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W 368	Continued From page 60 Z1 was interviewed on 12/5/12 at approximately 1:00 p.m. Z1 said, "I review the physician's orders quarterly, or when there are acute orders. I sign the M.D. (medical doctor) section of the Physician's order sheet.	W 368		
W9999	FINAL OBSERVATIONS FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.760a)b) 350.1210 350.1220j) 350.1230b)6)7) 350.1230d)1)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 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 350.760 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. Activities shall	W9999		

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W9999	Continued From page 61 be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident. 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: 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.	W9999		

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W9999	Continued From page 62 Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 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. These Regulations were not met as evidenced by: A. Based on record review and interview it was determined the facility failed to ensure an investigation was conducted for 1 of 1 resident (R5) in the supplemental sample, who was hospitalized and died unexpectedly. Findings include: According to the record, R5 was a 58 year old	W9999		

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with an IQ of 12 and diagnoses including Profound Intellectual Disability, Crouzon's Disease (chromosomal abnormality), Right eye prothesis, and Benign Prostatic Hypertrophy with urinary incontinence. The Speech Therapy assessment, dated 2/21/11, states R5 was non-verbal, but could communicate with limited gestures and head movements, such as nodding for yes. The record documents that R5 also followed simple commands, walked very short distances, but used a wheelchair (w/c) for longer distances.

A facility nurse's progress note states that R5 was hospitalized on 11/20/12. The hospital Emergency Department (ED) physician documented R5's admitting condition as "critical" with diagnoses including Myxedema Coma, Dehydration, Anemia, Pneumonia, Fecal Impaction, and elevated pancreatic enzymes. R5's expired in the hospital,on 11/28/12. The Death Certificate lists Pneumonia as the cause of death.

The facility record contains documentation that R5 started having respiratory congestion as early as 11/8/12, which continued until he was hospitalized with a diagnosis of Pneumonia, on 11/20/12.

The facility record includes documentation that R5 started having intermittent nausea and vomiting in June of 2012 and it continued until he was hospitalized on 11/20/12, with a diagnosis of Dehydration.

The facility record includes documentation that R5 started having constipation on 11/2/12. R5

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W9999	Continued From page 64 was admitted to the hospital 18 days later with Fecal Impaction. E1 (Administrator / Acting Director Nursing) stated on 12/4/12, at 1:50 PM, that R5's death was unexpected. E1 said there has not been an investigation regarding the events surrounding R5's hospitalization and death. Based on observation, interview and record review the facility failed to ensure that health condition changes are documented for 1 individual in the sample, R3 and 1 individual outside the sample, R5. Findings include: Facility policy titled, "Section 370 - Resident Records" requires, "4) ...each resident's medical record contains the following; c. An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. i) Consultants who provide direct care or treatment to residents make notations at the time of each visit with a resident. Facility policy titled, "Section 320 - Physician Services, dated 6/11/96" requires, "5. If for any reason a physician's order cannot be followed, the [facility] will endeavor to notify the physician and note such on the resident's record." A nurse's progress note dated 11/8/12, states R5 was seen that day by Z4 (Physician Assistant Certified / PAC) for cold symptoms, and that R5	W9999		

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had a "head cold". Z4's note, dated 11/8/12, states R5 had copious amounts of clear nasal drainage and a cough for a few days. Z4's documented diagnosis is Rhinitis, with treatment orders for saline nasal spray and follow up as needed.

The record lacked further documentation regarding R5's respiratory status, including vital sign (temperature, pulse, respirations and blood pressure) monitoring, until his hospital admission with Pneumonia, on 11/20/12.

However, on 12/6/12 at 11:30 AM, E1 (Acting Director of Nursing / Administrator) provided emailed nurse shift reports. E1 said the reports are not part of the record, but any emailed notations regarding resident health conditions should also be documented in the progress notes, however R5's are not.

E4 (QIDP) stated on 12/4/12, at 12 PM, that she and the DSPs were aware of R5's frequent coughing. She said the cough was weak and non-productive even though it sounded like he had chest congestion. E4 said she did not document her observations, or the concerns brought to her by direct support persons (DSP) regarding R5's respiratory status.

