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WOODSTOCK RESIDENCE	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Investigation of Complaints 0674232/IL25307-F222, F223, F224, F225, F309, F329, F431, F490, F492, F514. 0870179/IL32920- F222, F223, F224, F225, F309, F329, F431, F490, F492, F514 An extended survey was conducted.	F 000		
F 159 SS=B	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each	F 159		5/1/08

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to notify residents who receive Medicaid benefits when the amount in the resident's account reached $200.00 less than the $2000.00 Social Security resource limit, thereby putting residents at risk for losing their Medicaid or Social Security Income benefits. This is for 2 residents (R20, R21) out of 63 for which the facility handles funds. The example includes: Review of the facility's Resident Trust (as of 2/19/08) shows that R20 has a total of $1,979.93	F 159		

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F 159	Continued From page 2 and R21 has a total of $2,352.15 in their personal fund accounts. E8- A(Business Manager) was interviewed on 2/21/08 at 1:35 PM. E18-A confirmed that R20 and R21 are Medicaid recipients. E18-A stated that there is no formal way to notify residents or their families when their accounts come close to the $2000.00. E18-A stated that R20 and R21 were not notified when their account was at $1800.00.	F 159		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to: 1. make the survey result readily accessible, 2. have available the results of most recent survey. The examples include: During the three days of survey, the binders with the survey results were kept on the top shelf of the nursing bookcase. The surveyors had to ask	F 167		5/1/08

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F 167	Continued From page 3 the nurses for the binder containing the survey result. The most recent survey in the binder was dated 3/31/05 and this was confirmed by E15 (Nurse) on 2/21/08 at around 2:15 pm. E1 (Administrator) was interviewed on 2/22/08 at around 10:45 am. E1 stated that the survey result can be viewed at both nursing stations.	F 167		
F 222 SS=G	483.13(a) CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation of R32, the facility failed to assure that a resident is not given psychotropic medications without a medical reason, and for the purpose of staff convenience, for one resident outside the sample. (R32) The staff action of giving a combination of Ativan without MD order, and Seroquel outside the scheduled order resulted on R32 having a fall with injury and hospitalization. Findings include: 1. R32 has diagnoses of Olivopontocerebellar Degeneration with narcolepsy, Neurogenic Bladder, Degenerative Arthritis, History of Depression, Agitation. R32's medication order include Seroquel 25 mg P.O. at HS(hours sleep), Trazodone tab 50 mg twice a day. Care plan reflects reason for medication was due to his	F 222		5/1/08

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F 222	Continued From page 4 diagnosis of Olivopontocerebellar Degeneration with narcolepsy. No medical reason provided for the use of Antipsychotic medication. Nurse's note written by E9 (nurse) on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won't dilate. Res will respond by squeezing my hand.(Z5)nurse practitioner, notified" R32 was then sent to the hospital for evaluation. During interview 2/20/08, E9(nurse) indicated that R32 did fall down and his neuro checks were irregular -particularly his eyes. E9 remembered E14(day shift nurse) stating that she (E14) had given R32 a "cocktail and that he would not be bothering her during her shift." She called E14 at home to find out what exact medication was given to R32 during the day shift that made R32 fall. E14 admitted to giving R32 Ativan (amount not provided), Risperdal, and Seroquel 25 mg tablet scheduled for 9 PM earlier than ordered. E9 reported this to Z5 , the practitioner nurse for E4.(medical director, attending physician) E9 stated that Z5 got very upset because she was not called that date about any problem regarding R32, and stated that she never gave an order for Ativan, Risperdal and an extra dose of Seroquel. R32 was sent to the hospital for irregular vital signs and abnormal neurological signs evident after medication administration. During interview, E9 indicated that after E14's shift, residents who staff usually identified as	F 222		

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F 222	Continued From page 5	F 222		

restless or agitated would be calm or sleeping /sedated after E14's shift. E6 (nurse) and E 12 (nurse)also voiced the same concern about E14's care of residents during their interview. Both indicated that resident who would normally be restless or agitated were usually observed quiet or sedated after E14's shift.

Review ISP(Illinois State Police) interview of E13 on 10-26-06 reflect :"E13 (nurse) was working with E14 the day R31 died, but did not witness E14 dispense medication to the resident. E13 recalled she was out back of the facility smoking with E14 at approximately 9:00 am. E13 related that E14 told her she gave R31 morphine. E13 thought this was strange because R31 did not need any morphine. E13 stated that E14 told her," she wont make it through the day. I made sure of that." During interview with surveyors, E13 acknowledge the accuracy of the ISP interview. She had indicated that E14 came to her area that day and helped her give R31's medication and told her (E13) that R31" won't bother her the rest of the day." E13 stated that E14 often told staff that she had used "medication cocktails" such as the one given to R32, to control residents who are difficult to care for or restless, to have a quiet shift.

ISP interview of E12 on 10-29-06 also indicated: E12 went to say, it appeared that the residents" who were trouble with behavior and extra work always seemed to be the ones dying in the facility."
On interview 2/28/08, E12 clarified the above statement stating E14 used "Morphine and medication such as Ativan and other psych medications to control residents, keep them quiet for her shift at the nursing home".

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F 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE	F 223		4/7/08

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to protect residents receiving end of life care, from abuse due to the use of the controlled medication liquid Morphine Sulfate. E14 a nurse, made repeated negative statements to her peers about hastening the death of residents receiving end of life care. Morphine Sulfate was given without an order, or was not administered within the prescribed parameters (dosage/timing). These failures contributed in 5 suspicious deaths related to the use of liquid Morphine Sulfate from 4/2/06 to 9/18/06.

This abuse applies to 5 of 6 residents receiving end of life care (R27, R28, R29, R30, R31).

These Failures resulted in an Immediate Jeopardy that was identified on 4/4/08 and began on 4/2/06 when R27 expired. Immediate Jeopardy was called on 4/4/08 to E1. The Immediacy was removed on 10/31/06 when E14 was removed from duty at the facility by recommendation of the Illinois State Police.

The examples include:
1. R27, a 56 year old male, had diagnoses of Down's Syndrome, Seizure Disorder, Dysphagia,

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Parkinson's Disease, Depression and Shy Drager Syndrome per the facility's Admission Face Sheet dated 3/28/06. The Minimum Data Set (MDS) of 7/8/05 shows that R27 had short and long term memory deficits and was severely impaired in his ability to make decisions. R27 was totally dependent on staff for all activities of daily living.

R27's Doctor's Telephone Orders dated 3/28/06 state, "Admit to Hospice, add Roxanol 5 - 10 mg PO (By Mouth) PRN (As Needed), Ativan 0.5 mg every 4 -6 hours PRN for restlessness."

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 reported that E14 (LPN) said, "Those people aren't meant to live that long. They are meant to die in their teens and I'm going to help him along." The report further states, "E6 recalled that approximately forty-five minutes later, she observed E14 leaving R27's room after med pass. E6 thought this was odd because R27 should not have been given any Morphine for at least another hour and a half....E6 said that she compared the narcotics book with R27's Morphine bottle. E6 explained that the amount remaining in a morphine bottle could be determined by lines along the bottle. E6 put forth that she discovered that 160 mg of Morphine was missing."

On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 4/2/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

Nurse's Notes dated 4/2/06 at 11:50 AM, document that R27 was observed to be without

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F 223	Continued From page 8 pulse or respirations. 2. R28, a 78 year old female, has diagnoses of Cardiac Dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension, and Dementia per the Medication Administration Record for September 2006. The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). The report states, "E6 recalled R28 suffered from Dementia, was easily agitated, and would often hit people. E6 stated she came to the facility on Saturday, and had a conversation with E14 (LPN) in the smoking area. According to E6, E14 told her, R28" is going to die in half an hour." E14 then told E6 that she had given the resident 30 mg of Morphine. When E14 noticed the shocked expression on her (E6) face, E14 later said that she gave her 20 mg..." E6 further states in the report, E7 (RN) took over the care of R28 that night. E6 professed that E7 did not dispense any Morphine to R28 because she was unconscious at that time....E6 stated she determined that one Morphine bottle belonging to R28 had 160 mg of Morphine missing....E6 stated she knew that E14 was overheard bragging about over-medicating R28 in the smoking area in the back of the facility on that Saturday and Sunday. E6 explained E12 (LPN) and other CNA's overheard E14 state clearly," I can't believe she's still alive with all the Morphine I've given her." On 2/21/08 at 10:00 AM, E7 (RN) confirmed that she did not need to give R28 Morphine during the night 9/9/06 because she was not restless or short of breath.	F 223		

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On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/9/06 and 9/10/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

R28's undated Controlled Substance Sign Out Sheet documents that R28 was to receive Morphine 10 mg sublingual every 2 hours as needed.

Nurse's Notes dated 9/9/06 at 11:30 PM, state, "Resident (R28) unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea..."

Nurse's Notes dated 9/10/06 at 8:00 AM, document that E14 gave R28 Morphine while having agonal (associated with death) respirations with 30 to 40 sec periods of apnea. At 10:00 AM E14 documents that there was no change in R28's condition and another dose of Morphine was administered to the resident with the same medical status. At 12:28 PM on 9/10/06 the resident is found to have no pulse or respirations.

3. R29, a 52 year old male, had diagnoses of Liver Cirrhosis, Liver Cancer, Hepatitis C, and Ascites per Physician's Orders for September 2006. The Physician Orders dated 9/17/06 documents that R29 may receive Morphine Sulfate 10 - 20 mg sublingual every 4 hours prn (as needed) and Ativan 1 - 2 mg sublingual every 4 hours prn.

Nurse's Notes dated 9/17/06 at 2:00 PM show that R29 was up in his wheel chair for lunch. R29

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complained that he was in extreme pain. E14 documented that R29 was assisted back to bed and orders were received for a comfort pack (Morphine Sulfate and Ativan). E14 documents that she administered Morphine Sulfate with relief obtained. Nurse's Notes dated 9/17/06 at 3:00 PM less than 1 hour after dose, document that R29 was not responding at this time. At 7:00 PM R29 remained unresponsive with no response to verbal or painful stimuli. R29 was not breathing for 10 seconds and then would let out a long sigh. Review of R29's Nurse's Notes show that R29 never regained consciousness until his death on 9/18/06 at 6:30 PM.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 stated, "R29 a resident suffering from liver failure, had just been put on Hospice. E6 indicated that R29 had been sitting upright in his wheel chair, was alert, and was even smoking. E6 stated E14 (LPN) gave him (R29) his first dose of Morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered the Morphine. E6 indicated that she later discovered that 40 mg of Morphine was missing..."

On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/17/06 and 9/18/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

4. Two other residents died in the facility after receiving liquid Morphine Sulfate (R30 and R31) per the Illinois State Police Investigative Summary (Synopsis) dated 12/12/06. R30 received an order dated 8/14/06 for Roxinal liquid

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(Morphine) 10 to 20 mg sublingual every 2 hours as needed. An order for Morphine was received at 1:51 PM from R30's physician. At 6:50 PM, R30 was found to have no pulse or respirations. The Illinois State Police Investigative report dated 7/10/07 documents that E14 approached E2 (Director of Nursing) and stated that R30 was just prescribed Morphine but it had not been delivered from the pharmacy yet. E2 instructed E14 to use Morphine from a deceased resident(R31) who expired on 4/8/06. There was no documentation in R30's chart showing R30 received Morphine. The bottle of Morphine that was given to E14 could not be found the day after R30 expired.

R31 died on 4/8/06. The Illinois State Police Investigative Report dated 10/31/06 documents an interview with E13 (LPN). 'E13 related that E14 told her that she gave R31 Morphine. E13 explained that R31 was already unconscious, and could not be in any pain. E13 put forth that E14 then told her, "She won't make it through the day. I made sure of that." E13 indicated R31 died at noon that day.'

On 2/22/08 at 12:40 PM, E13 confirmed that the events of 4/8/06 and 8/14/06 as documented on the Illinois State Police Investigative Report were accurate. E13 also stated that E14 would boast making statements like, "I will make sure they get enough medications to be gone, I will take care of it." E13 said that she made E2 (DON) and E3 (ADON)aware of her concerns about E14's care of R27 on 4/3/06. E13 stated, "When I told E2 (DON) she giggled. She(E2) then went to E14 and said" I do not care if you play the angel of death, just don't let me know about it." E14 (LPN) was allowed to work in the facility as a

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F 223	Continued From page 12 nurse until 10/31/06 with no investigation regarding the allegations made over medication overuse and abuse made by other staff. The facility's undated Abuse Investigation and Reporting Policy and Procedure states, "Employees who have been accused may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed." The facility took the following steps to correct the Immediate Jeopardy which resulted in a lowered scope and severity level of 2, due to the need for time to evaluate effectiveness of new policy and procedures, allow time for additional training and inservicing as needed. Corrective action for F223: 1. Residents affected have since expired. 2.As of 4/5/08, each staff member has been surveyed prior to their shift to ensure potential abuse and neglect has been identified, reported and investigated. (see Attachment A) Director of Operations and Nurse Consultant will assure facility compliance regarding abuse and neglect. On 4/4/08 a walking round was performed by Acting DON and each resident assessed for signs/symptoms of over medication from psychoactive and pain medication. 3. Director of Nursing has been removed from her position, and qualified Registered Nurse has assumed the position of Acting Director of Nursing. The Administrator and Acting DON were in serviced by Contracted Nurse Consultant on 4/5/08 on regulations, facility policy and procedures for identifying, investigating, reporting events to IDPH and safeguarding residents from abuse during ongoing investigations. (see	F 223		

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F 223	Continued From page 13 Attachment B) As of 4/5/08, each staff member has been required to attend in service prior to beginning scheduled shift. Staff also inserviced on communicating unresolved issues, reporting all abuse and neglect , management concerns to Director of Operations. The Director of Operations will evaluate facility response to staff concerns to ensure prompt identification. (See Attachment C). Staff was also in serviced on communicating unresolved system issues, potentially abusive/ neglectful issues to Director of Operations. The Director of Operations will evaluate response to staff concerns. Director of Operations will conduct monthly meeting with staff for a minimum of 3 months. Daily monitoring meetings has been restructured to elicit concerns from Department Staff to include IDT review for potential abuse. Full investigation will start for all allegations of abuse and IDPH will be notified. Implemented on 4/7/08 a daily report will be completed by Administrator and submitted to Director of Operations for review. Director of Operations will review the morning meeting minutes and audit investigations to assure investigation and safeguard of residents done and notification of regulatory agencies. In addition, Director of Operations will interview 5 staff members bi weekly to ascertain if reported issues were addressed appropriately by management staff. Appropriate disciplinary action will occur when warranted 4. Audit findings will be submitted to QA Committee for 90 days. A monthly report regarding all abuse/neglect allegations submitted to QA for review ongoing basis. 5. Effective date: April 7, 2008.	F 223		
F 224 SS=K	483.13(c) STAFF TREATMENT OF RESIDENTS	F 224		4/7/08

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F 224	Continued From page 14 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected to: Initiate and conduct a complete and thorough investigation after allegations were made against a staff nurse working at the facility (E14, LPN)on 4/3/06; Protect other residents from possible injury/abuse related to the misuse of Morphine Sulfate during end of life care; Assess the need for, and monitor residents receiving Morphine Sulfate on a PRN basis (as needed) during end of life care; Ensure that there is an accurate account of all controlled medications to identify loss or diversion of controlled medications; Notify local law enforcement of possible criminal activity involving the potential missuse of narcotic medications by (E14 LPN); Ensure that medications administered to residents timely and have been ordered by a physician. This systemic neglect began on 4/3/06 when E13 (LPN) made E2 (DON) aware of E14's use of liquid Morphine Sulfate in the death of R27 on 4/2/06. Between 4/8/06 and 9/18/06 there were four other deaths related to the use of Morphine Sulfate (R28, R29,R30and R31). There was approximately 5 months between the time E13 reported her concerns about E14 (LPN) to E2 (DON) and R29's death on 9/18/06. On 9/30/04	F 224		

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during the day shift E14 gave R32 an undetermined amount of Ativan without a physician's order along with the scheduled PM dose of Seroquel 25 mg. On 9/30/06 R32 fell out of his wheel chair and sustained abrasions to his face and head on the evening shift. R32 was sent to the hospital for evaluation and treatment.

These areas of neglect apply to 5 of 6 residents receiving end of life care (R27, R28, R29, R30, and 31) and one resident who was administered a medication without a physician's order (R32).

These failures resulted in an Immediate Jeopardy that was identified on 4/4/08 and began on 4/3/06 when E2 was made aware of E14's suspicious use liquid Morphine Sulfate. Immediate Jeopardy called on 4/4/08 to E 1. The Immediate Jeopardy was removed on 4/7/08
The examples include:

1. R27, a 56 year old male, had diagnoses of Down's Syndrome, Seizure Disorder, Dysphagia, Parkinson's Disease, Depression and Shy Drager Syndrome per the facility's Administration Face Sheet dated 3/28/06.
R27's Doctor's Telephone Orders dated 3/28/06 state, "Admit to Hospice, add Roxianol 5 - 10 mg PO (Morphine Sulfate By Mouth) PRN (As Needed), Ativan 0.5 mg every 4 - 6 hours PRN for restlessness." R27 died at the facility on 4/2/06.
Nurse's Notes dated 4/2/06 at 11:50 AM, document that R27 was observed to be without pulse or respirations.

On 2/22/08 at 12:40 PM E13 (LPN) stated, "I told E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on 4/3/06 about my concerns

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with E14's (LPN) administration of liquid Morphine to R27 on 4/2/06. I know I went to them at least 3 times with my concerns." E13 confirmed that she was never questioned by E1 (Administrator), E2 (Director of Nursing), or E3 (Assistant Director of Nursing) about her concerns. E13 said that she was never asked to write a statement documenting her concerns about E14. E13 said that after another resident, R30, died on 9/18/06 she went to them (E1 and E2) a third time and voiced her concerns.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 also reported that E14 (LPN) said, "Those people aren't meant to live that long. They are meant to die in their teens and I'm going to help him along." The report further states, "E6 recalled that approximately forty-five minutes later, she observed E14 leaving R27's room. E6 thought this was odd because R27 should not have been given any Morphine for at least another hour and a half....E6 said that she compared the narcotics book with R27's Morphine bottle. E6 explained that the amount remaining in a morphine bottle could be determined by lines along the bottle. E6 put forth that she discovered that 160 mg of Morphine were missing."

