On 12/27/11, I do not think R2 changed his behavior from morning to afternoon. He was putting on his light every 15 - 20 minutes throughout the day. He was being suctioned every 30 to 45 minutes. It was after lunch I noticed 02-sat's would go down to 88% or 89%, but after suctioning they would go back up in the lower 90%'s and R2 would be calmer. I feel he was stable on my shift. None of the CNA's staff told me they thought R2 should go to the hospital."

On 1/5/12 at 11:00 AM, E5, stated, "I came in to work at 3:00 PM, was given report on R2, and

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saw him at 3:15 PM. I have have had training and cared for and suctioned trach patients in a previous job. At 3:15 PM, R2 looked uncomfortable and needy. I told E3, shouldn't R2 be sent out if he needed to be suctioned, so often. E3 did not agree and handed me R2's nebulizer medicine and told me to give the treatment to give R2. R2's 02-sat's were 88%, his pulse was over 100 and he appeared anxious and distressed. He was pointing at his trach site repeatedly. After the nebulizer treatment his Ps02 was 93%, and he did calm a little. R2, was on the call light about every 15 - 20 minutes, was very anxious, and seemed to need someone in the room with him to reassure him. I had E10, CNA, stay with him off and on and this helped him calm down. At 4:30 PM, I suctioned R2, he was teary, and after suctioning his 02-sat's were 90%. I spoke with him, he seemed easily consoled and calmer. At 5:00 PM, I suctioned R2, his 02-sat's was 87% and pulse was over 100 and he was again very anxious, so I suctioned R2 and then called the physician's office to discuss R2's being so anxious. At 5:15 PM, Z2, Nurse Practitioner (NP), returned my call. I told her R2 seemed very anxious. Z2 ordered Ativan 1mg IM / Now, to be given. I (E5) was not able to give the Ativan as there was none in the stock supply in the building. I called and faxed the order to the pharmacy to have Ativan sent out for R2. I did not call Z2 back and tell her we had no IM Ativan. At 5:30 PM, I (E5) saw R2 and he was resting in bed, gave him a stuffed animal to hold, I checked his tube feeding, he was resting, he nodded and opened his eyes when I spoke to him."

E5's nurses notes dated 12/27/11 at 3:15 PM, documented "Upon entering room, resident (R2)

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appeared to be in distress. Sp02 (O2-sats) @ 88%. Neb treatment given, resident denies pain with nod of head, wheezing noted in upper and lower bilateral lobes. No distress noted, will continue to monitor." At 4:30 PM, E5's notes documented, "Resident in room, teary eyed, continues to deny pain with nod of head, pointing to trach. Suctioned with small amount phlegm extracted. Sp02 at 90%." At 5:00 PM, E5 documented "resident appears anxious, Sp02 at 90%, writer called to Dr's exchange, awaiting call back. At 5:15 PM, E5's notes documented that Z2, returned the call and ordered Ativan 1mg for Anxiety. A review of the physician's order dated 12/27/11 documents "Give 1mg Ativan, Now."

On 1/5/12 at 2:50 PM, E5 stated "At 6:00 PM, E6, LPN, came on duty and I gave him report. I informed him of R2's status. During the report, between 6:10 PM and 6:20 PM, the pharmacy called back and said the Ativan had not been approved and needed the doctors signature. At about 6:30 PM, E6, called me to R2's room and told me R2 didn't look right. I attempted to locate an apical and radial pulse and found none. R2's eyes were fixed. E6 said to call 911 and he started CPR with E13, CNA. The Emergency Medical Technicians (EMT) / Ambulance was here within 10 minutes, and they continued CPR and left the building at about 6:50 PM."

A nurses note dated 12/27/11, 6:45 PM, by E5, documented in part, "Writer summoned to residents room, resident lying on back, eyes affixed, unable to obtain apical pulse, no respirations, requested crash cart, CPR started, 911 called, CPR continued. Ambulance here and 2 EMT's, continued CPR out of building."

On 1/6/12 at 2:37 PM in a telephone interview, E6, stated that he arrived at work at 6:00 PM, and

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received report on R2, from E5. E6 stated that at about 6:15 PM the pharmacy called and reported R2's Ativan order had not been approved and needed the physician's signature. E6 stated he went to do rounds at 6:30 PM and when he entered R2's room, R2 was unresponsive. R2 was lying in bed with no palpable pulse and eyes fixed. E6 stated he started CPR with E13, while E5, called for an ambulance. E6 stated the R2 had no vitals when he left the building.