E6 (RN) said on 12/5/12, at 1:15 PM, that she is the RN responsible for R5's home. She confirmed the record findings and the lack of follow up / monitoring documentation, regarding R5's respiratory problems

b,c) On 6/18/12, a Medical Concern Form (MCF), used by the DSPs to communicate medical concerns to nursing, was completed for

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R5. The following is documented on this MCF, "'Nature of Concern': [R5's] been vomiting tonight. He vomits frequently." E6 (RN) documented on the MCF, "'Nursing Reply': Continue to monitor for any further vomiting. Please notify nursing. Monitor for temp."

The record lacked further documentation regarding the nausea and vomiting (n/v), including vital sign monitoring, until a second MCF was initiated on 8/24/12. The DSP wrote under "'Nature of Concern': [R5] vomited a large circle of mucous on the bathroom floor. It was clear." E7's (LPN) MCF reply was"Monitor". The record lacked documentation of any monitoring or follow up of R5's n/v until 9/20/12, when a third MCF was initiated. The DSP wrote "[R5] vomiting tonight and last night. He vomits often. How about a gastroenterologist checking him out?" E6's nursing reply on the MCF is "Will address with Z4 (Physician Assistant Certified / PAC) to get referral to digestive diseases."

The next documentation of this n/v concern is E6's progress note, dated almost 3 weeks later on 10/11/12, -"Chart reviewed for resident regarding frequent episodes of intermittent emesis off and on. Recvd order to refer to Digestive Diseases."

The first physician related notation was by Z4 on 10/11/12, "Diagnosis: Vomiting. Plan: Patient will be referred to DDC (Digestive Disease Center)." There is no documentation that a physical assessment was completed, addressing whether or not R5 was having negative symptoms from the n/v.

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On 11/2/12, a DSP had initiated another MCF stating "[R5] would not eat lunch today and seemed very tired and would not talk or respond to me. Reported to nurse (E6)." E1's written MCF response is that R5's abdomen was round and slightly firm,and that staff were instructed to monitor for bowel movement and emesis, and encourage fluids. E1 documented the next morning that R5 had vomited and was having difficulty moving his bowels. On 11/3/12, E1 notified Z1 (Primary Care Physician / Medical Director) of R5's constipation. E1 received and administered a laxative to R5.. There is no further documentation that R5's GI status was monitored, including oral intake and bowel movements (BM), especially after he had received a laxative.

E6 (RN) confirmed on 12/5/12, at 1:30 PM, the above documentation and the lack of follow up documentation.
There is no documentation that R5's nutritional / fluid intake was monitored, since he had n/v first documented in 6/2012. R5 was admitted to the hospital on 11/20/12, with diagnoses including Dehydration and Fecal Impaction. R5 received intravenous fluids for hydration and was manually disimpacted.

The BM log form for 11/2012 showed that R5 had only 2 BMs from 11/1 to 11/20/12. There was no documentation that DSPs notified nursing.

d) A MCF, initiated by DSP on 10/19/12, states, "[R5] has a rash below his buttocks." E7's MCF nursing reply stated that E7 had left messages for

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Z1 (physician) on 10/20/12 and 10/21/12 regarding the rash, but Z1 did not return the call. Three days after the rash was first noted, on 10/22/12, E6 (RN) wrote in the progress notes that she called, and spoke to, Z1 regarding a blistered rash on R5's right hip and thigh. That day R5 was sent to, and discharged from, the hospital ED with a diagnosis of Shingles.

After R5's initial diagnosis of Shingles on 10/22/12, the record lacked documentation regarding this diagnosis, including monitoring of the rash and pain assessments. There is no documentation that the staff were trained to monitor R5's rash, his level of pain, or about contact isolation precautions for the Shingles rash, which is contagious at certain stages.
R5 was hospitalized one month later, on 11/20/12. According to the ED physician, and the hospital's wound care documentation including photographs dated 11/21/12, R5 was admitted with a diffuse rash and long scratch marks on his right buttocks and thighs.

E6 confirmed on 12/5/12 at 2 PM, there is no documentation that R5's rash was monitored, his pain level assessed, or DSPs were trained on R5's new diagnosis of Shingles.