The Illinois State Police Investigative Summary (Synopsis) dated 12/12/06 documents that between 4/8/06 and 9/18/06 four other residents died in the facility while receiving liquid Morphine Sulfate (R28, R29, R30, and R31).

Facility Incident Investigation Reports from 2006 to present were reviewed on 2/20/06. There was

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no documentation of investigations being conducted concerning the alleged abuse of liquid Morphine in the deaths of R27, R28, R29, R30, and R31.

During interviews conducted from 2/20/08 to 2/28/08 confirmed that E6 (LPN), E7 (RN), E8 (LPN), E9 (LPN), E10 (CNA), and E12 (LPN) were never questioned about E14's use of Morphine for residents during end of life care. All said that they were never asked about missing Morphine Sulfate or how it was to be administered to residents near end of life. E6, E9, E12, and E13 said that they talked to E1, E2, or E3 numerous times between 4/3/06 and 9/18/06 about concerns with E4's administration of liquid Morphine Sulfate to residents.

On 2/21/08 at 11:20 AM, E1 (Administrator) said that she was never made aware of any staff suspicions concerning E14 overdosing residents with liquid Morphine. E1 confirmed that no investigations were ever conducted concerning E14's alleged misuse of Morphine. E1 denied having any knowledge of E14's alleged misuse of Morphine Sulfate until 10/31/06 when the State Police entered the building. E1 confirmed that E14 was allowed to work in the facility as a nurse until 10/31/06.

On 2/26/08, E6 confirmed her interview with the ISP was accurate and restated that at 6:30 AM she had given R27 10 mg of Morphine. She said that she told E14 this on report during the shift change and that she specified the time the Morphine was given to E14. After the report, she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine on her hand. E6 stated

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that before she left, R27 was breathing normally without difficulty with respirations.

The Nurse's note on 4-2-06 at 7 am by E14, state, "Resident observed with rapid resp. abd. (abdominal) Very congested. PO2 86 on 4 liter O2. per mask.Morphine given."

With R27 displaying identified congestion and low PO2 while in Oxygen, E14 gave the Morphine. The Morphine was ordered to be given every two hours for pain or Dyspnea and E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 said that she emphasized this in her report.

On 2/22/08 at 12:40 PM, E13 confirmed that the events of 4/8/06 and 8/14/06 as documented on the Illinois State Police Investigative Report were accurate. E13 also stated that E14 would boast making statements like, "I will make sure they get enough medications to be gone, I will take care of it. E13 said that she made E2 (DON) and E3 (ADON)aware of her concerns about E14's care of R27 on 4/3/06. E13 stated, "When I told E2 (DON) she giggled. She then went to E14 and said I do not care if you play the angel of death just don't let me know about it." E14 (LPN) was allowed to work in the facility as a nurse until 10/31/06

2. R28, a 78 year old female, had diagnoses of Cardiac Dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension, and Dementia per the Medication Administration Record for September 2006.

The Illinois State Police Investigative Report

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F 224	Continued From page 19 dated 10/30/06 documents an interview with E6 (LPN). The report states, "E6 recalled R28 suffered from Dementia, was easily agitated, and would often hit people. E6 stated she came to the facility on Saturday, and had a conversation with E14 (LPN) in the smoking area. According to E6, E14 told her, R28 is going to die in half an hour. E14 then told E6 that she had given her 30 mg of Morphine. When E14 noticed the shocked expression on her (E6) face, E14 later said that she gave her 20 mg..." E6 further states in the report, "E7 (RN) took over the care of R28 that night. E6 professed that E7 did not dispense any Morphine to R28 because she was unconscious....E6 stated she determined that one Morphine bottle belonging to R28 had 160 mg of Morphine missing....E6 stated she knew that E14 was overheard bragging about over-medicating R28 in the smoking area in the back of the facility on that Saturday and Sunday. E6 explained E12 (LPN) and other CNA's overheard E14 state, I can't believe she's still alive with all the Morphine I've given her." On 2/21/08 at 10:00 AM, E7 (RN) confirmed that she did not need to give R28 Morphine during the night 9/9/06 because she was not restless or short of breath. On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/9/06 and 9/10/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate. R28's undated Controlled Substance Sign Out Sheet documents that R28 was to receive Morphine 10 mg sublingual every 2 hours as needed.	F 224		

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Nurse's Notes dated 9/9/06 at 11:30 PM, state, "Resident (R28) unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea..."

Nurse's Notes dated 9/10/06 at 8:00 AM, document that E14 gave R28 Morphine while having agonal (associated with death) respirations with 30 to 40 sec periods of apnea. At 10:00 AM E14 documents that there was no change in R28's condition and another dose of Morphine was administered. At 12:28 PM the resident is found to have no pulse or respirations.

During the night shift (11-7 am) between 9-9-06 to 9-10-06 documentation shows no Morphine was given to R28. On 2-21-08, E7 said that at the end of her shift she had given report to E14 regarding R28. She stated that E14 was very upset that R28 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. She stated that she had told her that R28 did not need Morphine as she was unresponsive and not in pain. An ISP interview dated 1-18-07 reflects "E7 recalled E14 told her that she should have given the Morphine anyway." E7 repeated that she had assessed the resident even before leaving to see how she (R28) was, as she knew E14 was going to report her. E7 indicated that her assessment before she left showed R28 was stable but unresponsive and not in pain.

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3.R29, a 52 year old male, had diagnoses of Liver Cirrhosis, Liver Cancer, Hepatitis C, and Ascites per Physician's Orders for September 2006. The Physician Orders dated 9/17/06 documents that R29 may receive Morphine Sulfate 10 - 20 mg sublingual every 4 hours prn (as needed) and Ativan 1 - 2 mg sublingual every 4 hours prn.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 stated, "R29 a resident suffering from liver failure, had just been put on Hospice. E6 indicated that R29 had been sitting upright in his wheel chair, was alert, and was even smoking. E6 stated E14 (LPN) gave him (R29) his first dose of Morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered the Morphine. E6 indicated that she later discovered that 40 mg of Morphine was missing..."

On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/17/06 and 9/18/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

R29 was admitted to the facility on 9/15/06 with diagnoses of Alcohol Abuse, Liver Cancer and Cirrhosis and was on palliative care on admission. The discharge chart from the previous facility included a copy of the Physician's Order Sheet that showed R29 was not on any type of pain medication and he was not complaining of any pain. R29's initial admission orders did not include any pain medication.

Nursing Notes shows R29 was not complaining

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of any pain or discomfort until he came back from lunch on 9/17/06. R29 then went back to bed. E14, the nurse taking care of R29, charted on 9/17/06, "Complaining of extreme pain so returned to bed. Orders rec'd from Registered Nurse Practitioner (RNP) for comfort pack of 10 milligrams (mg) Morphine Sulfate (MSO4) given with relief obtained. Resting comfortably".

The Illinois State Police (ISP) report dated 11/15/06, on page 00036, documented the interview of Z5, R29's sister who was visiting at the time of the incident. In the interview Z5 stated that she went to the nurse's station and told a nurse that R29 needed pain medication. The nurse replied that there was no physician order for Morphine. Z5 said that a different nurse came into the room and gave R29 Tylenol. Z5 went to the nurse's station to ask for another type of medication 3 times. On the third time, E14 said she didn't need a physicians order to give him Morphine. Z5 then witnessed E14 dispense morphine orally to R29. Z5 said that R29 became unconscious.

E4, the medical director and MD for R29, was interviewed on 2 /21/08. He said that as the Director, he would expect a pain assessment to be made before calling MD. There was no pain assessment protocol in the facility and no pain assessment was documented. E4 was informed of R29 being given Morphine Sulfate (on 9/17/06) and was not responsive after thirty minutes. E4 stated that he did not order any schedule II medication for that resident, as R29 is on another hospice agency and would be covered by their hospice doctor. E4 was informed that the Morphine order for R29 was signed as a telephone order from Z3, the nurse practitioner,

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with E4's name on it. He said that the facility would call him or Z3 if they couldn't ' reach the regular hospice doctor . He would only order minor pain medications for a resident he has not seen and give a one time order only. E4 stated he did not see R29 and would not order pain medication such as Morphine for him. E4 explained that R29's non responsiveness was either an adverse reaction to medication or a medication error such as higher dose was given than what was ordered. E4 denied being called about R29's change of condition. E4 indicated that he would have ordered the facility to send R29 to the hospital for evaluation. E4 also said that with a change of condition after initial dosing, Morphine should not have been given it was neglect. E4 was asked, if the facility continued to give the doses of Morphine with R29's condition, how long would it take before a person would expire. E4 replied that with the continued use every two hours or so, one would see an adverse effect such as a resident's demise in about 8 hours.

4.R32 has a diagnosis of Olivopontocerebellar Degeneration. The Nurse's note on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won ' t dilate. Res will respond by squeezing my hand. Z3 notified." R32 was sent to the hospital for evaluation.

On 2/20/08, E9 confirmed that R32 did fall down and his neuro checks were irregular particularly his eyes. She stated that she remembered E14

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F 224	Continued From page 24 during the 7-3 pm end of the shift report stating that she (E14) had given R32 a cocktail and that R32 would not be bothering her (E9) during her shift. She called E14 at home to find out what medication she gave R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided) and Seroquel 25 tablet scheduled for 9 PM. E9 then reported this to Z3, the nurse practitioner for E4. E9 stated that Z3 got very upset that she was not called about any problem for R32 and that she never gave order for Ativan and an extra dose of Seroquel. R32 was sent to the hospital due to his unstable vital signs. Two other residents died in the facility after receiving liquid Morphine Sulfate (R30 and R31) per the Illinois State Police Investigative Summary (Synopsis) dated 12/12/06. 5.R30 received an order dated 8/14/06 for Roxinal liquid (Morphine) 10 to 20 mg sublingual every 2 hours as needed. An order for Morphine was received at 1:51 PM from R30's physician. At 6:50 PM, R30 was found to have no pulse or respirations. The Illinois State Police Investigative report dated 7/10/07 documents that E14 approached E2 (Director of Nursing) and stated that R30 was just prescribed Morphine but it had not been delivered from the pharmacy yet. E2 instructed E14 to use Morphine from a deceased resident R31 who expired on 4/8/06. There was no documentation in R30's chart showing R30 received Morphine. The bottle of Morphine that was given to E14 could not be found the day after R30 expired. 6.R31 died on 4/8/06. The Illinois State Police Investigative Report dated 10/31/06 documents	F 224		

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an interview with E13 (LPN). 'E13 related that E14 told her that she gave R31 Morphine. E13 explained that R31 was already unconscious, and could not be in any pain. E13 put forth that E14 then told her, "She won't make it through the day. I made sure of that." E13 indicated R31 died at noon that day.'

On 2/22/08 at 12:40 PM, E13 confirmed that the events of 4/8/06 and 8/14/06 as documented on the Illinois State Police Investigative Report were accurate. E13 also stated that E14 would boast making statements like, "I will make sure they get enough medications to be gone, I will take care of it." E13 said that she made E2 (DON) and E3 (ADON)aware of her concerns about E14's care of R27 on 4/3/06. E13 stated, "When I told E2 (DON) she giggled. She then went to E14 and said I do not care if you play the angel of death just don't let me know about it." E14 (LPN) was allowed to work in the facility as a nurse until 10/31/06

The ISP (Illinois State Police) investigative reports from 10/26/2006 to 1/10/2007 had interviews of E6, E7, E8, E9, E12 and E13. These staff consistently stated that during the period of April 2006 until end of September 2006, extra bottles of Morphine Sulfate prescribed for residents who had expired were available and stored in the Narcotic box of the 200 wing. E6, E9, E12 and E13 all said that there were extra bottles of Morphine that belonged to residents who had died and were kept either in the locked narcotic box in the medication carts or were kept in a drawer in E2's office. All four stated that the narcotic medication should have been disposed of with two nurses witnessing. The bottles were kept per the instruction of E2, DON, in case

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another resident would need it. E8 stated that if a resident with a narcotic order died on the weekend, they would keep it in the locked boxes in the med cart. Then the narcotic would be brought to the DON's office where they were locked or left at her desk. E8 was not sure what happened when they were left in the DON's office.

ISP interview of E3, ADON, on 11/02/06 reflect: E3 was asked if E2 had been storing extra Morphine at the facility. E3 replied "yes" and stated E2 wanted the Morphine kept, " Just in case somebody needs it". E3 went on to say, the Morphine was not in the narcotics book... " . E3 explained that on 10-30-06, two bottles of Morphine, one bottle of Ativan, an unknown amount of Risperdal and an unknown amount of Vicodin were destroyed. E3 indicated that one of Morphine bottles belonged to R28 who expired on 9-28-06. The destruction of the medication only came about when E3 stated that the facility knew the State Police were coming.

During interview, E6, E9, E12 and E13 validated that before the state police started investigating, Controlled Substances, particularly the Morphine, were not destroyed as their standard of practice indicated but were saved according to the instructions of the DON. All indicated that the practices of destroying controlled substances were implemented after the state police started investigating the residents using Morphine.

ISP interview of E3 also reflect that E6 had brought to her (E3) attention a bottle of Morphine that had a different color and that E6 felt that there was a cover up. E3 recalled that it was after the death of R28. E3 then dumped the

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F 224	Continued From page 27 questionable Morphine in the toilet but did not investigate the allegation. ISP documentation of investigation reflects that on 11-02-06 reflect the facility continued to have extra bottle of Morphine kept in the medication cart of the 200 wing. During initial tour on 2-19-08, the medication cabinet of the 200 wing still had a bingo card containing Lorazepam 0.5 mg tablets belonging to a resident that has been discharged more than a month and the 400 wing contained a Lorazepam liquid being stored in the medication room since 6-6-06 Review of the Change of Shift Controlled Substance and Narcotic count reflect that Aug and Sept 2006 narcotic count were not consistently done on every end of each shift and in many shift, only one nurse charted. Review of the last three months of narcotic counts, Dec 2007 to Feb 2008 still showed the counts are not done at the end of each shift and/or by the oncoming and outgoing nurses. The pharmacy review records reflect no problem with the use of Morphine Sulfate and other drug regimens of residents even though there was no consistent documentation of any monitoring for side effects, the presence of side effects or the effectiveness of the pain medication. The pharmacy did not also see the irregularities in signing off on the Morphine count for R31 when 2 doses were signed out but only one dose was documented as given. The pharmacy came in to review all the charts for any irregularities in their drug regimen but did not identify any problems such as the change of condition on R29 resulting	F 224		

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from Morphine being given on an initial dose.

The facility was unable to provide any documentation showing that the local police were ever informed of E14's alleged misuse of Morphine Sulfate for resident's receiving end of life care. On 2/21/08 at 12:10 PM E1 (Administrator) confirmed that the police were never notified about any allegation concerning E14 (LPN). The facility was unable to provide a policy and procedure on when local law enforcement is to notified.

The facility's undated Policy and Procedure entitled Reporting Abuse to Facility Management states, "The administrator and director of nursing services must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and director of nursing services must be called at home or must be paged and informed of such incident. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: The State licensing/certification agency responsible for surveying/licensing the facility; The local/State Obudsman; The resident's representative (Sponsor) of record; Adult Protective Services; Law Enforcement Officials; The resident's attending physician; and the facility's Medical Director."

The facility's undated Policy and Procedure on Abuse Investigation and Reporting states, "Neglect is defined as failure to provide goods and services necessary to avoid phyisical harm, mental anguish, or mental illness....When an

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F 224	Continued From page 29 incident or suspected incident occurs, the Administrator will appoint a management member to investigate the allegation. The individual conducting the investigation will, at a minimum: Review the completed resident abuse report; Review the resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witness to the incident; Interview the resident if appropriate; Interview the resident's attending physician to determine the current mental status of the resident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care and services; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; and Review all events leading up to the alleged incident....While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents. Employees who have been accused may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed." The Facility's undated Policy and Procedure entitled Controlled Substance Discontinuation and Destruction states, "When a controlled substance is discontinued, the remaining medication should be sent to a designated area within the facility. They must be stored in a double locked container until destruction can be completed. The narcotics sign out sheet must accompany the medications to the designated area for all Schedule II medications and any Schedule III, IV, or V if determined by facility policy. Any discrepancy noted between	F 224		

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medication count and count on sign out sheet should be reported immediately to the Director of Nursing."

The facility took the following steps to correct the Immediate Jeopardy which resulted in a lowered scope and severity of level 2 due to the need for evaluating all new policies and procedures put into place by facility , effectiveness and evaluate of implemented plan .

Corrective Action for F224

1. Residents affected have since expired.
2. As of 4/5/08, each staff member has been surveyed prior to their shift to ensure potential abuse and neglect has been identified, reported and investigated. (see Attachment A)
Director of Operations and Nurse Consultant will assure facility compliance regarding abuse and neglect. On 4/4/08 a walking round was performed by Acting DON and each resident assessed for signs/symptoms of over medication from psychoactive and pain medication.
3. Director of Nursing has been removed from her position, and qualified Registered Nurse has assumed the position of Acting Director of Nursing. The Administrator and Acting DON were in serviced by Contracted Nurse Consultant on 4/5/08 on regulations, facility policy and procedures for identifying, investigating, reporting events to IDPH and safeguarding residents from abuse during ongoing investigations. (see Attachment B)
As of 4/5/08, each staff member has been required to attend in service prior to beginning scheduled shift. Staff also disservice on communicating unresolved issues, reporting all abuse and neglect , management concerns to

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F 224	Continued From page 31 Director of Operations. The Director of Operations will evaluate facility response to staff concerns to ensure prompt identification. (See Attachment C). Staff was also in serviced on communicating unresolved system issues, potentially abusive/ neglectful issues to Director of Operations. The Director of Operations will evaluate response to staff concerns. Director of Operations will conduct monthly meeting with staff for a minimum of 3 months. Daily monitoring meetings has been restructured to elicit concerns from Department Staff to include ID review for potential abuse. Full investigation will start for all allegations of abuse and DPH will be notified. Implemented on 4.7.08 a daily report will be completed by Administrator and submitted to Director of Operations for review. Director of Operations will review the morning meeting minutes and audit investigations to assure investigation and safeguard of residents done and notification of regulatory agencies. In addition, Director of Operations will interview 5 staff members bi weekly to ascertain if reported issues were addressed appropriately by management staff. Appropriate disciplinary action will occur when warranted 4. Audit findings will be submitted to QA Committee for 90 days. A monthly report regarding all abuse/neglect allegations submitted to QA for review ongoing basis. Effective date: April 7, 2008.	F 224		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		4/7/08

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of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to initiate and conduct a thorough investigation when staff nurses alleged that E14(LPN) was not administering Morphine

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Sulfate as ordered by the physician. Nursing staff alleged that six residents either received more Morphine Sulfate than was ordered, or received medications at times that were outside of the perscribed parameters (dosage/timing). Facility administration was made aware of the allegations concerning E14's care and treatment of R27 on 4/3/06. These failures contributed to the suspicious death of 4 other residents receiving liquid Morphine Sulfate during end of life care from 4/8/06 to 9/18/06

This applies to 5 of 6 residents receiving end of life care (R27, R28, R29, R30, and R31).