On 1/24/11, at 10:00 AM, in an telephone interview with E1, she stated "Prior to this incident, the facility had not provided the nurses any training in tracheostomy in the past year. I asked all the nurses if they had previous trach training or experience, and they E3, E5, E6, E7, and E12, told me they had been trained and had done suctioning in previous jobs, and were comfortable with it."

The facility provided a policy, Tracheal Suctioning 03/05, and a policy, Suctioning Tracheostomy 03/04. Both policies document reasons for and procedures to follow when suctioning a trach patient. However, both policies neglected to document how to assess the status of a tracheostomy resident, or to determine if suctioning is effective, or how frequently to suction. Both policies advise nurses to note the nature of secretions as to if they are thin, tenacious, bloody, foul odor, color and volume. The policy Tracheal Suctioning Policy does document #25 - Document in nurses notes the results of Suctioning.

On 1/5/12 at 2:00 PM, in a telephone interview with Z2, Nurse Practitioner, she stated, "On

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12/27/11, at dinner time, E5 did call me about R2. E5 told me he was a new trach patient, and he was very anxious. I asked if the facility had IM-Ativan available in the building, if so, give him 1mg / IM. If it helped his anxiety, I was thinking to make it a PRN order. It is not unusual for newer trach patients to feel anxious about their ability to breath. If he was requiring suctioning every 30 to 45 minutes, I should have been called much sooner. When E5 called, she did not tell me that R2 was requiring suctioning so frequently. Knowing this, I and may not have ordered the Ativan, and probably would have ordered him sent out to the Emergency Room to be sure he was stable. I was not notified that he had gone to the ER or that he had passed away.

On 1/5/12 at 3:00 PM, in a telephone interview with Z1, R2's physician, he stated; "Typically when you increase suctioning, it increases secretions. The question is, is this frequent suctioning the norm for R2. If staff had called and given this information about needing suctioning so often, we might have done something different, as Ativan can slow down the respirations. I believe they (facility) should have called sooner. As R2, was new to my service, I would probably have sent him to the hospital to be sure he was stable."

On 1/5/12 at 4:00 PM, in a telephone interview with Z3, Nurse Practitioner, she stated, "I was in the building on 12/27/11, and did see R2, between 10:00 AM and 11:00 AM. At that time he had just been suctioned, his lungs sounded okay, and his color was good. He was not demanding. After I saw R2, I moved to the other side of the building and was there till about 4:00 PM. At no

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time did any staff come to me and tell me they were suctioning R2 every 30 to 45 minutes. I should have been told or at least asked, about R2 having to be suctioned so frequently. No one came and asked me anything, or I would have looked at him.

On 1/24/12 at 11:10 AM, a telephone interview was done with Z5, RN(Register Nurse)-CCU(Critical Care Unit) Nurse Manager, and Z6-RN, responsible for the transfer of R2 to the nursing home.

Z6 stated, "On 12/26/11, when transferred, R2 was stable, meaning his vital signs were within normal parameters, and he was responding well to his trach. Prior to transfer, I told the nursing home nurse, that R2 was being suctioned frequently, about every 2 hours. At the hospital, he did have a lot of secretions that did cause his 02-sats to go down into the upper 80's and his pulse would go up to around 116 - 120. When suctioned this would reverse. He had his trach about 6 days. When he first got the trach he needed suctioning more frequently, but at the time of discharge he was being suctioned about every 2 hours. I put the telephone number to the CCU unit on the transfer information so the facility could call with any questions they might have about R2. No one called that night to me to ask anything about R2."

E5 stated, I believe R2 was being suctioned about every 2 hours at time of discharge. Depending on the person some people produce more secretions, and the amount can vary depending on the time of the day. However, more frequent suctioning every 30 to 45 minutes can sometimes produce more secretions. When people have pneumonia, they have thicker

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F9999	Continued From page 72 secretions, and this can be auscultated. None of my staff have reported, being contacted by the nursing home regarding R2. Being suctioned every 30 to 45 minutes would not be normal for a stable trach patient. If this happened while on the unit we would be calling the doctor to have the patient assessed." R2's Certificate of Death, dated 12/28/11 documented the cause of death was Aspiration Pneumonia and Tracheostomy. (A)	F9999		