2. According to the clinical record, R3 is a 60 year old male with multiple medical diagnoses including Cardiomyopathy, Mild Mitral Valve Prolapse, Alzheimer ' s, and Venous Stasis Dermatitis. R3 functions in the Severe range of Intellectual Disability. R3 has been hospitalized four times in 2012, twice in October. R3 requires oxygen per nasal cannula and wound care for decubitus, R3 has a catheter to remove the urine

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W9999	Continued From page 69 from his body. R3 is treated for decubitus at a local wound care clinic. Z2, wound care physician, was interviewed on 12/6/12 at 9:50 a.m. Z2 said the decubitus problems with R3 are not avoidable. Z2 said prevention and treatment are important. Surveyor observed R3 in the infirmary on 12/14/12 at 2:15 p.m. R3's decubitus to the left lower buttocks was covered with a wafer dressing. Surveyor reviewed the treatment record for R3. One treatment record is written by the nurse, E6, for the months of September, October, November and December 2012. The treatment record is used to document wound care to the left foot and to the buttocks. There is no wound description as to site and to condition of the wounds. E4, Qualified Intellectual Disability Professional, was interviewed on 12/6/12 at 9:25 a.m. E4 said there is no facility policy for wound care. E6 was interviewed on 12/6/12 at 1:15 p.m. E6 said I should have done a wound description; if it is not there I didn't do it. E6 was also interviewed on 12/11/12 at 9:55 a.m. E6 said staff are given verbal instructions related to the urinary catheter and skin care. E6 said she was not aware of written information provided for direct support staff. Based on record review and interview, the facility failed to ensure that the Medical Director	W9999		

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participated with updating the plan of care for 1of 1 resident (R5), in the supplemental sample with identified, ongoing health issues.

Findings include:

Facility Agreement titled, "Medical Director Agreement, dated 6/15/02" requires, "4. The Medical Director shall participate in development of a system providing a medical care plan for each patient, which covers medications, nursing care, restorative services, diet, and other services, and if appropriate, a plan for discharge."

Z4 (Physician Assistant Certified) documented on 10/11/12, that she was seeing R5 for "Vomiting" and referred him to a specialist. This note was co-signed by Z1 (Primary Care Physician / Medical Director).

R5's Medication Administration Record (MAR) for 11/2012, was reviewed for his physician ordered nutritional supplement. Fourteen of nineteen days before his hospitalization, R5 did not receive his supplement.

E4 (QIDP) stated on 12/4/12, at 12 PM, that the DSPs were not inserviced regarding R5's problems with Nausea, Vomiting, and Constipation, including what to watch for, and when to call nursing.
There is no documentation that R5's nutritional / fluid intake was monitored, after the n/v was first documented in 6/2012.

On 10/25/12, Z4 documented that she saw R5 for

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his new diagnosis of Shingles / Herpes Zoster. She listed R5's pain as '0' and described the rash on the right leg as scabbed with surrounding erythema (redness / inflammation). Z4's "Treatment Plan" listed R5's medications, but not the hospital ordered pain medication. Z4's note states "Follow up: prn [as needed]. Z4's Treatment Plan lacked instructions for ongoing pain assessments, contact precautions, wound care, and the hospital prescribed pain medication. Z4's note was co-signed by Z1.

After R5's initial diagnosis of Shingles on 10/22/12, other than Z4's note, the record lacked documentation regarding this diagnosis, including monitoring of the rash and pain assessments. There is no documentation that the staff were trained to monitor R5's rash, his level of pain, or about isolation precautions for the Shingles rash, which is contagious at certain stages/settings.

R5 was hospitalized one month after the initial Shingles diagnosis, on 11/20/12. According to the ED physician, and the hospital's wound care documentation including photographs dated 11/21/12, R5 was admitted with a diffuse rash and long scratch marks on his right buttocks and thighs.

E4 (QIDP) said on 12/6/12, at 11 AM, that direct staff had not received training on how to care for R5's Shingles, only that nursing said to wash his clothing separately.

R5's current Individual Habilitation Plan (IHP), dated 8/17/12, lacked documentation that the physician was involved in the development of the IHP. Under "Medical Plan and Needs" the IHP

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listed, "Blood Pressures monitored daily for medication. Labs, weight and diet are monitored as well" The IHP lacked documentation of, including a plan of care for, R5's identified and ongoing N/V, Constipation and Shingles.

E6 (RN) said on 12/5/12, at 1:15 PM, that she is the RN responsible for R5's home. She confirmed the record findings and the lack of follow up / monitoring documentation regarding R5's N/V, Constipation and Shingles. She said there was not a Special Team Meeting (STM) to address or revise R5's current Individual Habilitation Plan (IHP), dated 8/17/12, to include R5's ongoing GI problems or Shingles. She was unsure if medical staff had participated in the IHP.