An Immediate Jeopardy was identified on 4/4/08. The Immediate Jeopardy was determined to have begun on 4/3/06 when E13 (LPN) made E2 (DON) aware of her suspicions concerning E14 giving R27 too much Morphine to hasten his death. E1 was informed of the Immediate Jeopardy on 4/4/08, removed on 4/7/08.

The examples include:

R27, a 56 year old male, had diagnoses of Down's Syndrome, Seizure Disorder, Dysphagia, Parkinson's Disease, Depression and Shy Drager Syndrome per the facility's Administration Face Sheet dated 3/28/06. R27's Doctor's Telephone Orders dated 3/28/06 state, "Admit to Hospice, add Roxianol 5 - 10 mg PO (Morphine Sulfate By Mouth) PRN (As Needed), Ativan 0.5 mg every 4 - 6 hours PRN for restlessness." R27 died at the facility on 4/2/06.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 reported that E14 (LPN) said, "Those

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F 225	Continued From page 34 people aren't meant to live that long. They are meant to die in their teens and I'm going to help him along." The report further states, "E6 recalled that approximately forty-five minutes later, she observed E14 leaving R27's room. E6 thought this was odd because R27 should not have been given any Morphine for at least another hour and a half....E6 said that she compared the narcotics book with R27's Morphine bottle. E6 explained that the amount remaining in a morphine bottle could be determined by lines along the bottle. E6 put forth that she discovered that 160 mg of Morphine were missing." On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 4/2/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate. On 2/22/08 at 12:40 PM E13 (LPN) stated, "I told E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on 4/3/06 about my concerns with E14's (LPN) administration of liquid Morphine to R27 on 4/2/06. I know I went to them at least 3 times with my concerns." E13 confirmed that she was never questioned by E1 (Administrator), E2 (Director of Nursing), or E3 (Assistant Director of Nursing) about her concerns. E13 said that she was never asked to write a statement documenting her concerns about E14. E13 said that after R30 died on 9/18/06 she went to them (E1 and E2) a third time and voiced her concerns. The Illinois State Police Investigative Summary (Synopsis) dated 12/12/06 documents that between 4/8/06 and 9/18/06 four other residents died in the facility while receiving liquid Morphine	F 225		

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Sulfate (R28, R29, R30, and R31).

During interviews conducted from 2/20/08 to 2/22/08 confirmed that E6 (LPN), E7 (RN), E8 (LPN), E9 (LPN) E10 (CNA), and E12 (LPN) were never questioned about E14's use of Morphine for residents during end of life care. All said that they were never asked about missing Morphine Sulfate or how it was to be administered to residents near end of life. E6, E9, E12, and E13 said that they talked to E1, E2 or E3 numerous times between 4/3/06 and 9/18/06 about concerns with E4's administration of liquid Morphine Sulfate to residents.

On 2/20/08 at 2:00 PM, E2 (Director of Nursing) said that the only nursing concerns she was aware of related to R27's death on 4/2/06. E2 said that she did review R27's charting to include Nurse's Notes, Medication Administration Record and the Controlled Substance Proof of Use Sheet. E2 said that she did not see any problems. E2 confirmed confirmed that she did not interview nursing staff, direct care staff, or residents about allegations of misuse of Morphine.

On 2/21/08 at 11:20 AM, E1 (Administrator) said that she was never made aware of any staff suspicions concerning E14 overdosing residents with liquid Morphine. E1 confirmed that no investigations were ever conducted concerning E14's alleged misuse of Morphine. E1 denied having any knowledge of E14's alleged misuse of Morphine Sulfate until 10/31/06 when the State Police entered the building. E1 confirmed that E14 was allowed to work in the facility as a nurse until 10/31/06.

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Facility Incident Investigation Reports from 2006 to present were reviewed on 2/20/08. There was no documentation of investigations being conducted concerning the alleged abuse abuse of liquid Morphine in the deaths of R27, R28, R29, R30, and R31.

The facility's undated Policy and Procedure on Abuse Investigation and Reporting states, "Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness....When an incident or suspected incident occurs, the Administrator will appoint a management member to investigate the allegation. The individual conducting the investigation will, at a minimum: Review the completed resident abuse report; Review the resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witness to the incident; Interview the resident if appropriate; Interview the resident's attending physician to determine the current mental status of the resident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care and services; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; and Review all events leading up to the alleged incident....While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents. Employees who have been accused may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed."

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The facility took the following steps to correct the Immediate Jeopardy which led to a lowered scope/ severity of level 2 of that continues in order for the facility to evaluate all new procedures implemented to assure ongoing correction.

Correction for F225:
1. Residents affected have since expired.
2. As of 4/5/08, each staff member has been surveyed prior to their shift to ensure potential abuse and neglect has been identified, reported and investigated. (see Attachment A)
Director of Operations and Nurse Consultant will assure facility compliance regarding abuse and neglect. On 4/4/08 a walking round was performed by Acting DON and each resident assessed for signs/symptoms of over medication from psychoactive and pain medication.
3. Director of Nursing has been removed from her position, and qualified Registered Nurse has assumed the position of Acting Director of Nursing. The Administrator and Acting DON were in serviced by Contracted Nurse Consultant on 4/5/08 on regulations, facility policy and procedures for identifying, investigating, reporting events to IDPH and safeguarding residents from abuse during ongoing investigations. (see Attachment B)
As of 4/5/08, each staff member has been required to attend in service prior to beginning scheduled shift. Staff also inserviced on communicating unresolved issues, reporting all abuse and neglect , management concerns to Director of Operations. The Director of Operations will evaluate facility response to staff concerns to ensure prompt identification. (See Attachment C). Staff was also in serviced on communicating unresolved system issues,

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F 225	Continued From page 38 potentially abusive/ neglectful issues to Director of Operations. The Director of Operations will evaluate response to staff concerns. Director of Operations will conduct monthly meeting with staff for a minimum of 3 months. Daily monitoring meetings has been restructured to elicit concerns from Department Staff to include IDT review for potential abuse. Full investigation will start for all allegations of abuse and IDPH will be notified. Implemented on 4/7/08 a daily report will be completed by Administrator and submitted to Director of Operations for review. Director of Operations will review the morning meeting minutes and audit investigations to assure investigation and safeguard of residents done and notification of regulatory agencies. In addition, Director of Operations will interview 5 staff members bi weekly to ascertain if reported issues were addressed appropriately by management staff. Appropriate disciplinary action will occur when warranted 4. Audit findings will be submitted to QA Committee for 90 days. A monthly report regarding all abuse/neglect allegations submitted to QA for review ongoing basis. 5. Effective date: April 7, 2008.	F 225		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to provide necessary housekeeping and maintenance services to maintain a clean and comfortable interior for 71 residents.	F 253		5/1/08

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The examples include:

I. During the tour of the facility with E20 (Maintenance Director) on 2/20/08 from 9:40 am to 12:50 pm the following observations were made:
1. In the 100 wing shower room a piece of baseboard approximately 1 foot long was missing from the shower wall. One whole course/line of tile was also missing form the shower room wall.
2. The tub room in the 100 wing was used as a storage room. The floor of the tub room was very dirty. E20 stated that the floor was "filthy". On the adult reclining chair was a funnel shaped plastic insert probably for the commode which had two brownish black smear which was approximately one inch long. E20 stated that "it looked like fecal matter".
3. In the Assist Dining Room there was ground in black dirt and cob webs near the door jams. Chipped paint was noted on the fire doors of the dining room. There was ground in dirt behind the door around the magnetic hold of the door. The dining floor had ground in dirt all over. There was a fan kept on the dining room floor which was covered (frames and the blades) with with dust and hair. There were food particles on the window sills in the dining room. There was a washcloth with brownish smear noted on the floor near the dining room. There were food particles including a package of jelly and chicken bone observed on the heating panel/radiator.
4. The smoking room was located at the far end on the Assist Dining Room. The floor of the smoking room entry area had ground in dirt and the walls were noted with splash marks. The plastic strips (looks like freezer strips) over the doorway of the smoking room was very dirty with

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F 253	Continued From page 40 food smears. According to E20 the strips are "filthy". The smoking doorway was missing a piece of moulding. In the smoking room there were four residents smoking, the room was filled with smoke. The baseboard cover approximately six feet long over the heating panel was missing. A baseboard approximately 6 feet in length was placed at the corner of the room. The floor of the smoking room was very dirty with black ground in dirt. 5. In the Dining Room the vents of the air conditioner was covered with dust. The edges/perimeter of the dining room has ground in dirt. 6. In the 400 shower room the plaster approximately six feet long was chipping off the wall. There was a crescent shaped hole at the toilet water feed/supply line. The inside corner of the shower wall plaster was cracked. The heat vent was covered with dust and the dust was observed falling. 7. a. In Room 101 the baseboard was loose from the wall. The radiant heat cover was off the track. There were rust marks on the floor tiles. There was a loose toilet paper holder. b. In Room 103 there were rust marks on the floor. The dresser had chipped wood veneer. The floor had ground in dirt. c. In Room 105, the nightstand had chipped wood veneer. The top drawer of the dresser was broken. Flaking paint was noted by the window frame. Soiled caulking was noted around the toilet. d. In Room 107, multiple rust marks were noted on the floor. The night stand had chipped wood veneer. Food stains were noted on the seat and the arm rest of the adult reclining chair. The floor has ground in dirt. Soiled and cracked caulking was noted around the toilet. The tile around the	F 253		

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toilet was cracked.
e. In Room 402 there was a crescent shaped hole at the toilet water feed/supply line. The tile around the toilet is grayish in color.
f. In Room 401 there was chipped paint on the toilet wall and the door. There was a fan kept on the dresser which was covered with dust.
g. In Room 303 there was a fan observed on the floor. The fan was covered with dust and hair. The tiles around the toilet had brownish discoloration and tub was covered with dirt. Resident stated that he uses the tub.
g. Other examples of maintenance and housekeeping issues include Rooms 109, 110, 108, 106, 102, 205, 207, 211, 214, 212, 210, 206, 202, 305, 307, 309, 311, 315, 317, 319, 318, 316, 312, 310, 308, 306, 304, 302, 402, 404, 406, 405, and 403.
8. The rub rails on the walls in all the wings were covered with ground in dirt.
9. The handrails in 300 wing was very dusty. Fingers marks were noted on the handrail after touching the handrail.

During the daily status meeting on 2/21/08 at around 10:00 am E1 stated "it is an old building" in response to all the maintenance and housekeeping issues that were observed during the survey. At 2:55 pm E1 also stated that there were no specific routines for cleaning and repair.

E22 (Head of Housekeeping and Laundry) stated that she has three housekeepers on the weekdays and two housekeepers on the weekends. E22 stated that there are total of 70 rooms that the housekeepers have to clean, out of which 55 are resident rooms.

II. During the initial tour of the facility on 2/19/08

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F 253	Continued From page 42 from 10:40 am till 11:20 am the following observations were made: 1. In the Assist Dining Room there was a dirty janitor's bucket and dirty mop by the air duct. The grates/ ducts/ vents along the dining room wall was dusty and dirty. A dirty washcloth was noted on the floor next to vending machine. Rust was noted around the base of the vending machine. A tile with a large piece missing was noted by the vending machine. 2. In the Smoking Room which is located at the far end on the Assist Dining Room there were three residents smoking, the exhaust fan and unit purifier was off. The whole room including the walls and the ceiling was yellow in color. The smoke could be smelled in other areas of the facility like the Conference Room. 3. In the Dining Room the outside surface area of the ice machine was dirty. 4. The 100 hallway was cluttered with adult reclining chair, diaper bins, plastic ADL supply container. The white top of the plastic ADL supply containers were dirty. 5. The shower room in the 100 wing had built up dirt on the tiles. The two hopper/sink were dirty, and the drains were also dirty 6. The floor of the CNA supply closet was dirty. The shelf was sticky and looked as if there was some liquid spilled on it. 7. The floor of the closet near room 202 was not clean. There were spider webs in the corner.	F 253		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		5/1/08

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F 272	Continued From page 43 A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a comprehensive assessment of a resident's needs is being done in the area of pain and comfort for 4 (R1, R6, R11, R14) of 15 residents sampled. Findings include: 1. R1 is a 39 year old resident with diagnoses that include chronic liver disease, gastroesophageal reflux disease, and viral	F 272		

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hepatitis C. The MDS (minimum data set) that was completed on 1/10/08 indicates that R1 has daily pain at a moderate level in the stomach. When the rest of the record was reviewed, there was no further pain assessment completed. While at the facility R1 has received Vicodin as well as Tylenol for pain relief. R1 not only has constant daily pain, but also has a history of substance abuse and compromised liver function which has caused R1 to be placed on a liver transplant list.

2. R6 is a 65 year old resident that was admitted in 7/07 with diagnoses of multiple sclerosis, neurogenic bladder, and hypertension. R6 has multiple contractures and a Stage IV pressure sore. Review of the clinical record confirmed that there was no pain assessment or plan of care for pain management done.

3. R11 is a 57 year old resident with diagnoses that include osteomyelitis, paraplegia, T7 compression fracture, and back pain. R11, even with a diagnosis of pain, has no pain assessment in the clinical record. R11 receives Tylenol, neurontin and ultram among her medications.

4. R14, a 73 year old resident with renal failure, diabetic neuropathy, cellulitis, and peripheral vascular disease, has no pain assessment in the clinical record. MDS of 12/24/07 reflects that R14 has pain daily and among the medication R14 has ordered is Darvocet N and Vicodin.

On interview, during the daily status meeting of 2/21/07, E2 (DON) confirmed that none of the residents had had a pain assessment completed. The facility had not done them up until that time, but they would be starting to do them now.

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have individualized Diabetic Management care plans that identified the residents specific concerns, and failed to have individualized goals and approaches to address concerns, and failed to have care plans for residents with pain. This is for 8 (R9, R18, R12, R11, R10, R16, R14, R1) out of 17 residents residing at the facility who have a diagnosis of Diabetes. The examples include:	F 279		5/1/08

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F 279	Continued From page 46 1) R9 has diagnoses of Diabetes and Dementia and has physician's orders for diabetic medications, including insulin according to the physician's order sheets (POS) for December 2006, January 2007 and February 2007. R9 had 13 (6:00 AM) blood glucose levels below 70 between 12/6/07 and 2/20/08 (6 of these levels were below 60), and 3 (4:00 PM) blood glucose levels below 70 between 1/21/08 and 2/10/08 (1 of these levels was below 50) according to documentation on the Medication Administration Record (MAR). R9's Diabetic Management care plan does not identify R9's frequent low blood glucose levels and does not give approaches for preventing and treating low blood glucose. R9 was observed in the facility on 2/19, 2/20 and 2/21/08. R9 was interviewed on 2/20/08 regarding her 6:00 AM low blood sugar result of 59 mg/dL. R9 stated that she didn't know what her blood sugar was that morning but that she she didn't feel well. 2) R16 has diagnoses of Insulin Dependent Diabetes and Legal Blindness and has a physician's order for administration of insulin before each meal and at bedtime according to the February 2008 POS. R16 had 15 blood glucose levels below 70 mg/dL (11 were below 60) between 12/2/07 and 2/19/08, and 14 blood glucose levels greater than 350 mg/dL between 12/7/07 and 2/18/08 according to the December 2007, January 2008 and February 2008 MAR. R16's Diabetic Management care plan does not provide individualized goals or approaches to managing R16's severely high and severely low	F 279		

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F 279	Continued From page 47 blood glucose levels. 3) R18, R12, R11 and R10 are other examples of residents who have a diagnosis of Diabetes and have multiple low and/or high blood glucose levels but do not have the problems identified and/or individualized approaches in their Diabetic Management care plans. 4) R14, a 73 year old resident with renal failure, diabetic neuropathy, cellulitis, and peripheral vascular disease, has no pain assessment in the clinical record. MDS of 12/24/07 reflects that R14 has pain daily and among the medication R14 has ordered is Darvocet N and Vicodin. There is also no care plan developed to address R14's pain management. 5) R1 is a 39 year old resident with diagnoses that include chronic liver disease, gastroesophageal reflux disease, and viral hepatitis C. The MDS (minimum data set) that was completed on 1/10/08 indicates that R1 has daily pain at a moderate level in the stomach. When the rest of the record was reviewed, there was no further pain assessment completed. While at the facility R1 has received Vicodin as well as Tylenol for pain relief. R1 not only has constant daily pain, but also has a history of substance abuse and compromised liver function which has caused R1 to be placed on a liver transplant list. There is no care plan that addresses R1's pain.	F 279		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		5/1/08

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to follow physician's treatment orders, failed to follow physician's order for medication administration, failed to sign the medication administration record (MAR) immediately after administering medication to the resident, failed to assess a resident for signs and symptoms of urinary tract infection and failed to consistently document the urine output on the output sheet. This is for 5 residents (R6, R19, R26, R18, R4) in the sample of 15.

The examples include:

1. R6 is a 65 year old resident who has diagnoses including multiple sclerosis, depression, sepsis, and neurogenic bladder. R6 currently has pressure areas on several areas of his body.
On 2/20/08 at 10:15am the treatment dressing changes were observed. The treatment care was done by E15. E15 began the process by removing the old dressings. There was a bordered Telfa dressing to the right hip, a DuoDerm dressing to the coccyx and another bordered Telfa dressing to the left outer knee. E15 cleansed the stage IV hip area with 4 x 4 gauze saturated with a clear liquid, packed the wound bed with calcium alginate and then covered it with a fresh bordered Telfa dressing. The order calls for "R hip cleanse with NS (normal saline), pack with Calcium Alginate and cover with Telfa border dressing everyday." The clear liquid used by E15 turned out to be sterile water, not normal saline.

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The coccyx area was reddened with several small (approx .2-.4cm) open areas. The area was cleansed again with the same sterile water solution. E15 then proceeded to apply "Calmoseptine" cream on the coccyx and the perineum. E15 commented that this was a new product that they were "trying out" and she was very positive about its effect so far. There was no order for a treatment to the coccyx on the POS (physician order sheet) up to this time.

The left knee was cleansed with the sterile water and a bordered Telfa dressing was taken and had two packets of Bacitracin ointment placed on it and applied to the knee. The order reads:"L knee cleanse with NS. Apply TAO and cover with Telfa border dressing everyday until healed."

After the dressing changes were completed, E15 said she was going back to the desk to document her work. E15 was asked to show the treatment record for R6's wounds. E15 went to the TAR and as it was being observed, E15 began to cross out treatments and state that 'we are not doing that anymore.'
The orders for the L knee were verified and called for TAO which E4-A stated was "triple antibiotic ointment". When brought to her attention that she applied Bacitracin, E15 said that they are the same. E15 was corrected.
E15 was then asked about the treatment for the coccyx, since none was present on the TAR.
E15 started to write the date 2/20/08 and the treatment she had just performed for the coccyx with the Calmoseptine. She said that she would call the doctor for the order when she got back to the desk.

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F 281	Continued From page 50 2. During morning medication pass observation on 2/20/08, E17 gave R19 her Glyburide 1.25mg. medication around 9:05am. Review of physician (MD)order sheet (POS), showed an order dated 1/5/07, which say's " Glyburide 1.25mg., 1 tablet by mouth daily at 8am with breakfast. E6-A stated that R19 already had her breakfast. During noon med. pass the same day (2/20/08), R18 was given Phoslo 2 capsules at around 12;15pm. Review of POS showed an order which states "Phoslo 667 mg.gelcap 2 caps (1334 mg) p.o. three times daily (take with meals). As noted R 18 was given his meds before lunch. Meal time schedule reviewed and verified by staff (E2, E8 and E17) showed that breakfast starts at 8:00 AM ; lunch at 1:00 PM and supper at 6:00 PM. 3. During morning medication pass observation on 2/21/08, E21 was observed not signing the the MAR after giving medication to R26. When brought to her (E21) attention, she stated she signs the MAR after she is done passing all her medications. 4. R4 is 80 years old who was readmitted to the facility on 4/4/07 with diagnoses including urinary retention. A history and physical from the local hospital dated 6/5/07 documents that R4 had a urinary tract infection with sepsis. R4's Nurse's Notes dated 2/4/08 at 11:30 am documents R4 was moaning, skin was warm, axillary temperature 99.6 degrees Farenheit. The Nurse's Notes further documents that R4's indwelling catheter output was moderate in amount and it was cloudy amber urine. It also documents that the nurse was unable to irrigate the indwelling	F 281		

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F 281	Continued From page 51 catheter so a new indwelling catheter was inserted and a specimen for urine analysis was sent to the laboratory. E21 (Nurse) was interviewed on 2/19/08 at around 2:05 pm. E21 stated that she did not send the urine specimen to the laboratory as R4 just needed his indwelling catheter changed. The output sheet dated 2/5/08 for 3-11 shift documents 1000 cubic centimeters (cc) of dark brown-yellow urine with sediments. Most of the output documented from 1/31/08 to 2/19/08 documents urine with sediments. There was no nursing documentation after 2/4/08 to show that R4 was assessed for signs and symptoms of urinary tract infection. R4 has an indwelling catheter. R4's "Record of Foley Catheter Output" sheets from 1/18/08 to 2/19/08 were reviewed. The review indicated that R4's urine output was inconsistently documented.	F 281		
F 309 SS=K	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility systemically failed to:(I.) monitor their diabetic residents safely,(II.) assure that all resident can correctly self administer their own medications without	F 309		4/7/08

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significant error, and (III.) assess and deliver pain medications/ narcotics with monitoring as to contraindications and effectiveness in accordance with physician orders.

(I.). The facility, in the area of diabetic care, failed to:

1) notify the physician of alert value and severely low and high blood glucose results
2) monitor the clinical condition of residents surrounding the time of low or high blood glucose results
3) recheck and treat low blood glucose levels
4) have a written policy regarding the treatment and rechecking of abnormal blood glucose levels
5) ensure that staff are knowledgeable of the facility's policy for hypoglycemia and hyperglycemia
6) give the correct dose of insulin per the physician's sliding scale order
7) follow the physician's order for administering daily insulin and performing blood glucose checks

These failures are likely to result in serious hypoglycemic or hyperglycemic reactions and have the potential to affect all 17 residents with Diabetes who reside at the facility. The examples include 6 (R9, R16, R10, R11, R18, R12) of the 17 residents with Diabetes who reside at the facility and 1 resident (R14) who was discharged.
These failures in the area of diabetic monitoring resulted in an Immediate Jeopardy called and identified on 2/21/08 at 3:30 PM to E1(Administrator) and E2 (Director of Nursing). The Immediate Jeopardy began on 12/3/07 when

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it was identified through record review that the potential for serious harm related to hypoglycemic and/or hyperglycemic reaction occurred, and persisted during the time of survey.
The Immediate Jeopardy was removed on 2/22/08 when the facility took the following actions to reduce the severity to Level 2:
(for which time is needed to evaluate the effects of staff in servicing and effectiveness of new Diabetic Monitoring policy and procedures put in place.)
On 2/21/08 all nurses were in serviced on hypo and hyperglycemia protocol, notifying physician, and assessing residents .
On 2/22/08 continued in servicing of nurses, including agency staff and part time workers.
There is a plan in place to in service all nurses prior to starting their shifts with a total completion date set for 3/1/08 to completely inform staff of issues raised at Immediate Jeopardy level cited.
Facility developed a new hypoglycemic and hyperglycemic policy and procedure and a new Diabetic Monitoring Audit Sheet.
Facility developed a new policy on "Alert" or "Critical" lab results and subsequent action to be taken by nursing staff.

(II)
Based on observation, interview and record review the facility ,in the area of monitoring and assessing that a resident can safely self administer, failed to assess 1 resident for his ability to self-administer medication prior to handing the medications over to the resident to self-administer. This failure resulted in R1 taking his 9:00 AM, 1:00 PM and 5:30 PM medications (15 medications in all) all at once on 1/11/08. On

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1/28/08 R1 was again given all of his medications to take out with him to self-administer thus exposing him to harm for the second time. The facility did not monitor and respond to the overdose they were aware of for R1 weeks before
These failures resulted in an Immediate Jeopardy called and identified on on 2/21/08 at 3:30 PM to E1(Administrator) and E2 (Director of Nursing).
The Immediate Jeopardy was begun on 1/11/08 when R1 consumed all his medications at once.
The Immediate Jeopardy was removed on 2/22/08
(when facility instituted in services and new policy and procedures which reduced it to severity level 2 in order to allow facility time to monitor new procedures and effectiveness.)
The facility took the following actions to reduce the jeopardy:

On 2/21/08 the facility in serviced all nurses on duty on protocol, calling physicians, assessing all residents for safety of self administration of medications

On 2/22/08, continued in services were helld with nurses, including agency staff and part time staff. The plan is to in service all nurses prior to working their shift with a completion date set for 3/1/08 to cite the medication issue identified as immediate jeopardy.

No resident will be given drugs to give themselves without assessment as to safety first.

(III) Based on record review, staff and other interviews, the facility failed to maintain the highest practicable physical and mental well

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being of the residents through appropriate management of each residents pain medication and other medications on 6 out 7 sampled residents with medication management concerns. (R27, R28, R29, R30, R31 and R33)

The lack of proper assessment, inappropriate pain management, and provision of medication without orders, monitoring and follow through led to system failures resulted in residents R27, R28, R29, R30, R31 and R33 functional deterioration and contributed to their deaths.
The Immediate Jeopardy was identified on 4/4/08 The Immediate Jeopardy was callled on 4/4/08 to E1 The Immediate Jeopardy was determined to have begun on 4/2/08 and removed 4/7/08.

EXAMPLES FOR ABOVE:
The examples include: (diabetic system failure review) (For I)
1. R16 is a 62 year old resident who was admitted to the facility on 4/27/04 with diagnoses including Insulin Dependent Diabetes Mellitus according to the facility's face sheet. R16's current Physician Order Sheet (POS) documents a physician's order dated 8/16/06 to monitor blood glucose twice daily (6:00 am, 4:00 pm) and notify the physician if blood glucose is less than 70 milligram per deciliter (mg/dL). R16's current POS also documents to administer Novolog 3 units before breakfast (8:00 am), Novolog 5 units before lunch (12 noon), Novolog 8 units daily before supper (5:00 pm) and Lantus 16 units daily at bedtime (9:00 pm).
R16's clinical records from 12/1/07 till 2/20/08 were reviewed. R16's Medication Administration

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Record (MAR) documents on 1/12/08 at 6:00 am R16's blood glucose was 41 mg/dL. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation of how R16's low blood glucose level was treated or when it was re-tested. This was confirmed by E15 (Nurse) on 2/21/08 at around 12:20 pm.

A review of the facility's Nursing Summary Sheet documents that on 12/10/07 during the 11 to 7 shift R16's blood glucose was 38 mg/dL and "orange and glutose" was given. On 2/21/08 at around 2:15 pm E15 confirmed that it was R16's 6:00 am blood glucose level. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition. There was no documentation of the amount of orange juice and glutose given and no documentation when R16's blood glucose was re-tested. There was no nursing documentation that R16's physician was notified about this low blood glucose reading. All these were confirmed by E4-A on 2/21/08 at around 2:15 pm.

A further review of R16's clinical record also indicated that 6 times between 12/3/07 and 2/20/08 R16's blood glucose level ranged from 53 mg/dL to 57 mg/dL There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation of how R16's low blood glucose level was treated or when it was re-tested. There was no nursing documentation that R16's physician was notified about these low blood glucose readings. All these were confirmed by E15 on 2/21/08 at around 12:20 pm. On 2/10/08 at 6:00 am R16's blood glucose was 52 mg/dL according to R16's MAR. there was "OJ" written next to "52". There was no

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nursing documentation regarding the amount of orange juice that was given. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation when R16's blood glucose was re-tested. There was no nursing documentation that R16's physician was notified about this low blood glucose reading.

The review of R16's clinical record also indicated that there were 12 times between 12/2/07 and 2/20/08 when R16's blood glucose level was below 70 mg/dL. Z2's (Endocrinologist) progress note dated 12/4/07 documents to notify the physician if R16's blood glucose level is less than 70 mg/dL. There was no nursing documentation that R16's physician was notified about these low blood glucose level.

E15 was interviewed regarding the treatment for low blood glucose level on 2/21/08 at around 12:35 pm. E15 stated if the blood glucose level was below 90 mg/dL then she would give 4 ounces of milk and 2 graham crackers with peanut butter. E4-A further stated that she would check resident's blood glucose level every 15 minutes until it was greater than 90 mg/dL.

E15 (Nurse) was interviewed regarding the treatment for low blood glucose level on 2/21/08 at around 12:40 pm. E15 stated if the blood glucose level was below 40 mg/dL then she would give 3/4 ounce of peanut butter, two saltine/graham crackers and 5.5 ounce of orange juice and she would check resident's blood glucose level every 15 minutes till it was greater than 80 mg/dL.

There were 11 times between 12/1/07 and

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2/20/08 when R16's blood glucose level was greater than 350 mg/dL (ranged from 358 to 499 mg/dL). There was no nursing documentation that R16's physician was notified about these high blood glucose level. The facility's policy and procedure titled "Hyperglycemia" documents to notify the physician for blood glucose above 350 mg/dL. E9 (Nurse) was interviewed on 2/20/08 at around 3:00 pm regarding notifying the physician about R16's high blood glucose level. E9 stated that "(R16) is better running higher level"

A further review of R16's MAR from 12/1/07 till 2/20/08 indicated that the scheduled dose of insulin (Novolog 8 units) at 5:00 pm was not administered on 12/20/07, 1/25/08, and 1/27/08. E9 was interviewed on 2/20/08 at around 3:00 pm. E9 stated that if R16's blood sugar is below 100 mg/dL she holds the scheduled dose of insulin. E9 confirmed that she held the 5:00 pm dose of Insulin on 12/20/07, 1/25/08, and 1/27/08. A review of R16's clinical records showed no physician's order to hold the scheduled dose of insulin There was no nursing documentation to indicate that R16's physician was notified about the Insulin being held.

Z2 (Physician) was interviewed on 2/26/08 at around 1:50 pm. Z2 stated that he does not recall giving orders to hold Insulin for R16. Z4 further stated that if he was managing a resident with Diabetes Mellitus he would prefer to be notified if the resident's blood glucose level was below 70 mg/dL and above 400 mg/dL.

2) R9 is a 78 year old resident with multiple diagnoses including Diabetes and Dementia according to the facility's face sheet. R9 has physician orders for Glipizide 5 mg at 9:00 AM,

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Lantus 15 units subcutaneous at 9:00 PM and Accucheck twice daily at 6:00 AM and 4:00 PM according to the physician's order sheet (POS) for December 2007, January 2008 and February 2008. R9's cognitive skills for daily decision-making are moderately impaired - decisions poor according to the facility's most current Minimum Data Sets (MDS) dated 12/31/07. R9 was observed on 2/19/08, 2/20/08 and 2/21/08 in her wheelchair.

On 12/12/07 R9 had an alert level blood glucose of 46 mg/dL at 4:44 AM according to the lab report in the medical record. The lab report documents that E16 (Nurse) was notified at 3:52 PM on 12/12/07 with the alert value. There is no documentation that E16 notified R9's physician regarding this alert level or that any additional blood glucose monitoring was done. There is no nursing note documentation of R9's clinical condition on that day. R9 had 13 (6:00 AM) blood glucose levels below 70 between 12/6/07 and 2/20/08 (6 of these levels were below 60). R9 had 3 (4:00 PM) blood glucose levels below 70 between 1/21/08 and 2/10/08 (1 of these levels was below 50) according to documentation in the Medication Administration Record (MAR). There is no documentation in the nursing notes regarding the medical treatment, physician notification or rechecks of these low blood glucose levels. There is no nursing note documentation of R9's clinical condition at the time of these low blood glucose levels. R9's 12/20/07 dietary assessment does not address these low morning blood sugars, nor is it identified in the care plan titled Diabetic Management.

E16 was interviewed on 2/21/08 at 3:40 PM. E16

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stated that she has no specific recollection of R9's alert low blood glucose level that was phoned to her on 12/12/07. E16 stated that in general when she receives an alert value level she calls the doctor and waits for a response depending on the lab result and if it was accurate for that time. E16 said that in the case of R9's result she would not have tried again to reach the physician because blood glucose levels had already been checked on R9 since the time of the alert value draw. E16 stated that she would not feel it necessary to document in the nursing notes regarding this issue. E16 reviewed the medical record and stated that she could not find documentation that R9's physician was notified. E16 stated that she does not know what the facility's policy and procedure is regarding low blood glucose levels.

E17 (Nurse) was interviewed on 2/20/08 at 11:20 AM. E17 stated that it was conveyed to her in shift change report that R9 had a blood sugar of 59 at 6:00 AM and that orange juice was given. E17 stated that R9's blood sugar level was not rechecked. E17 said that a blood sugar under 60 should be rechecked on some people. E17 stated that she was a new employee and did not know what the facility's policy and procedure was regarding low blood sugar levels.

R9 was interviewed on 2/20/08 regarding her 6:00 AM low blood sugar result of 59 mg/dL. R9 stated that she didn't know what her blood sugar was that morning but stated that she didn't feel well.

E2 (Director of Nursing) was interviewed on 2/20/08 at 12:20 PM. E2 stated that alert value results should be "red stamped" and faxed to the

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physician immediately. E2 and E17 confirmed that R9's lab report was not "red stamped." Regarding the facility's policy on hypoglycemia E2 stated that if the blood sugar level was less than 70 with no symptoms the nurse is to treat the low blood sugar with peanut butter and crackers and recheck the level in 15 minutes.

Z6 (R9's daughter) is listed as the responsible person to notify according to the face sheet. Z6 was interviewed by phone on 2/21/08. Z6 stated that she has never been notified about R9's alert level blood glucose nor about any other low blood glucose results.

Z2 (R9's physician) was interviewed by telephone on 1/26/08 at 12:15PM. Z2 stated that he does not specifically remember if the glucose alert of 12/12/07 was called to him. Z2 said that he would expect staff to call him for any blood glucose levels below 70 mg/dL.

The facility's policy titled, "Hypoglycemia Policy and Procedure" dated 5/1/06 does not provide any guidelines for treating and rechecking low blood sugar levels. The policy states, "notify physician if blood sugar is fewer than 50..."

The American Diabetes Association 2007 Position Statement defines hypoglycemia as glucose less than 70 mg/dL. The paper states that 15-20 g of Glucose is the preferred treatment for hypoglycemia and that blood glucose levels should be re-tested in approximately 15 minutes because additional treatment may be necessary. The paper further states that adding fat (i.e., peanut butter) may retard and then prolong the acute glycemic response. The American Dietetic Association also concurs with these guidelines

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according to the Manual of Clinical Dietetics 5th Edition 1996.

During the group interview on 2/20/08 eight out of eight residents stated that they are not offered bedtime snacks. Four of the residents in group (R11, R12, R24, R25) have a diagnosis of Diabetes and confirmed that they do not regularly receive a bedtime snack.