E4 stated on 12/6/12, at 10:45 AM, that there had not been a STM to address R5's ongoing GI problems, nor his newly diagnosed Shingles. E4 said neither the IHP nor the plan of care been updated to include these medical issues. E4 said that neither the physician, nor nursing attended R5's IHP, but nursing had sent a summary to be included.

Z1 and Z4 were interviewed on 12/5/12, at 12:30 PM. Z1 said he was not involved in R5's IHP, and did not participate in IHP updating to include N/V and Shingles. Z1 said Z4 works under his license and he is aware of all care and documentation provided to the residents.

1. Based on record review and interview, it was determined that the facility failed to provide

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adequate health care services and monitoring for 1 of 1 supplemental resident (R5) with identified, ongoing medical issues. R5 expired after being admitted to the hospital.
The facility failed to provide preventative and prompt medical treatment, along with timely and adequate health care monitoring.

a) Had symptoms of respiratory problems. R5 was admitted to the hospital with Pneumonia, which is listed as the cause of death.

Findings include:

The facility failed to monitor and document nausea and vomiting symptoms which R5 was experiencing.

Facility policy titled, "Abuse and Neglect. Section 243" states, "Neglect means failure to provide adequate medical or personal care or maintenance to an individual which results in physical or mental injury or in the deterioration of an individual's physical or mental condition."

Facility policy titled, "Section 320 - Physician Services, dated 6/11/96" requires, "5. If for any reason a physician's order cannot be followed, the [facility] will endeavor to notify the physician and note such on the resident's record."

Facility policies titled, "Job Description - Registered Nurse. Section 821 / Licensed Practical Nurse Section 822" requires, "2. Assists in the formulation and presentation of inservice training to other employees. 8. Treats injuries and illnesses as they occur, consulting with the physician as necessary."

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Facility policy titled, "Section 370 - Resident Records" requires, "4) ...each resident's medical record contains the following; c. An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. i) Consultants who provide direct care or treatment to residents make notations at the time of each visit with a resident."

A nurse's progress note dated 11/8/12, states R5 was seen that day by Z4 (Physician Assistant Certified / PAC) for cold symptoms, and that R5 had a "head cold". Z4's note, dated 11/8/12, states R5 had copious amounts of clear nasal drainage and a cough for a few days. Z4's documented diagnosis was Rhinitis, with treatment orders for saline nasal spray and follow up as needed. The record lacked further documentation regarding R5's respiratory status, including vital sign (temperature, pulse, respirations and blood pressure) monitoring, until his hospital admission with Pneumonia, on 11/20/12.

On 11/20/12 - no time, E1(Acting Director of Nursing / Administrator) documented in the progress notes that day training (DT) staff reported to nursing, "R5 continues to have trouble eating, and coughs a great deal", that he spit out undigested food and had not urinated since his 9 AM arrival. E1 documented that Z4 was contacted and ordered R5 to the hospital, where he was admitted with Pneumonia. According to the hospital Emergency Record, upon arrival, R5's T was 88 degrees (Hypothermia), requiring emergent body warming, and his blood pressure

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(b/p) was 88/60 (low), requiring warm intravenous (IV) fluids.
The hospital chest Xray, done upon admission, showed bilateral lung infiltrates, suggestive of Pneumonia, which was diagnosed by the hospital physician.

E1 confirmed the above documentation, and lack of follow up documentation, on 12/4/12 at 2 PM. E1 said he examined R5 before sending him to the hospital, however neither a T or p/ox was done at that time. E1 said R5's mouth and skin were dry, stomach firm but with bowel sounds, and right lung field was congested.

E4 (QIDP) stated on 12/4/12, at 12 PM, that she and the DSPs were aware of R5's frequent coughing. She said the cough was weak and non-productive even though it sounded like he had chest congestion. E4 said she did not document her observations, or the concerns brought to her by direct support persons (DSP) regarding R5's respiratory status. E4 said that even though R5 had been seen by nursing, his coughing and congestion did not improve.

E6 (RN) said on 12/5/12, at 1:15 PM, that she is the RN responsible for R5's home. She confirmed the record findings and the lack of follow up / monitoring documentation, regarding R5's respiratory problems. She said the physician was not notified of the Infirmary visits on 11/12 and 11/15/12, nor was he notified of the low T and p/ox. She said that DSPs were not inserviced on monitoring R5's respiratory status.