3. R14 is a 73 year old resident with diagnoses that include IDDM (insulin dependent diabetes mellitus), renal failure, diabetic neuropathy, cellulitis, and S/P BKA (below the knee amputation). Review of the medical record indicated that R14 had orders for Lantus insulin 10 units SQ every morning. R14 also had orders for accuchecks before meals and at bedtime (6am, 11am, 4pm, 9pm.) Sliding scale insulin was to be given based on the results of the checks as follows:
Novolin R 100 units/ml SS: 151-200 = 4U, 201-250 = 6U, 251-300 = 8U, > 350 = 10U then recheck BS and cover with SS, if BS > 350 = call MD.
Review of the MAR (medication administration record) indicates that on multiple occasions in December, 2007 and January, 2008, R14 was given the incorrect dose of insulin, or there is no documentation that the MD was called as the parameters call for, or that the BS was rechecked as ordered. Examples include: The 4pm accucheck results were: 12/15/07 BS result: 167--no coverage given--should have rec'd 4 units;12/25/07 BS result: 342--no coverage given--should have rec'd 10 units; 12/13/07 BS result: 300--8 units given--should have rec'd 10 units.
On 12/20/07, 12/22/07, 12/13/07, 12/24/07, and

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F 309	Continued From page 63 1/1/08 the BS results were greater than 350, but there is no documentation of the MD being notified or of a recheck being done. Also on these days and several others, when the resident had blood glucose levels over 300, the resident experienced falls. This occurred on 12/13/07, 12/14/07-two falls, 12/20/07, on 12/24/07, and on 12/28/07-two falls and 1/1/08. The BS ranged between 300 and 500 on these days and there is no notification to the MD documented. There is also no assessment or correlation made between the BS and the falls and the care plans were not reevaluated or updated. 4.R11 is a 57 year old resident with diagnoses that include paraplegia, back pain, IDDM, T7 compression fracture. R11 is ordered to receive Glucophage 250 mg every 12 hours, NPH insulin 10 units SQ twice a day and have accuchecks done twice a day with sliding scale insulin based on the results of the checks as follows: Novolog 100 units/ml SS: 151-200 = 2U, 201-250 =4U, 251-300 =6U, 301-350 = 8U, 351-450 = 15 U, 451 -over call MD. During December there were several times when the insulin was not given according to the sliding scale or notification made to the MD as ordered. On 1/8/08 the BS was 596. The MAR does not document this result for this date, but the nurse's note dated 1/8/08 1600 documents that the 'maximum dose of insulin was given'. There is no mention of notifying the MD. On 12/22/07 the 4pm BS was 281--4U were given, 6U are ordered; on 12/25/07 the 4pm BS was 351--8U were given, at that time the MD was to be called, this is not evident; again on 12/27/07 4pm BS was 353 --8 U were given, MD was to be called, no evidence he was; 12/11/07 6am BS result was 162--3 U given, 2 U ordered; 12/18/07	F 309		

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the BS was 282--the MAR documentation appears to read 9U given--6U were ordered.

The 2007 8th Edition Drug Information Handbook for Nursing by Turkoski, Lance and Bonfiglio states the following regarding Insulin: "The Institute for Safe Medication Practices includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error."

5. R10 is a 72 years old resident admitted to the facility on July 2002 with a diagnosis which includes Renal failure, Insulin Dependent Diabetes Mellitus,Congestive Heart Failure and AKA (above the knee amputation) of both lower extremities. R10 is also on dialysis and goes 3 x a week (Mon., Wed., and Fri.), for dialysis treatment.

Review of R10's physician (MD)order sheet (POS) showed an order which say's "Accucheck twice daily", with Novolin R sliding scale coverage, which say's, " <150 = 0; 151-200 = 3U (units); 201- 250 = 6U; 251- 300 = 9U; 301-350 = 12U; 351-400 = 15U; 401-450 = 18U. Medication Administration Record (MAR) reviewed showed that accucheck was done at 6am and 4pm.

Review of the December 2007 and January 2008 MAR showed the following ;

Dec.6, 2007, 4pm accucheck result was 538. There was no documentation that insulin was given nor was the physician notified of the result.

Dec. 8, 2007, 4pm accucheck result was 500. R10 was given 18 units of Novolin R insulin.

Dec. 11, 2007, 4pm accucheck result was 474. R10 was given 18 units of Novolin R insulin.

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F 309	Continued From page 65 Dec. 13 and 15, 2007, 4pm accucheck result was 451. R10 was given 18 units of Novolin R insulin. Dec. 12, 2007, MAR showed no 6am accucheck was done Jan. 7, 2008, 4pm accucheck result was 297. No documentation that Insulin was given. R10 also has MD orders for Novolin N 22 units sub-Q every morning (6am) and evening (4pm). That same day (1/7/08), as documented in the MAR, at 6am, R10 was given 7 units of insulin instead of 22 units ordered by MD, and was not given the 4pm dose. Jan. 14, 2008, 6am accucheck result was 185. No insulin was given as ordered. Jan. 21, 2008, 4pm accucheck result was 218. R10 was given 3 units instead of 6 units Novolin R ordered by physician. Jan. 29, 2008, 4pm accucheck result was 456. R10 was given 18 units of Novolin R insulin. On these four (4) instances (12/8, 12/11, 12/13, and 1/29/08), review of the nurses notes and the daily summary sheet presented by the facility, showed that the Novolin R was given without MD order,and there was no evidence or documentation that the attending MD was notified about these high blood glucose level results. Facility policy reviewed, states, " Notify MD if blood sugar is fewer than 50 or above 350, unless otherwise ordered". R10's sliding scale physician order states " 401-450 give 18 units of Novolin R insulin". 6. R18 is a 64 years old resident admitted to the facility on 5/1/06, with a diagnosis which includes	F 309		

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Insulin Dependent Diabetes Mellitus (IDDM), Congestive Heart Failure (CHF), End Stage Renal Disease and Cerebro-Vascular Disease (CVA) with Left sided weakness. R18 is also a dialysis patient and goes for dialysis treatment 3 x a week (Tues.,Thurs and Sat).

Review of R18's quarterly MDS, signed as completed on 1/30/08, documents his cognitive decision making skills as independent with no memory problem. As observed on 2/19 and 2/20/08, and verified by staff, R18 is capable to do his activities of daily needs independently except his bath were he needs a one person assist.

Review of R18's physician order sheet (POS), showed an order which say's " Accucheck before meals and at bedtime", with a sliding scale insulin coverage of Novolin which say's, " 151 - 200 = 2 U (units); 201 - 250 = 4 U; 251 - 300 = 6 U; 301 - 350 = 8 U; 351 - 400 = 10 U. Review of the MAR showed that the accucheck was done at 6am, 11am, 4pm and 9pm.

Review of the December, 2007 MAR showed the following;

Dec.1, 2007, Dec.17, Dec 26, 2007, 11am accucheck was not done as ordered.

Dec.6, Dec.24, 2007, 4pm accucheck was not done as ordered.

Dec. 16, 2007, 4pm. accucheck result was 251. R18 was not given the 6 units insulin coverage ordered.

Dec. 22, 2007, 6am accucheck result was 161. R18 was not given the 2 units insulin coverage ordered.

Dec. 24, 2007, 6am accucheck result was

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196, R18 was not given the 2 units insulin coverage ordered.

Dec. 25, 2007, 6am accucheck result was 151. R18 was not given the 2 units insulin coverage ordered.

On Jan. 16 and Jan.21, 2008, the physician's orders were not followed for checking the 11am accuchecks for R18.

7. R12 is an insulin dependent diabetic (IDDM) who has physician's orders for his blood to be checked twice a day at 6:00a.m. and 4:00p.m. with insulin coverage on a sliding scale. This order includes the physician to be notified when R12's blood sugar (accu check) is over 351. At 4:00p.m. on 1/1/08 R12's accu check is documented on his Medication Administration Record (MAR) as being 353, on 1/4/08 it was 359, on 1/7/08 it was 479, on 1/8/08 it was 354 and 1/11/08 it was 428. There is no documentation in R12's Nurses Notes that the physician was called. E2 (DON) told surveyors that it should be documented in the Nurses Notes. Also, the physician's orders are to give 9 units of insulin when R12's accu check is between 251 and 300. On 1/3/08 at 4:00p.m. R2's MAR documents that his accu check was 253 and 3 units were given instead of 9 units.

Examples included for (II).Failure to monitor and assess resident for safe self administration of medication

During the initial tour on 2/19/08 at 10:30a.m. R1 was found sitting in his room with a medication cup on his overbed table that contained 3 white round pills of different sizes, 1 small orange round pill and 1 pink and black capsule. When the surveyor asked R1 if he knew what the

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F 309	Continued From page 68 names of these pills were and what they were for he said "no he did not" and that "the nurse left them there." Based on the potential danger posed to this resident by allowing medications to be left at bedside without nursing supervision, R1 was included in sample. Nurses Notes of 1/11/08 document that R1 was to go to the hospital for a test that he was to be fasting for. E3 -A gave R1 his 9 a.m. medications which were: Thiamine 100mg, Prevacid 30mg., Folic Acid 1mg., .Multi Vitamin, Inderal 10mg., Cytotec 100mcg, Lasix 40mg., Spironolactone 100mg. in one envelope. His 1:00p.m. medication of Spironolactone 50mg. which was in another envelope, and his 5:00p.m. medications which were Inderal 10mg., Cytotec 100mcg.,Lasix 40mg., and Spironolactone 100mg. in yet another envelope and 2 tablets of Vicoprofen 200/7.5. if needed for pain in another envelope which was documented as being taken by resident at 5:30p.m. on his MAR. A total of 15 medications were given to him. R1 announced to E8 that he ate breakfast already and E8 then cancelled his hospital appointment. R1 then approached E3-A and told her that he took all of the medications she had given him in all of the envelopes. R1 told E8 that he did not know why he did it. The physician was notified and said to watch him. The facility failed to make out an incident report nor report this incident to IDPH or give the resident any education or assessment on his ability to slf medicate. An incident report has been written today, 2/21/08. On 1/28/08 R1 was again going to the hospital for tests and documentation on his MAR as well as his Nursing Notes of 1/28/08 note that he again was given all of his medications to take with him without an assessment or safety concern considering that he incorrectly took an	F 309		

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F 309	Continued From page 69 entire day's dosage at one time using poor judgement. The facility put the resident in jeopardy for the second time by assuming he could safely self administer his own meds at the correct time exposing him to potential for harm or overdose. III. Examples Pain Assessment, Monitoring, Control Based on record review and interview of staff and others, the following conditions were noted leading to system failures: 1. Assess residents for pain and their need for pain medications. (R27, R28, R29, R30, R31 and R33) 2. Assess and monitor residents after providing controlled medications to identify side effects, medication reactions and/or the need for additional pain medication or the holding of a medication when side effects or adverse reaction were present.(R27, R28, R29, R30, R31 and R33) 3. Prevent controlled medication from being administered without physician (MD) orders. (R29 and R32) 4. Assure that a staff nurse followed MD orders when giving controlled substances. (R27, R28, R30, R31 and R32) and 5. Notify the MD and document a change of condition after the Morphine was given to a resident without an MD order. (R29). Examples of the above conditions are: 1. Based on record review, R29 was admitted to	F 309		

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the facility on 9/15/06 with diagnosis including Alcohol Abuse, Liver Cancer and Cirrhosis and was on palliative care on admission. The discharge chart from the transferring facility included a copy of the Physician's order sheet that showed R29 was not on any type of pain medication and he was not complaining of any pain. The Initial orders also did not include any pain medication. R29 was up in a wheelchair alert, responsive and went out to smoke throughout the day.

(Nursing Note) documentation shows he was not complaining of any pain or discomfort until he came back from lunch on 9/17/06. R29 then went back to bed. E14, the nurse taking care of R29, charted on 9/17/06, "Complaining of extreme pain so returned to bed. Orders rec'd from Registered Nurse Practitioner (RNP) for comfort pack of 10 milligrams (mg) Morphine Sulfate (MSO4) given with relief obtained. Resting comfortably".

The Illinois State Police (ISP) report dated 11/15/06, on page 00036, documented the interview of Z5, R29's sister who was visiting at the time of the incident. In the interview Z5 stated that she went to the nurse's station and told a nurse that R29 needed pain medication. The nurse replied that there was no physician order for Morphine. Z5 said that a different nurse came into the room and gave R29 Tylenol. Z5 went to the nurse's station to ask for another type of medication 3 times. On the third time, E14 said she didn't need a physicians order to give him Morphine. Z5 then witnessed E14 dispense morphine orally to R29. Z5 said that R29 became unconscious.

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F 309	Continued From page 71 The next Nurses Note written by E9 on 9/17/06 at 3 PM, states " Mother in to visit. Res.not responding at this time. Appears to be resting comfortably". The next Nurses' note charting at 7 PM by E9 states " Resident remains non responsive. Eyes fluttered briefly. 154/81, 98 (pulse) Respiration 14 irregular, t 97.8, Non responsive to painful or verbal stimuli. Pulse Ox remained at 85-88 %. At 9 PM BP 165/91, (pulse) 98, Respiration unable to ascertain. Not breathing for 10 seconds then letting out a long sigh. " Hospice was called about the condition but MD was not informed of the problems. E4, the medical director and MD for R29, was interviewed on 2 /21/08. He said that as the Director, he would expect a pain assessment to be made before calling MD for any pain medication order. There was no pain assessment protocol in the facility and no pain assessment was documented. E4 was not informed of R29 being given Morphine Sulfate on 9/17/06 and was not responsive after thirty minutes. E4 stated that he did not order any schedule II medication for that resident, as R29 is on another hospice agency and would be covered by their hospice doctor. During the interview, E4 was informed that the Morphine order for R29 was signed as a telephone order from Z5, the nurse practitioner, with E4's name on it. He said that the facility would call him or Z5 if they couldn ' t reach the regular hospice doctor. He would then only order minor pain medications for a resident he has not seen and give a one time order only. E4 stated he did not see R29 and would not order pain medication such as Morphine for him.	F 309		

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E4 explained that R29's non responsiveness was either an adverse reaction to medication or a medication error such as overdose was given than what was ordered. E4 denied being called about R29's change of condition. E4 indicated that he would have ordered the facility to send R29 to the hospital for evaluation. E4 also said that with a change of condition after initial dosing, Morphine should not have been given thereafter.E4 was asked, if the facility continued to give the doses of Morphine with R29's condition, how long would it take before a person would expire. E4 replied that with the continued use every two hours or so, one would see an adverse effect such as a resident's demise.

Z5 was interviewed on 3/3/08 at 5:30 PM. Z5 could not remember ever being called regarding R29's need for pain medication. Z5 was informed of the telephone order that had been written showing the following:

"9/17/06 MSO4 liquid 10-20 mg s/l q4 hours prn.
Ativan Lotensol 1-2 mg S/L q 4 hour PRN.
TO(Telephone order) Z3/E4" Signed as received by E14

Z5 responded, that her practice as an advanced practitioner nurse, did not allow her to order schedule II narcotic medications such as Morphine. Z5 said that she would not order it and did not remember being called about it. Z5 stated that the Doctor would have to be called for Morphine.

R29 received additional doses of Morphine from a falsified APN/MD order with 10 mg at 2:30 AM,

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20 mg at 8 AM, 12 PM, 2 PM, 4 PM and 6 PM on 9-18-06. The facility did not notify MD but continued to give Morphine which was not ordered to resident with documented irregular respiration. The facility did not evaluate the effects of Morphine specifically with R29 already non responsive to pain stimuli and having liver problems but continued giving it. On interview E4 said that when a resident is given Morphine this frequently, the staff nurse or the Hospice nurse should be at the bedside all the time to monitor the effects of Morphine. R29 expired at 6:30 PM.

2. R32 has a diagnosis of Olivopontocerebellar Degeneration. The Nurse's note on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremeties per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won ' t dilate. Res will respond by squeezing my hand. Z3 notified." R32 was sent to the hospital for evaluation.

On 2/20/08, E9 confirmed that R32 did fall down and his neuro checks were irregular particularly his eyes. She stated that she remembered E14 during the 7-3 pm end of the shift report stating that she (E14) had given R32 a cocktail and that R32 would not be bothering her (E9) during her shift. She called E14 at home to find out what medication she gave R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided), Risperdal and Seroquel 25 tablet scheduled for 9 PM. E9 then reported this to Z3, the nurse practitioner for E4. E9 stated that Z3 got very upset that she was not called about any problem for R32 and that she

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never gave order for Ativan and an extra dose of Seroquel. R32 was sent to the hospital due to his unstable vital signs and irregular neurological signs.

3. R31 was a hospice resident with a diagnosis that included COPD, Alcohol Abuse, MI, Muscle Atrophy, Depression and Alzheimer's Disease. Review of chart showed R31 was regularly seen by the MD reflecting progress note on 2/3/06. E4, MD wrote "No problem per staff. Denies abdominal pain, nausea or vomiting. Lung has no crackles, no wheezes." On 3/3/06, E4 wrote the same progress note with no pain noted. On 4-6-06, E4 wrote the same progress note adding Patient is comfortable, continue with current management and watch closely. Charting by nurses and hospice nurse did not reflect any pain assessment or show that R31 was in pain.

On 3-30-06, a telephone order was written to increase R31 ' s pain medication from Morphine 5-10 mg every three to four hours to Morphine 10-20 mg every three to four hours despite the fact that there were no pain assessment . There was no assessment of the effectiveness of the Morphine medication by nurse giving it or by the visiting Hospice staff. The chart did not show R31 regularly complaining of pain.

On 2/28/08 interview, E13, the nurse in charge of R31 on the day she expired 4-8-06, stated she saw R31during the initial part of her shift. E13 said that she saw R31 briefly and did not see anything wrong. E13 remarked that R31 did not look like she was in pain nor was she having any problem breathing. E13 then stated that E14 came to help her give R31 her medication. E13 noted that after E14 gave the medication, E14

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stated " R31 would not be bothering you for the rest of the day as I (E14) took care of it. " E14 was asked about the statement made to ISP. E13 stated that the comment E14 made about R31 not making it through the day during smoking break was correct and that she had reported this to the DON.

E14 documented she gave Roxanol 1 cc (20 mg) at 7:30 am on R31's MAR(Medication Administration Record) but took out 2 cc (40 mg) and distributed the amount by signing 1 cc at 7:30 am and 1 cc at 9:30 am. The amount taken was verified as accurate by E2 by when she signed the amount left when the bottle was discarded 4/8/06. R31 expired at 10:30 am.

4. R28 has diagnoses of Cardiac Dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension and Dementia per the Medication Administration Record (MAR) dated Sept. 2006.

The Nurse's note on 9/9/06 at 11:30 PM, states, " Resident unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea " .

During the night shift (11-7 am) between 9-9-06 to 9-10-06 documentation shows no Morphine was given to R28. On 2-21-08, E7 said that at the end of her shift she had given report to E14 regarding R28. She stated that E14 was very upset that R28 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. She stated that she had told E14 that R28 did not need Morphine as she was unresponsive and not in pain. An ISP interview dated 1-18-07 reflects "E7 recalled E14 told her

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that she should have given the Morphine anyway." E7 repeated that she had assessed the resident even before leaving to see how she (R28) was, as she knew E14 was going to report her. E7 indicated that her assessment before she left showed R28 was stable but unresponsive and not in pain.