The facility failed to provide preventative and

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W9999	Continued From page 76 prompt medical treatment, along with timely and adequate health care monitoring, after R5; b) Had multiple episodes of nausea and vomiting. R5 was admitted to the hospital with Dehydration. c) Had abnormal laboratory results prior to his hospitalization. R5 was admitted to the hospital with Anemia and received blood transfusions. d) Had signs and symptoms of Constipation. R5 was admitted to the hospital with Fecal Impaction. The record lacked documentation of any monitoring or follow up of R5's n/v until 9/20/12, when another MCF was initiated. The DSP wrote "[R5] vomiting tonight and last night. He vomits often. How about a gastroenterologist checking him out?" E6's nursing reply on the MCF is "Will address with Z4 (Physician Assistant Certified / PAC) to get referral to digestive diseases." The next documentation of this n/v concern is E6's progress note, dated almost 3 weeks later on 10/11/12, "Chart reviewed for resident regarding frequent episodes of intermittent emesis off and on. Recvd order to refer to Digestive Diseases." The first physician related notation was by Z4 on 10/11/12, "Diagnosis: Vomiting. Plan: Patient will be referred to DDC (Digestive Disease Center)." There is no documentation that a physical assessment was completed, addressing whether or not R5 was showing negative symptoms from the n/v.	W9999		

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The DDC / GI Physician consultation, dated 10/29/12, ordered blood work, an abdominal ultrasound (US) and an upper G-I test (UGI). According to the record, the blood work was drawn on 11/1/12, and the US and UGI were completed on 11/7/12.

A fax date show the blood test results were sent to the facility on 11/1/12. The abnormal lab results are as follows: The blood count = Hemoglobin (hgb) - 8.81 (range 12.7-16.3), Hematocrit (hct) - 27.4 (range 37-46), White blood cells (wbc) - 8.81 (range 2.6-7.8). R5's previously recorded results from 2/2/12, show a blood count closer to normal levels = Hgb-11.4, Hct- 34.7, Wbc-5.27.
Additional abnormal lab results from 11/1/12 are an Albumin (protein) level of 2.9 (range 3.6 - 5.4) and Total Protein level of 5.9 (range 6 - 8.2). The previous Albumin and Total Protein from only 3 weeks earlier, 10/11/12, were normal. There is no documentation the physician was aware of the abnormal results, until Z4 wrote her initials and dated the test result forms on 11/29/12, the day after R5 expired.

The results of the UGI, completed on 11/7/12, state "A moderate amount of fecal matter is noted within the ascending and proximal transverse colon. ...Impression: Positive for gastroesophageal reflux."

On 11/8/12, Z4 wrote a note that she saw R5 in the Infirmary for cold symptoms, and also dated and initialed the US and UGI results, however Z4's progress note did not address R5's continuing G-I issues of n/v and constipation, nor

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did the note address the US, UGI and abnormal blood test results.

Prior to 11/8/12, on 11/2/12, a DSP had initiated another MCF stating "[R5] would not eat lunch today and seemed very tired and would not talk or respond to me. Reported to nurse (E6)." E1's written MCF response is that R5's abdomen was round and slightly firm,and that staff were instructed to monitor for bowel movement and emesis, and encourage fluids. E1 documented the next morning that R5 had vomited and was having difficulty moving his bowels. On 11/3/12, E1 notified Z1 (Primary Care Physician / Medical Director) of R5's constipation. E1 received and administered a laxative to R5.. There is no further documentation that R5's GI status was monitored, including oral intake and bowel movements (BM), especially after he had received a laxative.
The BM log sheet for the month of 11/2012 documented only two BMs for R5: 11/4 - the day after the laxative = M (medium), and 11/8 = L (large).

R5's Medication Administration Record (MAR) for 11/2012, was reviewed for his physician ordered nutritional supplement. Fourteen of nineteen days before his hospitalization, R5 did not receive his supplement.
E8 (DSP) stated on 12/5/12, at 12:30 PM, that R5 had been refusing his supplement and not drinking much because he was nauseated, but she did not, and was unsure if nursing had been informed.

E6 (RN) confirmed on 12/5/12, at 1:30 PM, the above documentation and the lack of follow up

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documentation. She said Z4 saw the US and UGI results, including "GI reflux", but did not order treatment. She said nursing should review the BM logs, and the physician should have been notified that R5's constipation continued after the laxative. E6 said she was not aware R5 had been refusing his nutritional supplement, that the DSPs should have been notifying nursing, however nursing should have noticed it on the MAR. She said R5 did not have his vital signs monitored, other than routinely which is once per month, or when seen at the Infirmary. She said DSPs were not inserviced about monitoring R5's nutritional and fluid intake, along with his bowel movements after his n/v and constipation. E6 confirmed that the blood test results were faxed to the facility on 11/1/12 and that they were abnormal, but was unsure why neither Z1 nor Z4 were notified of these abnormal results.