The Nurses note dated 9/10/06 at 8 am, documented that E14 gave R28 Morphine despite having agonal respirations with 20 to 30 seconds period of apnea (no breathing.) At 10 am, E14 documents that there was no change in condition and another dose of Morphine was administered. In addition, E14 also gave Benadryl 50 mg and Ativan. There were no indication for the need of these medications. All three can cause further respiratory depression. The PDR (Physician ' s desk reference) Morphine Drug interactions as follows: " Use with other Central Nervous System Depressant. The depressant effects of Morphine are potentiated by the presence of other CNS depressant such as antihistamine (Benadryl) or psychotropic drugs (Ativan) " CNS depression such as repiratory depression, Hypotension and profound sedation and Coma.

At 12:28 PM, resident was found to have no pulse or respirations.

5. R27 had diagnoses that included Down's Syndrome, Dysphagia, Parkinson's Disease, Depression and Shy Dragger Syndrome per facility Face Sheet dated 3/28/06.

R27's Doctor's telephone orders dated 3/28/06 state "Admit to Hospice, Add Roxanol 5-10 mg PO (by mouth) PRN (as needed)."

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On 2/26/08, E6, night shift nurse confirmed that her interview with the ISP was accurate and restated that at 6:30 AM she had given R27 10 mg of Morphine. She said that she told E14,the day shift nurse, about this dose on report during the shift change and that she specified the time the Morphine was given to E14. After giving the report , she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine on her hand. E6 stated that before she left, R27 was breathing normally without difficulty with respirations.

The Nurse's note on 4-2-06 at 7 am by E14, state, "Resident observed with rapid resp. abd. (abdominal) Very congested. PO2 86 on 4 liter O2. per mask.Morphine given."

With R27 displaying identified congestion and low PO2 while in Oxygen, E14 gave the Morphine. The Morphine was ordered to be given every two hours for pain or Dyspnea and E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 said that she emphasized this in her chnage of shift report.

Again at 10:30 am, E14 charted "Continues to have labored respiration 28-30 min c congested gurgling. MSO4 given."

At 11:50 AM the resident expired. There was no assessment to show if Morphine was appropriate for R27 with the congested gurgling and labored respirations.

6. The medical records of R30 and R33 were reviewed. Both records reflect orders for

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Morphine which was given regularly until they expired. R30 and R33's records did not reflect an initial pain assessment or base-lining prior to the use of Morphine. The Morphine was used regularly with no documentation of the type and amount of pain the staff were trying to control the pain nor were there assessments to show effects and side effects of the Morphine for each resident.

The facility took the following actions to remove the immediacy and lower it to severity level 2:
1. The residents affected have since expired.
2. On 4/5/08 an audit completed and each resident in facility with existing order for psychoactive/pain medication was checked to assure order secured by physician with acceptable dosage and instructions and clinical indication for use.(see Attachment D) Audit also included resident reviews receiving Scheduled II-V pain medication to assure "Step Approach to Pain Management" was followed (see Attachment E) All issues identified were corrected. On 4/4/08 DON made walking rounds and each resident visually assessed for overmedication. On 4/5/08 each resident administered a controlled substance in last 48 hours assessed for rspiratory depression, confusion, lethargy, etc (see Attachment D) No resident identified.
3. To ensure provision of necessary care and to safeguard each resident from receiving unnecessary drugs, each nurse required to attend in services prior to administering medications. In servicing conducted in coordination with nursing schedule as of 4/6/08 and included "Step Approach to Pain Management" and Pain Management Standard (see Attachment F) Nurses re inserviced on

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F 309	Continued From page 79 obtaining MD orders with specific dosing and frequency and indications of clinical necessity(see Attachment G) New Pain Flow Sheet (see Attachment H) implemented on 4/6/08. Nurses had to complete post test. New Medication and Treatment Error reporting form implemented 4/5/08. As of 4/6/08, all phone orders will be routed to Acting DON who will audit. As of 4/7/08, DON will present MD orders to IDT for review. The Acting DON will audit 5 residents receiving controlled substances to ensure compliance. Issues of staff non compliance will be addressed by Acting DON and disciplinary action will occur when warranted as per facility policy. Consultant Pharmacist will review medication regime at least monthly. 4.Audit findings will be reported to QA Committee monthly for next 90 days and they will review and revise. Medication and Treatment error sheet reviewed by DON and QA. Action plan will be developed for pattern and trends. Consultant Pharmacist will submit monthly report Effective date April 7, 2008	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to keep a safe environment for residents by:	F 323		5/1/08

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F 323	Continued From page 80 1. Leaving hazardous chemicals unlocked and accessible to residents, 2. Having medications at the bedside, 3. Not fixing the radiator cover bracket, which had sharp edges. 4. Not having oxygen signs to indicate oxygen use. The examples include: I. During the initial tour of the facility on 2/19/08 from 10:40 am till 11:20 am the following observations were made: a. The closet by Room 202 was open and it contained silvasorb gel, promogran wound dressing, boxes of rubbing alcohol bottles, boxes of hydrogen peroxide bottles, Allevyn dressing and bottles of Calmoseptine. b. There were no oxygen signs for the following rooms where oxygen was in use: 201, 215, 207, 107, 106, and 105. During the daily status meeting E1(Administrator) on 2/21/08 at around 10:00 am E1 stated that she was not aware that oxygen signs were needed to indicate oxygen use in resident's room. c. In 100 wing the housekeeping closet was found unlocked. There were soap and unidentified clear liquid spray bottles on the shelf. d. In 100 wing the soiled utility room was found open. There was a container of TB Cide Quart with caution label to Keep Out of Reach of Children. e. The oxygen storage room was cluttered and not all oxygen tanks were secured. II. During the tour of the facility with E10-A (Maintenance Director) on 2/20/08 from 9:40 am to 12:50 pm the following observations were made:	F 323		

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F 323	Continued From page 81 a. In 100 wing the soiled utility door was unlocked. the following things were observed: (i) On the counter was a sharp container, (ii) On the floor was a biohazard box containing multiple red bags of isolation garbage, (iii) A 32 ounce container of TB-Cide Quat Cleaner/Deodorizer/Disinfectant with a caution label Keep Out of Reach of Children was kept in the hand sink cabinet. b. In 100 shower room in the overhead cabinet which was unlocked (the lock was hanging from the latch) there were 30 twin blade disposable razors, two 22 fluid ounce containers of "Shout" - Triple Acting Stain remover with caution label to Keep Out of Reach of Children. c. In Room 103 there was a 5 gram container of Biofreeze Pain Relieving gel and 11 fluid ounce of Selsum Blue shampoo with caution label to Keep Out of Reach of Children. d. In Room 105 there was a brown bottle labelled "Selsum Blue" kept on the bedside table. e. In Room 109 there was 1.76 ounce container kept on the night stand. f. In Room 110 there was a 16 ounce container of Balmex- Diaper rash cream with caution label to Keep Out of Reach of Children. was kept on the night stand. g. On the linen cart which was located in wing 100 there was a 4 ounce container of Balmex-Diaper rash cream with caution label to Keep Out of Reach of Children. h. In wing 200, next to Room 211 the radiator cover bracket was hanging and the bracket had sharp edges. i. In Room 212 there was a 17.5 ounce container of Raid-Ant and Roach killer with caution label to Keep Out of Reach of Children kept on top of the refrigerator. j. In Room 303 there were two containers of	F 323		

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F 323	Continued From page 82 Fluticasone Propionate nasal spray. k. In Room 312 there were 4 boxes of Diphenhydramine HCL 25 milligrams kept on the night stand. Each box contained 48 medications. l. In Room 308 there were two containers of Deep Sea Premium saline kept on the night stand. On 2/20/08 at around 11:55 am R1 stated that he uses it whenever he needs it. m. In Room 306 there was a 10 fluid ounce container of Hand Sanitizer with caution label to Keep Out of Reach of Children kept on the bedside table. There were 2 lighters and 3 twin blade disposable razors kept ob the bedside table. III. During the initial tour on 2/19/08 at 10:30a.m. R1 was found sitting in his room with a medication cup on his overbed table that contained 3 white round pills of different sizes, 1 small orange round pill and 1 pink and black capsule. When the surveyor asked R1 if he knew what the names of these pills were and what they were for he said "no he did not" and that the nurse left them there. The facility's HCFA -672 (Resident Census and Condition of Resident) was reviewed. It indicates that there were 20 residents with psychiatric diagnoses and 38 residents with Dementia who reside at the facility.	F 323		
F 329 SS=K	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		4/7/08

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F 329	Continued From page 83 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff and other interview, the facility failed to promote and maintain the highest practicable mental, physical, and psychosocial of the resident through proper drug/ medication management and the monitoring of 5 out of 6 residents receiving hospice care and one resident receiving medication that was not ordered. These system failures of the drug regimen resulted in harm to resident (R27, R28, R29, R30, R31 and R32), and contributed to the death of R27, R28, R29, R30 and R31. These failures resulted in an Immediate Jeopardy identified on 4/4/08 and determined to have begun on 4/2/08. E1 was informed of the Immediate Jeopardy on 4/4/08 and Immediate	F 329		

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Jeopardy was removed on 4/7/08.
System failures were identified in areas of medication administration and drug storage as well as facility lack of assessments in pain monitoring:
Facility failed to:
1. Provide appropriate pain medication through accurate assessment of resident needs forR27, R28, R29, R30, R31, R32 and R33.
2. Prevent the use of Schedule II medication such as Morphine in excessive unmonitored doses for R27, R28, R29 and 31
3. Provide adequate monitoring for the continued use of Morphine according to current standard of practice or manufacturer's guidelines for R27, R28, R29, R30, R31 and R33.
4. Stop the use of Schedule II medication such as morphine after a noticeable change of condition from possible adverse reaction or possible overdose for R29
5. Assure that residents only receive pain medications as ordered by physician for. R27, R31
6. Prevent controlled medication from being given to residents without orders for R29 and R32
7. Failed to show a policy on how to identify the parameters for administration of the pain medication based on assessment, monitoring of side effects of pain medication and the effectiveness, recognizing potential side effects and untoward reactions to med administration.
8. Act upon the presence of adverse side effects of Morphine by notifying MD and documenting follow up and monitoring for one resident with change of condition after the Morphine was given without MD order. R29.
9. Assure that contracted pharmacy accurately reviews the drug regimen of residents using Morphine Sulfate and promptly identify

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irregularities when orders for Morphine were being written by Advance Practitioner Nurse.

Examples of the above failures are:

1. Based on record review, R29 was admitted to the facility from another long term care facility on 9/15/06 with diagnosis including Alcohol Abuse, Liver Cancer and Cirrhosis and was on palliative care on admission. Discharge chart from the other facility included a copy of the Physician's order sheet that indicates R29 was not on any type of pain medication and he was not complaining of any pain. Initial orders also did not include any pain medication. R29 was up in a wheelchair alert, responsive and went out to smoke throughout the day.

Documentation showed he was not complaining of any pain or discomfort until he came back from lunch on 9/17/06. R29 then went back to bed. E14, the nurse taking care of R29 charted on 9/17/06 "Complaining of extreme pain so returned to bed. Orders rec'd from Z3, RNP for comfort pack 10 mg MSO4 given with relief obtained. Resting comfortably"

The next documentation on the Nurses Note written by E9 on 9/17/06 at 3 PM state" Mother in to visit. Res.not responding at this time. Appears to be resting comfortably"

Nurses' note at the next charting at 7 PM by E9 State " Resident remains non responsive. Eyes fluttered briefly. 154/81- 98 (pulse) Respiration 14 irregular t 97.8 Non responsive to painful or verbal stimuli. Pulse Ox remained at 85-88 %. At 9 PM BP 165/91, (pulse) 98 Respiration unable to ascertain. Not breathing for 10 seconds

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then letting out a long sigh " .. Hospice was called of the condition but not the MD.

Z4 the medical director and MD for R29 was interviewed on 2/21/06. He indicated that as the Director he would expect a pain assessment to be made before calling MD. There was no pain assessment protocols in the facility and no pain assessment documented. E4 was not informed of R29 being given Morphine Sulfate and was not responsive after thirty minutes. E4 stated that he did not order any schedule II medication for that resident as R29 is on another hospice and would be covered by the hospice doctor. E4 was reminded that the Morphine order for R29 was signed as a telephone order from Z5, the nurse practitioner with E4's name on it. He indicated that the facility would call him or Z5 if they can ' t reach the regular hospice doctor but he would only order minor pain medications for resident he has not seen and order a one time order only. E4 indicated he did not see R29 and would not order pain medication such as Morphine for him.

E4 also indicated that with the change of condition after initial dosing, Morphine should not have been given thereafter. E4 was asked if the facility continued to give the doses of Morphine with R29's condition, how long it would take before the person would expire. E4 indicated that with the continued use every two hours or so, one would see adverse effect such as resident's demise in eight hours or so.

Z5, the nurse practitioner for E4 was interviewed on 3/3/08 at 5:30 PM. Z5 could not remember ever been called regarding R29's need for pain

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medication. Z5 was reminded of the telephone order written showing the following:

"9/17/06 MSO4 liquid 10-20 mg s/l q4 hours prn.
Ativan Lotensol 1-2 mg S/L q 4 hour PRN.
TO(Telephone order) Z3/E4" Signed by E14.

Z5 responded that her practice as an advanced practitioner nurse did not allow her to order schedule II narcotic medication such as Morphine. Z5 indicated that she would not order it and did not remember being called about it. Z5 indicated that the Doctor would have to be called for Morphine.

On ISP record review, E6 was interviewed on 10-26-06 reflecting the following: " E6 related E14 gave him (R29) his first dose of morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered him the morphine. E6 indicated she later discovered that 40 mg of morphine was missing. E6 put forth that R29 ' s liver disease would have metabolized how the drug metabolized in his system, and 40 mg could be a lethal dose. " This documentated interview was confirmed as accurate during interview on 2/21/08.

R29 continued to receive Morphine from falsified APN/MD order with 10 mg at 2:30 am 9-18-06, 20 mg at 8 am, 12 PM, 2 PM, 4 PM and 6 PM. The facility did not notify MD but continued to give Morphine which was not ordered to R29 with documented irregular respirations. The facility did not evaluate the effects of Morphine especially with R29 already non responsive to

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WOODSTOCK RESIDENCE	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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pain stimuli and having liver problems but continued giving it.

E4 on interview indicated that when resident is given Morphine this frequently, staff nurse or Hospice nurse should be at bedside all the time to monitor the effects of Morphine. R29 expired at 6:30 PM.

2. R32 has a diagnosis of Olivopontocerebellar Degeneration. Nurse's note on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won ' t dilate. Res will respond by squeezing my hand. Z3 notified" R32 was sent to the hospital for evaluation

During interview 2/20/08, E9 indicated that R32 did fall down and his neuro checks were irregular particularly his eyes. She had remembered E14 stating that she (E14) had given R32 a cocktail and that he would not be bothering her (E9) during her shift. She called E14 at home to find out what medication did she give R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided) Risperdal and Seroquel 25 mg tablet scheduled for 9 PM. E9 then reported this to Z5, the practitioner nurse for E4. E9 stated that Z5 got very upset indicating that she was not called about any problem regarding R32 and that she never gave order for Ativan, Risperdal and an extra dose of Seroquel.

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3. R31 was a hospice resident with a diagnosis that included COPD, Alcohol Abuse, MI, Muscle Atrophy, Depression and Alzheimer's Disease. Review of chart show regularly seen by MD reflecting progress note on 2/3/06 where E4 wrote "No problem per staff. Denies abdominal pain, nausea or vomiting. Lung has no crackles no, wheezes." On 3/3/06, E4 wrote the same progress note with no pain noted. On 4-6-06, E4 wrote the same progress note adding "Patient is comfortable, continue with current management and watch closely."

On 3-30-06, a telephone order was recieved to increase pain medication from Morphine 5-10 mg every 3 to 4 hours to Morphine 10-20 mg every 3 to 4 hours. There were no pain assessments to show the effectiveness of the Morphine medication by nurse giving it or the Hospice staff visiting. The chart did not reflect R31 complaining of pain regularly.

During interview on 2/28/08, E13, the nurse in charge of R31 on the day R31 expired, stated she saw R31during the initial part of her shift. E13 indicated that she saw R31 briefly and did not see anything wrong. E13 indicated R31 did not look like she was in pain nor having problem breathing. E13 then indicated that E14 came to help her give R31 her medication. E13 indicated that after E14 gave the medication E14 stated " R31 would not be bothering you for the rest of the day as I (E14) took care of it" E14 documented she gave Roxanol 1 cc (20 mg) at 7:30 am on R31's (Medication Administration Record) but took out 2 cc (40 mg) and distributed the amount by signing 1 cc at 7:30 am and 1 cc at 9:30 am.

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The amount taken was verified by E2 by indicating the amount left when the bottle was accurate when it was discarded 4/8/06. R31 expired at 10:30 am.

4. R28 has diagnoses of Cardiac Dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension and Dementia per MAR dated Sept. 2006.

Nurse's note on 9/9/06 at 11:30 PM, state, "Resident unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea. "

During the night shift (11-7 am) 9-9-06 to 9-10-06 documentation show no Morphine was given. On 2-21-08, E7 indicated on interview that at the end of her shift (9-10-06 11-7 am) she had given report to E14 regarding R28. She had indicated that E14 was very upset that R28 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. E7 indicated that she had told E14 that R28 did not need Morphine as she was unresponsive and not in pain. ISP interview dated 1-18-07 reflect "E7 recalled E14 told her that she should have given the Morphine anyway." E7 repeated that she had assessed resident even before leaving to see how (R28) was as she knew E14 was going to report her. E7 indicated that her assessment before she left show R28 was stable, no respiratory distress but unresponsive and not in pain.

Nurse note dated 9/10/06 at 8 am, documented that E14 gave R28 Morphine despite having agonal respirations with 20 to 30 seconds period of apnea (no breathing.) At 10 am, E14

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documents that there is no change in condition and another dose of Morphine is administered. In addition, E14 also gave Benadryl 50 mg and Ativan. There was no indication for a need for these medications. All three can cause further respiratory depression.
The PDR (Physician 's desk reference) Morphine Drug interactions as follows: " Use with other Central Nervous System Depressant. The depressant effects of Morphine are potentiated by the presence of other CNS depressant such as antihistamine (Benadryl) or psychotropic drugs (Ativan) " CNS depression such as respiratory depression, Hypotension and profound sedation and Coma.
E14 was aware of the respiratory depression as she documented this when she gave the Morphine and added two medications that would increase respiratory depression. R28 had no signs indicating the need for these PRN (as needed medication)
At 12:28 PM, resident is found to have no pulse or respirations. No assessment documented showing rationale for giving more Morphine and the added PRN.

5. R27 had diagnoses that included Down's syndrome, Dysphasia, Parkinson's disease, Depression and Shy Drager Syndrome per facility Face Sheet dated 3/28/06.

R27's Doctor's telephone orders dated 3/28/06 state "Admit to Hospice, Add Roxanol 5-10 mg PO (by mouth) PRN (as needed)

E6 interviewed on 2/26/08 confirmed her interview with ISP was accurate and restated that at 6:30 AM she had given R27 10 mg of Morphine. She had indicated that she told E14

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this on report during the shift change and that she specified the time given to E14. After the report, she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine on her hand. E6 indicated in her interview that before she left, R27 was breathing normally without difficulty with respiration.

Nurse's note on 4-2-06 at 7 am by E14, state, "Resident observed with rapid resp. abd. (abdominal) Very congested. PO2 86 on 4 liter O2. per mask. Morphine given."

With identified congestion and low PO2 while in Oxygen, E14 gave the Morphine. The Morphine is ordered to be given every two hours for pain or Dyspnea. E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 indicated that she emphasized this in her report.

Again at 10:30 am, E14 charted "Continues to have labored respiration 28-30 min c congested gurgling. MSO4 given." At 11:50 am resident expired. There were no assessments to show if Morphine was appropriate for R27 with the congested gurgling with labored respiration. E6 indicated that E14 made a remark during report "Those people aren't ment to live that long. They are ment to die in their teens and I'm going to help him along."

ISP interview of E6 done on 10-26-06 reflects the following statement: " E6 stated the narcotic book revealed that E14 had allegedly dispensed morphine to R27 every two hours.E6 said the last entry made by E14 was crossed out as R27 was already dead. E6 stated that she compared the

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F 329	Continued From page 93 narcotics book with R27 ' s bottle. E6 explained that the amount remaining in a morphine bottle could be determined by the lines along the side of the bottle. E6 put forth that she discovered that 160 mg of morphine was missing. " This statement was confirmed with interview of E6. 6. The medical records of R30 and R33 were reviewed. Both reflect orders for Morphine which was given regularly until they expired. R30 and R33's record did not reflect initial pain assessment or baselining prior to the use of Morphine and the Morphine was used regularly with no documentation of the type and amount of pain the staff were trying to control nor assessment to show effects and side effect of the Morphine for each resident. 7. The facility could not show policy and procedures on how to identify the parameters of the pain medication from assessment, requesting orders and how to follow up of the pain medication for side effect, adverse reaction and effectiveness. 8. The pharmacy review records reflect no problem with the Morphine and other drug regimen of residents above even though there was no consistent documentation of any monitoring for side effects, the presence of side effects or the effectiveness of the pain medication. The pharmacy did not also see the irregularities in signing of on Morphine count such as R31's when 2 doses were signed out but only one dose was documented as given. The pharmacy came in to review the entire chart for any irregularities in their drug regimen but did not	F 329		

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identify any problems such as the change of condition on R29 resulting from Morphine being given on an initial dose.

The facility took the following actions to reduce the severity of the Immediate Jeopardy to Level 2 in order to allow time for implementing and testing correction plan in regards to controlled substances and ongoing resident evaluations.

The facility took the following actions to remove the immediacy and lower it to severity level 2:
1. The residents affected have since expired.
2. On 4/5/08 an audit completed and each resident in facility with existing order for psychoactive/pain medication was checked to assure order secured by physician with acceptable dosage and instructions and clinical indication for use.(see Attachment D) Audit also included resident reviews receiving Scheduled II-V pain medication to assure "Step Approach to Pain Management" was followed (see Attachment E) All issues identified were corrected. On 4/4/08 DON made walking rounds and each resident visually assessed for overmedication. On 4/5/08 each resident administered a controlled substance in last 48 hours assessed for rspiratory depression, confusion, lethargy, etc (see Attachment D) No resident identified.
3. To ensure provision of necessary care and to safeguard each resident from receiving unnecessary drugs, each nurse required to attend in services prior to administering medications. In servicing conducted in coordination with nursing schedule as of 4/6/08 and included "Step Approach to Pain Management" and Pain Management Standard

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F 329	Continued From page 95 (see Attachment F) Nurses re inserviced on obtaining MD orders with specific dosing and frequency and indications of clinical necessity(see Attachment G) New Pain Flow Sheet (see Attachment H) implemented on 4/6/08. Nurses had to complete post test. New Medication and Treatment Error reporting form implemented 4/5/08. As of 4/6/08, all phone orders will be routed to Acting DON who will audit. As of 4/7/08, DON will present MD orders to IDT for review. The Acting DON will audit 5 residents receiving controlled substances to ensure compliance. Issues of staff non compliance will be addressed by Acting DON and disciplinary action will occur when warranted as per facility policy. Consultant Pharmacist will review medication regime at least monthly. 4. Audit findings will be reported to QA Committee monthly for next 90 days and they will review and revise. Medication and Treatment error sheet reviewed by DON and QA. Action plan will be developed for pattern and trends. Consultant Pharmacist will submit monthly report effective Date 4/7/08.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial	F 368		5/1/08

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F 368	Continued From page 96 evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, observation and record review the facility failed to ensure that all residents residing at the facility, including 17 residents with Diabetes, are offered a bedtime snack. The examples include: During the group interview on 2/20/08 eight out of eight residents stated that they are not offered bedtime snacks. Four of the residents in group (R11, R12, R24, R25) have a diagnosis of Diabetes and confirmed that they do not regularly receive a bedtime snack. The residents residing on the 300-400 wing stated that snacks are brought to the nursing station and left there. The residents stated that there is only one staff member who will occasionally go from room to room and offer bedtime snacks. E19 (Food Service Supervisor) was interviewed on 2/20/08 at 12:30 PM. E9-A stated that evening snacks are sent to the wings every evening. E9-A stated that specific labeled snacks for residents with Diabetes are not sent to the wings. R9 had 13 (6:00 AM) blood glucose levels below 70 between 12/6/07 and 2/20/08 (6 of these levels were below 60) according to documentation on the Medication Administration	F 368		

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F 368	Continued From page 97 Record (MAR). R9 has physician order for the administration of insulin at bedtime according to the February 2008 Physician's order sheet. R9's cognitive skills for daily decision-making are moderately impaired - decisions poor according to the facility's most current Minimum Data Sets (MDS) dated 12/31/07. R9 was observed on 2/19/08, 2/20/08 and 2/21/08 in her wheelchair. R16 has diagnoses of Insulin Dependent Diabetes and Legal Blindness and has a physician's order for administration of insulin before each meal and at bedtime according to the February 2008 POS. R16 had 11 blood glucose levels below 70 mg/dL (9 were below 60) between 12/2/07 and 2/19/08 according to the December 2007, January 2008 and February 2008 MAR.	F 368		
F 372 SS=C	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the dumpster was covered and the area around the dumpster was free of kitchen waste. The findings include: On 2/20/08 at around 12:50 pm the dumpster, which was situated behind the facility was observed to be partially (one third of the dumpster) open. There was kitchen waste like carrots, tomatoes, pieces of meat, scattered on	F 372		5/1/08

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F 372	Continued From page 98 the ground next to the dumpster. All these were confirmed by E20 (Maintenance Director) on 2/20/08 at around 12:50 pm.	F 372		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that residents are seen by their physician (Z8), in a timely manner for 2 residents (R8, R9) sampled. Findings include: R8 is an 81 year old resident who was admitted to the facility on 3/14/07. As of 2/20/07, R8 had only had three visits from the physician in charge of her care and these were documented as having been on 3/16/07, 6/5/07, and 10/207. This does not meet the requirement of at least once every 30 days for the first 90 days or once every 60 days thereafter. 1. R9 was admitted to the facility on 9/23/05 with multiple diagnoses, including Diabetes, Hypertension and Dementia according to the	F 387		5/1/08

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F 387	Continued From page 99 facility's face sheet. R9's cognitive skills for daily decision-making are moderately impaired - decisions poor according to the facility's most current Minimum Data Sets (MDS) dated 12/31/07. R9 was observed on 2/19/08, 2/20/08 and 2/21/08 in her wheelchair. R9 had 13 (6:00 AM) blood glucose levels below 70 between 12/6/07 and 2/20/08 (6 of these levels were below 60), and 3 (4:00 PM) blood glucose levels below 70 between 1/21/08 and 2/10/08 (1 of these levels was below 50) according to documentation on the Medication Administration Record (MAR). R9 is only being seen by her primary physician (Z8) every 4 months according to the physician progress notes. The physician notes (6/5/07, 10/2/07 and 1/30/08) do not address R9's low blood glucose levels. E15 (Nurse) was interviewed on 2/21/08 at 4:40 PM. E15 confirmed that Z8's progress notes do not address R9's low blood glucose levels. E2 (Director of Nursing) stated that the medical records person has sent letters to Z8 regarding the requirement to see his residents every 60 days.	F 387		
F 431 SS=K	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		4/7/08

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F 431	Continued From page 100 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation of storage areas, and interview of staff, the facility failed to assure safe, and secure storage, accurate labeling, and safe administration of drugs. Also the facility failed to properly enforce disposition of controlled medication, properly monitor controlled substances through an acceptable medical system that reconciled and accounted for all the controlled medication, and provide a consistent and accurate narcotic count that identified missing medications, named medications that should have been disposed off, and provide these medication to the resident	F 431		

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WOODSTOCK RESIDENCE	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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accurately as ordered.

These combined system failures resulted in an inaccurate provision of controlled medications, in excessive amount without check and balance, observed excess provisions of schedule II medications without orders, and obtaining other resident's schedule II medication to provide a medication dose in excess of the ordered medication. This resulted in resident's being harmed and contributing to their death.(R29, R32, R28, R27)

These failures resulted in an Immediate Jeopardy called on 4/4/08 at 3:30 PM to E1 (Administrator) and E2 (Director of Nursing).

Findings include:

The facility has a Controlled Substance Discontinuation and Destruction policy showing the following procedure:
1. When controlled substance is discontinued, the remaining medication should be sent to a designated area within the facility. They must be stored in a double locked container under destruction can be completed.
2. Do not return controlled substance to pharmacy. The narcotic sign out sheet must accompany to the designated area for all schedules III, IV, or V if determined by the facility policy.
3. The narcotic sign out sheet must accompany to the designated area for all schedule II if determined by the facility policy.
4. Any discrepancy between medication count and count on sign out sheet should be reported to the Director of Nursing.
5. Regulation requires documentation of the

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F 431	Continued From page 102 disposition of by remaining controlled substances in nurse's note or on MAR. 6. Two licensed personnel need to count and list schedule II medications to be destroyed on the DEA drug destruction form 7. The number of pills remaining in the bubble card or unit box should correspond with the balance shown in the narcotic count sheet. Date of disposition and signature of two licensed staff should be placed in the disposition box at the bottom of the narcotic sign out sheet. This form becomes a part of the resident's permanent record. 8. Medication should be destroyed and disposed of in an irretrievable manner by two licensed staff. 9. The DEA form should be signed by the two licensed staff. These policies were not followed. Based on interview and review of ISP (Illinois State Police) investigative report of individual staff interview, E6, E7, E8, E9, E12 and E13 all indicated consistently that during the period of April 2006 until end of September 2006, extra bottles of Morphine Sulfate from residents prescribed for residents that have expired were available and stored particularly on the Narcotic box of the 200 wing. E6, E9, E12 and E13 all indicated on their interview that there were extra bottles of Morphine which had belonged to residents who have died kept either in the narcotic box of the medication carts or on kept in a drawer on E2's office. All four stated that the narcotic medication should have been disposed of with two nurses witnessing but the bottles were kept per instruction of E2, DON, in case another person would need it. E8 stated that if a resident	F 431		

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F 431	Continued From page 103 died with narcotic on the weekend, they were kept in the boxes. Then the narcotic is brought to the DON's office where they were locked or left at her desk. E8 was not sure what happens when they are left at the DON's office. ISP interview of E3, ADON, on 11/02/06 reflects: E3 was asked if E2 had been storing extra Morphine at the facility. E3 replied "yes" and stated E2 wanted the Morphine kept, " Just in case somebody needs it". E3 went on to say, the Morphine was not in the narcotics book... E3 explained that on 10-30-06, two bottles of Morphine, one bottle of Ativan, an unknown amount of Risperdal and an unknown amount of Vicodin were destroyed." E3 indicated that one of Morphine bottles belonged to R28, who expired on 9-28-06. The destruction of the medication only came about when E3 stated that the facility knew the State Police were coming. During interview, E6, E9, E12 and E13 validated that before the state police started investigating, Controlled Substances, particularly the Morphine, were not destroyed as their standard of practice indicate but were saved as were the instruction by DON. All indicated that the practices of destroying controlled substances were implemented after the state police started investigating the residents using Morphine. ISP interview of E3 also reflect that E6 had brought to her (E3) attention a bottle of Morphine that had a different color and that E6 felt that there was a cover up. E3 recalled that it was after the death of R28. E3 then dumped the questionable Morphine in the toilet but did not investigate the allegation.	F 431		

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ISP documentation of investigation reflects that on 11-02-06 the facility continued to have extra bottle of Morphine kept in the medication cart of the 200 wing.

During initial tour on 2-19-08, the medication cabinet of the 200 wing still had a bingo card containing Lorazepam 0.5 mg tablets belonging to a resident that has been discharged more than a month and the 400 wing contained an extra bottle that was unaccounted for of Lorazepam liquid being stored in the medication room since 6-6-06.

Review of the Change of Shift Controlled Substance and Narcotic count reflect that Aug and Sept 2006 narcotic count were not consistently done on every end of each shift and in many shift, only one nurse signed. Review of the last three months of narcotic count, Dec 2007 to Feb 2008 still showed the counts are not done every end of the shift and/or by oncoming and outgoing nurse.

The facility's poor controlled substance/medication monitoring and control led to the following concerns:

1. Per interview of E4, MD and Z5, it was established that they did not order the comfort pack including the Morphine that E14 wrote as a telephone order:
"9/17/06 MSO4 liquid 10-20 mg s/l q4 hours prn.
Ativan Lotensol 1-2 mg S/L q 4 hour PRN.
TO(Telephone order) Z3/E4" Signed by E14.

Z4, family member on ISP interview stated that

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F 431	Continued From page 105 E1stated that she can give Morphine without medical order. During interview, E10 indicated that on 9-17-06 she was approached by E14 if she had any extra bottles of Morphine. E10 indicated that she initially denied that she had any in her Narcotic box but, E2 the DON told her to give E14 the bottle that belonged to R31 who had expired 4-8-06. E10 indicated the bottle still had R31 ' s name on it. E10 indicated that she handed the unopened bottle of Morphine to E14. E10 stated that the next day, she went to look for the bottle to check how much was given or how much was left. E10 indicated that she went to all the narcotic boxes and medication rooms but there was no trace of the bottle nor the record of the Narcotic sign off sheet for the Morphine. E14 gave R29 Morphine at 2:30 pm. E14 also sent the falsified order to Pharmacy. Pharmacy received the falsified order and sent the medications to the facility. The facility has no record of where the Morphine medication came from as the pharmacy delivered the Morphine after 8 pm. The next documentation on the Nurses Note written by E9 on 9/17/06 at 3 PM state" Mother in to visit. Resident not responding at this time. Appears to be resting comfortably" Nurses' note at the next charting at 7 PM by E9 State " Resident remains non responsive. Eyes fluttered briefly. 154/81 98 (pulse) Respiration 14 irregular t 97.8 Non responsive to painful or verbal stimuli. Pulse Ox remained at 85-88 %. At 9 PM BP 165/91, (pulse) 98 Respiration unable to ascertain. Not breathing for 10 seconds	F 431		

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then letting out a long sigh.. Hospice was called of the condition but not the MD.

On ISP record review, E6 was interviewed on 10-26-06 reflecting the following: " E6 related E14 gave him (R29) his first dose of morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered him the morphine. E6 indicated she later discovered that 40 mg of morphine was missing. E6 put forth that R29's liver disease would have affected how the drug metabolized in his system, and 40 mg could be a lethal dose. "

R29 continued to receive Morphine from falsified APN/MD order with 10 mg at 2:30 am 9-18-06, 20 mg at 8 am, 12 PM, 2 PM, 4 PM and 6 PM. The facility did not notify MD but continued to give Morphine which was not ordered for R29 with documented irregular respirations. The facility did not evaluate the effects of Morphine especially with R29 already non responsive to painful stimuli and having liver problems but continued giving it.

E4 on interview indicated that when a resident is given Morphine this frequently, staff nurse or Hospice nurse should be at bedside all the time to monitor the effects of Morphine. R29 expired at 6:30 PM.

2. R32 has a diagnosis of Olivopontocerebellar Degeneration. Nurse's note on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed

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F 431	Continued From page 107 won ' t dilate. Res. will respond by squeezing my hand. Z3 notified" R32 was sent to the hospital for evaluation During interview 2/20/08, E9 indicated that R32 did fall down and his neuro checks were irregular particularly his eyes. She had remembered E14 stating that she(E14) had given R32 a cocktail and that he would not be bothering her during her shift. She called E14 at home to find out what medication did she give R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided) Risperdal and Seroquel 25 mg tablet scheduled for 9 PM. E9 then reported this to Z5, the practitioner nurse for E4. E9 stated that Z5 got very upset indicating that she was not called about any problem regarding R32 and that she never gave order for Ativan, Risperdal and an extra dose of Seroquel. The facility did have Ativan belonging to expired residents being stored in Medication rooms during 2006 and still at present. The facility had not obtained R32's medication from the Pharmacy but E14 admitted to giving medication without order. The facility did not investigate where controlled medication were obtained from. Record of signed out level of Ativan were not kept and facility did not follow its procedure to prevent controlled drug/ medication abuse or overuse. 3. R31 was a hospice resident with a diagnosis that included COPD, Alcohol Abuse, MI, Muscle Atrophy, Depression and Alzheimer's Disease. Review of chart show regularly seen by MD reflecting progress note on 2/3/06 where E4 wrote "No problem per staff.. Denies abdominal pain, nausea or vomiting. Lung has no crackles	F 431		

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no, wheezes." On 3/3/06, E4 wrote the same progress note with no pain noted. On 4-6-06, E4 wrote the same progress note adding Patient is comfortable, continue with current management and watch closely.