Z1 (Medical Director / Primary Care Physician) stated on 12/5/12, at approximately 12:30 PM, that he was not aware of the blood test results, but was aware of the US and UGI. He said that he was going to address the UGI diagnosis of GI reflux if R5 continued to have symptoms, but was not aware the symptoms continued. When asked how often he sees the residents, Z1 said if a resident is having significant problems, he sees them, otherwise Z4 (PAC) conveys residents' medical conditions to him. Z1 could not verify when he last saw R5. The record includes documentation from Z4, which is co-signed by Z1, however it lacks documentation that Z1 saw R5 since the complaints of n/v started in 6/2012. Z1 said he would expect staff to monitor R5 for BMs and notify him of constipation, especially only 2 BMs in 20 days. Z1 said staff should have

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monitored R5's nutritional and fluid intake after the complaints of n/v, and notified him of any problems.

There is no documentation that R5's nutritional / fluid intake was monitored, since he had n/v first documented in 6/2012. R5 was admitted to the hospital on 11/20/12, with diagnoses including Anemia, Dehydration and Fecal Impaction. R5 received intravenous fluids for hydration, blood transfusions for the Anemia and was manually disimpacted. The hospital chest CAT scan, dated 11/21/12, showed a "small Hiatus Hernia. [stomach]"

E4 (QIDP) stated on 12/6/12, that there had not been a special team meeting after R5 continued to have n/v, was diagnoses with Shingles, had constipation, and had respiratory problems.

3. Based on record review and interview, it was determined that the facility failed to provide adequate health care services and monitoring for 1 of 1 supplemental resident (R5) with identified,ongoing medical issues. R5 expired after being admitted to the hospital.
The facility failed to provide preventative and prompt medical treatment, along with timely and adequate health care monitoring, after R5;
e) was diagnosed with Shingles.

A MCF, initiated by DSP on 10/19/12, states, "[R5] has a rash below his buttocks." E7's MCF nursing reply stated that E7 had left messages for Z1 (physician) on 10/20/12 and 10/21/12 regarding the rash ,but Z1 did not return the call. Three days after the rash was first noted, on

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10/22/12, E6 (RN) wrote in the progress notes that she called, and spoke to Z1 regarding a blistered rash on R5's right hip and thigh. That day R5 was sent to, and discharged from, the hospital ED with a diagnosis of Shingles.
The ED sent prescriptions to the facility for antiviral medication, and for pain medication. The facility's MAR, and physician order sheets (POS), for the month of 10/2012, show the antiviral medication was transcribed and administered to R5, but the hospital prescription for pain medication was never transferred to the facility record.

On 10/25/12, Z4 (PAC) documented that she saw R5 for his new diagnosis of Shingles / Herpes Zoster. She listed R5's pain as '0' and described the rash on the right leg as scabbed with surrounding erythema (redness / inflammation). Z4's "Treatment Plan" listed R5's medications, but not the hospital ordered pain medication." Z4's note states "Follow up: prn [as needed].: Z4's Treatment Plan lacked instructions for ongoing pain assessments, contact precautions, wound care, and the hospital prescribed pain medication.

After R5's initial diagnosis of Shingles on 10/22/12, other than Z4's note, the record lacked documentation regarding this diagnosis, including monitoring of the rash and pain assessments. There is no documentation that the staff were trained to monitor R5's rash, his level of pain, or about contact isolation precautions for the Shingles rash, which is contagious at certain stages.
R5 was hospitalized one month later, on 11/20/12. According to the ED physician, and the

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hospital's wound care documentation including photographs dated 11/21/12, R5 was admitted with a diffuse rash and long scratch marks on his right buttocks and thighs.

E6 stated on 12/5/12 at 2 PM, that she was not aware of the pain medication prescription, but confirmed that the hospital had sent one to the facility. She confirmed there is no documentation that R5's rash was monitored, his pain level assessed, or DSPs trained on R5's new diagnosis of Shingles.

E4 (QIDP) stated on 12/6/12 at 10:45AM, that there had not been a special team meeting after R5 continued to have n/v, was diagnosed with Shingles, had constipation, and had respiratory problems. E4 said nursing told staff that R5's clothes should be washed separately from his room-mates because of the Shingles, but never gave or wrote further instructions.

Z1 (Medical Director / Primary Care Physician) stated on 12/5/12, at approximately 12:30 PM, that universal precautions should be used for Shingles and if the wound is covered, there is no need for additional precautions. He said the hospital ordered pain medication was not carried over to the facility because when Z4 examined R5, he did not appear to be in pain and the expectation is that staff should call if pain is apparent.

Based on observation, interview and record review the facility failed to ensure direct support staff were trained regarding identified health care needs for 1 individual in the sample, R3 and 1

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individual outside the sample, R5. R3 had a urinary collection bag and a wound. R5 had Nausea, Vomiting, Constipation, Respiratory Congestion, and Shingles.

Findings include:

Facility policies titled, "Job Description - Registered Nurse. Section 821 / Licensed Practical Nurse Section 822" requires, "2. Assists in the formulation and presentation of inservice training to other employees.

#2) "11/15/12 = [R5] brought to Infirmary by staff reporting that he refused lunch and will not drink, is congested and unable to spit outmucous. Examined: color pale, skin warm and dry, nasal congestion noted. Afebrile (no fever) at present. [No other vital signs documented] Drank 2 glasses of water with no apparent difficulty. Cough syrup given. Returned to class." There is no documentation that R5 received follow up monitoring.

E1 (Administrator / Acting Director of Nurses) confirmed the above record documentation, and lack of follow up documentation, on 12/4/12 at 2 PM.

E6 (RN) said on 12/5/12, at 1:15 PM, that she is the RN responsible for R5's home. She confirmed the record findings and the lack of follow up / monitoring documentation, regarding R5's respiratory problems.

E4 (QIDP) stated on 12/4/12, at 12 PM, that she

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and the DSPs were aware of R5's frequent coughing. She said the cough was weak and non-productive even though it sounded like he had chest congestion. E4 said she did not document her observations, or the concerns brought to her by the DSPs regarding R5's respiratory status E4 stated that the DSPs did not receive training for monitoring R5's respiratory symptoms.

On 6/18/12, a Medical Concern Form (MCF), used by the DSPs to communicate medical concerns to nursing, was completed for R5. The following is documented on this MCF, "'Nature of Concern': [R5's] been vomiting tonight. He vomits frequently." E6 (RN) documented on the MCF, "'Nursing Reply': Continue to monitor for any further vomiting. Please notify nursing. Monitor for temp."

The record lacked further documentation regarding the nausea and vomiting (n/v), including vital sign monitoring, until a second MCF was initiated on 8/24/12. The DSP wrote under "'Nature of Concern': [R5] vomited a large circle of mucous on the bathroom floor. It was clear." E7's (LPN) MCF reply was"Monitor". The record lacked documentation of any monitoring or follow up of R5's n/v until 9/20/12, when a third MCF was initiated by a DSP. The DSP wrote "[R5] vomiting tonight and last night. He vomits often. How about a gastroenterologist checking him out?"

The next documentation of this n/v concern is E6's progress note, dated almost 3 weeks later on 10/11/12, -"Chart reviewed for resident regarding frequent episodes of intermittent emesis off and on. Recvd order to refer to Digestive Diseases."

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W9999	Continued From page 85 On 11/2/12, a DSP had initiated another MCF stating "[R5] would not eat lunch today and seemed very tired and would not talk or respond to me. Reported to nurse (E6)." E1's written MCF response is that R5's abdomen was round and slightly firm,and that staff were instructed to monitor for bowel movement and emesis, and encourage fluids. E1 documented the next morning that R5 had vomited and was having difficulty moving his bowels. On 11/3/12, E1 notified Z1 (Primary Care Physician / Medical Director) of R5's constipation. E1 received and administered a laxative to R5.. There is no further documentation that R5's GI status was monitored, including oral intake and bowel movements (BM), especially after he had received a laxative. The BM log form for 11/2012 showed that R5 had only 2 BMs from 11/1 to 11/20/12. There was no documentation that DSPs notified nursing. R5's Medication Administration Record (MAR) for 11/2012, was reviewed for his physician ordered nutritional supplement. Fourteen of nineteen days before his hospitalization, R5 did not receive his supplement. E8 (DSP) stated on 12/5/12, at 12:30 PM, that R5 had been refusing his supplement and not drinking much because he was nauseated, but she did not, and was unsure if nursing had been informed. E6 (RN) confirmed on 12/5/12, at 1:30 PM, the above documentation and the lack of follow up monitoring. She said the DSPs should have notified nursing that R5 did not have regular BMs, and was not taking his supplements as ordered.	W9999		

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E4 (QIDP) stated on 12/4/12, at 12 PM, that the DSPs were not inserviced regarding R5's problems with Nausea, Vomiting, and Constipation, including what to watch for and when to call nursing.
There is no documentation that R5's nutritional / fluid intake was monitored, since he had n/v first documented in 6/2012. R5 was admitted to the hospital on 11/20/12, with diagnoses including Dehydration and Fecal Impaction.

A MCF, initiated by a DSP on 10/19/12, states, "[R5] has a rash below his buttocks." E7's MCF nursing reply stated that E7 had left messages for Z1 (physician) on 10/20/12 and 10/21/12 regarding the rash ,but Z1 did not return the call. Three days after the rash was first noted, on 10/22/12, E6 (RN) wrote in the progress notes that she called, and spoke to, Z1 regarding a blistered rash on R5's right hip and thigh. That day R5 was sent to, and discharged from, the hospital ED with a diagnosis of Shingles.

After R5's initial diagnosis of Shingles on 10/22/12, the record lacked documentation regarding this diagnosis, including monitoring of the rash and pain assessments. There is no documentation that the staff were trained to monitor R5's rash, his level of pain, or about contact isolation precautions for the Shingles rash, which is contagious at certain stages.
R5 was hospitalized one month later, on 11/20/12. According to the ED physician, and the hospital's wound care documentation including photographs dated 11/21/12, R5 was admitted with a diffuse rash and long scratch marks on his right buttocks and thighs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G350	A. BUILDING _____ B. WING _____	C 01/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS HERBSTRITT HOUSE	4003 N RTES 1 & 17, P.O. BOX 260 MOMENCE, IL 60954

(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 87	W9999		

E6 confirmed on 12/5/12 at 2 PM, there is no documentation that R5's rash was not monitored, his pain level assessed, or DSPs were trained on R5's new diagnosis of Shingles.

E4 (QIDP) stated on 12/4/12, at 12 PM, that staff were not trained regarding R5's Shingles, including monitoring for pain and wound precautions. E4 said nursing only had said R5's clothes should be washed separately.

2) According to the clinical record, R3 is a 60 year old male with multiple medical diagnoses including Cardiomyopathy, Mild Mitral Valve Prolapse, Alzheimer's, and Venous Stasis Dermatitis. R3 functions in the Severe range of Intellectual Disability. R3 has been hospitalized four times in 2012, twice in October. R3 requires oxygen per nasal cannula and wound care for decubitus, R3 has a catheter to remove the urine from his body. R3 is treated for decubitus at a local wound care clinic.

Z2, wound care physician, was interviewed on 12/6/12 at 9:50 a.m. Z2 said the decubitus problems with R3 are not avoidable. Z2 said prevention and treatment are important.

Surveyor observed R3 in the infirmary on 12/14/12 at 2:15 p.m. R3's decubitus to the left lower buttocks was covered with a wafer dressing. R3 had a catheter in place; urine was collected in a drainage bag.

Surveyor interviewed E5, Direct Support Person (DSP) on 12/5/12 at 7:55 a.m. E5 said we use protective ointment on him. He gets repositioned

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	14G350	A. BUILDING _____ B. WING _____	C 01/03/2013

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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
W9999	Continued From page 88 every 2 hours. We call the nurses if there is a problem with the wafer dressing. Surveyor reviewed the written training information provided to staff in the home, there are no specific instructions related to the care of the decubitus ulcer in the buttocks area. The training information was provided to staff in April 2012 when R3's pressure ulcer was on his foot. There is no training information for staff related to the urinary catheter. E6, Registered Nurse (R.N.) was interviewed on 12/6/12 at 1:15 p.m. E6 said she was not aware of staff training related to the skin issues in the buttocks area. E6 was also interviewed on 12/11/12 at 9:55 a.m. E6 said staff are given verbal instructions related to the urinary catheter. E4, Qualified Intellectual Disability Professional, was interviewed on 12/6/12 at 9:25 a.m. E4 said there is no facility policy for wound care. (B)	W9999		