During interview on 2/28/08, E10, the nurse in charge of R31 on the day she expired stated she saw R31during the initial part of her shift. E13 indicated that she saw R31 briefly and did not see anything wrong. E13 indicated R31 did not look like she was in pain nor having problem breathing. E13 then indicated that E14 came to help her give R31 her medication. E13 noted that after E14 gave the medication E14 stated " R31 would not be bothering you for the rest of the day as I (E14) took care of it" E14 documented she gave Roxanol 1 cc (20 mg) at 7:30 am on R31's (Medication Administration Record) but took out 2 cc (40 mg) and distributed the amount by signing 1 cc at 7:30 am and 1 cc at 9:30 am. The amount taken was verified by E2 by indicating the amount left when the bottle was discarded 4/8/06. R31 expired at 10:30 am.

Per interview of E2 on 2-20-08, she indicated that the nurse's came to her about irregularities on R31's care particularly the use of Morphine. E2 stated she reviewed R31 ' s whole chart and found E14's charting to be wonderful and accurate. There were no investigations on the provision of 2 doses of Morphine given at the same time.

4. R28 has diagnoses of Cardiac dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension and Dementia per MAR dated Sept. 2006.

Nurse's note on 9/9/06 at 11:30 PM,

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state,"Resident unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea. "

During the night shift (11-7 am) 9-9-06 to 9-10-06 documentation show no Morphine was given. On 2-21-08, E7 indicated on interview that at the end of her shift she had given report to E14 regarding R28. She had indicated that E14 was very upset that R14 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. . She indicated that she had told her that R28 did not need Morphine as she was unresponsive and not in pain. ISP interview dated 1-18-07 reflect "E7 recalled E14 told her that she should have given the Morphine anyway." E7 repeated that she had assessed resident even before leaving to see how she(R28) was as she knew E14 was going to report her. E7 indicated that her assessment before she left show R28 was stable, no respiratory distress but unresponsive and not in pain.

Nurse note dated 9/10/06 at 8 am, documented that E14 gave R28 Morphine despite having agonal respirations with 20 to 30 seconds period of apnea (no breathing.) At 10 am, E14 documents that there is no change in condition and another dose of Morphine is administered. In addition, E14 also gave Benadryl 50 mg and Ativan. At 12:28 PM, resident is found to have no pulse or respirations. Review of ISP interview of E6 on 10-26-06 reflect: " R28 died that Sunday morning. E6 stated she came to the facility that Sunday night, and examined the narcotic book. E6 said she compared the narcotic book with the morphine bottles on the medication cart. E6 advised she and E12 had

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F 431	Continued From page 110 previously marked the morphine bottles in order to detect any morphine that was missing. E6 determined that one bottle belonging to R28 had 160 mg missing. E6 advised she found an extra bottle of morphine that had been full and unopened the previous day. E6 maintained that the bottle now contained a bright yellow liquid. E6 advised Morphine is clear or pink in color. E6 related she smelled the bottle and it smelled sweet like juice. E6 stated she came back to the facility at 7:00 am and went to the Assistant Director of Nursing, E3 's office. E6 added that the administrator E1 and the Social Service Director E19 were present. E6 told them of the missing morphine and the bottle containing a yellow liquid. E6 advised E3 looked at the bottle containing the yellow liquid and commented, " she can't be doing this. " E3 said maybe they should try to scare E14 by telling her that autopsies could be conducted on the dead residents. E6 advised that E3 then dumped the morphine bottle containing the yellow liquid and any extra bottles of morphine in the facility. " E6 confirmed statements as accurate during interview on 2-26-08. 5. R27 had a diagnoses that included Down's Syndrome, Dysphagia, Parkinson's Disease, Depression and Shy Drager Syndrome per facility Face Sheet dated 3/28/06. R27's Doctor's telephone orders dated 3/28/06 state "Admit to Hospice, Add Roxanol 5-10 mg PO (by mouth) PRN (as needed)." E6 interviewed on 2/26/08 confirmed her interview with ISP was accurate and restated that at 6:30 am she had given R27 10 mg of Morphine. She had indicated that she told E14	F 431		

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this on report during the shift change and that she specified the time given to E14. After the report, she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine on her hand. E6 indicated in her interview that before she left, R27 was breathing normally without difficulty with respiration.

Nurse's note on 4-2-06 at 7 am by E14, state, "Resident observed with rapid resp. abd. (abdominal) Very congested. PO2 86 on 4 liter O2. per mask. Morphine given."

With identified congestion and low PO2 while in Oxygen, E14 gave the Morphine. The Morphine is ordered to be given every two hours for pain or Dyspnea and E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 indicated that she emphasized this in her report.

Again at 10:30 am, E14 charted "Continues to have labored respiration 28-30 min c congested gurgling. MSO4 given." At 11:50 am resident expired. There were no assessment to show if Morphine was appropriate for R27 with the congested gurgling with labored respiration. E6 indicated that E14 made a remark during report "Those people aren't meant to live that long. They are meant to die in their teens and Im going to help him along."

E14 despite being observed, and documenting that she gave the Morphine at 7 am adjusted the time she signed off on the Narcotic sign out sheet to reflect what was ordered one at 8:30 am and one at 10:30 am.

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ISP interview of E6 done on 10-26-06 reflects the following statement: " E6 stated the narcotic book revealed that E14 had allegedly dispensed morphine to R27 every two hours.E6 said the last entry made by E14 was crossed out as R27 was already dead. E6 stated that she compared the narcotics book with R27 ' s bottle. E6 explained that the amount remaining in a morphine bottle could be determined by the lines along the side of the bottle. E6 put forth that she discovered that 160 mg of morphine was missing. " This statement was confirmed with interview of E6.

6. The medical records of R30 and R33 were reviewed. Both reflect orders for Morphine which was given regularly until they expired. R30 and R33's record did not reflect initial pain assessment or base lining prior to the use of Morphine and the Morphine was used regularly with no documentation of the type and amount of pain the staff were trying to control nor assessment to show effects and side effect of the Morphine for each resident.

7. The pharmacy review records reflect no problem with the Morphine and other drug regimen of residents above even though there were no consistent documentation of any monitoring for side effects, the presence of side effect or the effectiveness of the pain medication. The pharmacy did not also see the irregularities in signing of on Morphine count such as R31's when 2 doses were signed out but only one dose was documented as given. The pharmacy came in to review all residents' charts for any irregularities in their drug regimenns but did not identify any problems such as the change of condition on R29 resulting from Morphine being given on an initial dose. The pharmacy filled the

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F 431	Continued From page 113 falsified telephone order Morphine for R29 when the document reflect it was ordered by MD ' s Advance Practitioner Nurse who was not authorized to order Level II controlled medication such as Morphine. Pharmacy visit failed to report the presence of extra morphine on the narcotic boxes on the medication cart which the nurses indicated on their interview was always present. E13 indicated that R31 ' s extra bottle of Morphine was kept in the 200 wing medication cart from April when she expired till it was used on another resident on August 14, 06. Pharmacy visit failed to monitor the continued unlawful storage of controlled medication such as the Ativan found on the 400 wing medication room 2/19/08 being stored in the facility since 6/6/06. The Immediate Jeopardy was identified on 4/4/08, begun on 4/2/06 called on 4/4/08 and removed 4/7/08. The facility took the following actions to reduce severity to Level 2 in order to allow time to implement and evaluate new policies and procedures. 1. Medications for all resident audited 4/7/08. 2. Walking round of entire facility done 4/5/08 by Acting DON to ensure all controlled substances properly stored and secured. On 4/5/08,DON and nurse conducted audit on all controlled substances. Audit also include analysis of accountability record with actual number of doses available to ensure acountability for each dose. Audit completed 4/7/08 and all issues identified at time corrected. 3.As of 4/6/08 nurses required to attend in service on Controlled Medication Storage Policy which requires meds to be properly stored and secured. Physical inventory done of scheduled	F 431		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTOCK RESIDENCE	309 MCHENRY AVENUE WOODSTOCK, IL 60098

(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
F 431	Continued From page 114 drugs. Any discrepancy reported to DON after 2 nurses conduct at shift change. DON will do audit on 5 med accountability records. In addition, DON or designee will audit meds for 5 residents weekly to assure proper labeling. 4. Findings reported to QA for 90 days for tracking and trending. Pharmacist will submit monthly report to QA ongoing basis and QA will review and revise as necessary. Effective Date: 4/7/08.	F 431		
F 490 SS=L	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to be administered in a manner that ensures: 1. (Resident Behavior and Facility Practice) Residents are free form the Misuse of chemical restraints; That residents are free from abuse; Residents are free from neglect; When allegations are made against staff that they are immediately and completely investigated; 2. (Quality of Life) Housekeeping and maintenance services are provided throughout the facility for a clean and safe environment; 3. (Comprehensive Assessment) Comprehensive assessments are based on the resident's RAI;	F 490		4/7/08

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Comprehensive care plans are developed for resident specific needs;
Services meet professional standards of quality;
4.(Quality of Care)
Residents receive the necessary care and services to attain their highest practicable well well being;
Residents are supervised and the environment is free of accident hazards;
Residents do not receive unnecessary drugs;
5. (Dietary Services)
Diabetic residents receive a bedtime snack;
6. (Physician Services)
Residents are seen by their physicians in a timely manner;
7. (Pharmacy Services)
The facility maintains an accurate account of all controlled medications to identify loss and diversion of controlled medications; and
8. (Administration)
The facility has a functional quality assurance committee.
Immediate Jeopardies began on 4/3/06.
The facility remains out of compliance at a Severity Level 2. Additional time is needed to monitor and evaluate the effectiveness of the revised policies and procedures to ensure their implementation.

These failures apply to all 71 residents residing in the facility.

The examples include:

1. (A) Administration failed to ensure that a resident is not given psychotropic medication without a medical reason and for the purpose of convenience. The staff action to give a

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combination of Ativan without MD order and Seroquel outside the scheduled order resulted on R32 having a fall with injury and hospitalization

(B.) Through interviews and record review it was determined that the facility failed to protect residents receiving end of life care, from abuse of the controlled medication liquid Morphine Sulfate. E14 a nurse made repeated negative statements to her peers relating to hastening the death of residents receiving end of life care. Morphine Sulfate was given without an order or was not administered within the prescribed parameters (dosage/timing). These failures contributed in 5 suspicious deaths (R27, R28, R29, R30, and R31) related to the use of liquid Morphine Sulfate from 4/2/06 to 9/18/06.

(C.) Through interviews and record review it was determined that the facility neglected to: Initiate and conduct a complete and thorough investigation after allegations were made against a staff nurse working at the facility (E14 LPN)on 4/3/06; Protect other residents from possible injury/abuse related to the misuse of Morphine Sulfate during end of life care; Assess the need for and monitor residents receiving Morphine Sulfate on a PRN basis (as needed) during end of life care; Ensure that there is an accurate account of all controlled medications to identify loss or diversion of controlled medications; Notify local law enforcement of possible criminal activity involving the potential missuse of narcotic medications by (E14 LPN); and Ensure that medications administered to residents are timely and have been ordered by a physician.

This neglect began on 4/3/06 when E13 (LPN) made E2 (DON) aware of E14's use of liquid

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Morphine Sulfate in the death of R27 on 4/2/06. Between 4/8/06 and 9/18/06 there were four other deaths related to the use of Morphine Sulfate (R31, R30, R28, and R29). There was approximately 5 months between the time E13 reported her concerns about E14 (LPN) to E2 (DON) and R29's death on 9/18/06. On 9/30/04 during the day shift E14 gave R32 an undetermined amount of Ativan without a physician's order along with the scheduled PM dose of Seroquel 25 mg. On 9/30/06 R32 fell out of his wheel chair and sustained abrasions to his face and head on the evening shift. R32 was sent to the hospital for evaluation and treatment. These areas of neglect apply to 5 of 6 residents receiving end of life care (R27, R28, R29, R30, and 31) and one resident who was administered a medication without a physician's order (R32).

(D.) Based on interview and record review the facility failed to initiate and conduct a thorough investigation when staff nurses alleged that E14 (LPN) was not administering Morphine Sulfate as ordered by the physician. Nursing staff alleged that six residents either received more Morphine Sulfate than was ordered, or received medications at times that were outside of the prescribed parameters (dosage/timing). Facility administration was made aware of the allegations concerning E14's care and treatment of R27 on 4/3/06. These failures contributed to the suspicious death of 5 other residents receiving liquid Morphine Sulfate during end of life care from 4/8/06 to 9/18/06 (R27, R28, R29, R30, and R31).

2. (A.) Facility administration failed to provide necessary housekeeping and maintenance services to maintain a clean and comfortable

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interior for 71 residents.

E12 (Head of Housekeeping and Laundry) stated that she has three housekeepers on the weekdays and two housekeepers on the weekends. E12 stated that there are total of 70 rooms that the housekeepers have to clean, out of which 55 are resident rooms.

3. (A.) Through observation, interview and record review facility administration failed to ensure that a comprehensive assessment of a resident's needs is being done in the area of pain and comfort for 4 of 15 sampled residents sampled (R1, R6, R11, R14).

(B.) Through surveyor observation, interview and record review facility administration failed to have individualized Diabetic Management care plans that identified the residents specific concerns. Administration also failed to ensure that resident care plans have individualized goals and approaches to address specific concerns, and failed to have care plans for residents with pain. This applies to 8 of 17 residents residing at the facility who have a diagnosis of Diabetes.

(C.) Through surveyor observation, interview and record review facility administration failed to ensure that: Staff nurses follow physician's treatment orders; Staff Nurses follow physician's order for medication administration; Sign the medication administration record (MAR) immediately after administering medication to the resident; Assess a resident for signs and symptoms of urinary tract infection and consistently document the urine output on the output sheet. This applies to 5 of 15 residents in the sample (R6, R19, R26, R18, R4).

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4. (A.) (I) Through surveyor observation, interview and record review facility administration failed to ensure that: Staff nurses notify the physician of alert value and severely low and high blood glucose results; Monitor the clinical condition of residents around the time of low or high blood glucose results; Recheck and treat low blood glucose levels; Have a written policy regarding the treatment and rechecking of abnormal blood glucose levels; Staff are knowledgeable of the facility's policy for hypoglycemia and hyperglycemia; The correct dose of insulin was administered per the physician's sliding scale order; and follow the physician's order for administering daily insulin and performing blood glucose checks. These failures are likely to result in serious hypoglycemic or hyperglycemic reactions and have the potential to affect all 17 residents with Diabetes who currently reside at the facility.

(II) Administration failed to ensure that nursing staff assess a resident for his ability to self-administer medication prior to handing the medications over to the resident to self-administer. R1 took his 9:00 AM, 1:00 PM and 5:30 PM medications (15 medications in all) all at once on 1/11/08. On 1/28/08 R1 was again given all of his medications to take out with him to self-administer.

(III) Administration failed to: Ensure staff nurses assess residents for pain and their need for pain medications prior to administering pain medica tions; Ensure staff nurses assess and monitor residents after providing controlled medications to identify side effects, medication reactions and/or the need for additional pain medication, or

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the holding of a medication when when residents are having an adverse reaction; Ensure controlled medications are being administered only when there is a physician's order; Ensure that a staff nurse followed physician's orders when giving controlled medications to (R27, R28, R31, and R32).
Notify the MD and document a change of condition after the Morphine was given to a resident without an MD order (R29).

(B.) Administration failed to maintain a safe environment for residents by: Leaving hazardous chemicals unlocked and accessible to residents; Having medications at the bedside; Not fixing the radiator cover bracket, which had sharp edges; and not having oxygen signs to indicate oxygen use.

5. Administration failed to ensure that all residents residing at the facility, including 17 residents with Diabetes, are offered a bedtime snack.

During the group interview on 2/20/08 eight out of eight residents stated that they are not offered bedtime snacks. Four of the residents in group (R11, R12, R24, R25) have a diagnosis of Diabetes and confirmed that they do not regularly receive a bedtime snack. The residents residing on the 300-400 wing stated that snacks are brought to the nursing station and left there. The residents stated that there is only one staff member who will occasionally go from room to room and offer bedtime snacks.

6. Administration failed to ensure that residents are seen by their physician (Z3), in a timely manner for 2 residents (R8, R9) sampled. R8 is

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F 490	Continued From page 121 an 81 year old resident who was admitted to the facility on 3/14/07. As of 2/20/07, R8 had only had three visits from the physician in charge of her care and these were documented as having been on 3/16/07, 6/5/07, and 10/207. This does not meet the requirement of at least once every 30 days for the first 90 days or once every 60 days thereafter. E4 (Nurse) was interviewed on 2/21/08 at 4:40 PM. E4 confirmed that Z3's progress notes do not address R9's low blood glucose levels. E2 (Director of Nursing) stated that the medical records person has sent letters to Z3 regarding the requirement to see his residents every 60 days. 7. Administration failed to ensure safe and secure storage, accurate labeling and safe administration of drugs, proper disposition of controlled medication, proper monitoring of controlled substances through an acceptable medical system that reconciled and accounted for all the controlled medication, provide a consistent and accurate narcotic count that identifies missing schedule II medications to include medications that should be disposed. These combined system failures resulted in inaccurate provision of controlled medications in excessive amount without check and balance, provisions of schedule II medications without orders, obtaining other residents' schedule II medication to provide medication dose in excess of ordered medication. These resulted in residents being harmed and contributing to their death.(R29, R32, R28, R27) 8. Based on record review and interview the facility failed to ensure the presence of a quality	F 490		

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F 490	Continued From page 122 assessment and assurance committee that included the participation of a physician on the committee. On 2/21/08, a list of the QA committee members was requested from E1. When the list was presented, there was a notable lack of a physician listed. The list provided indicated that the committee had met on 11/14/07 with no physician and also on this day no director of nursing present. It met again on 12/5/07, with no physician, and on 1/2/08 with no physician present. When interviewed, E1 stated that the medical director never attends the meetings. Upon further inquiry, E1 stated that the Medical Director (Z4) had not been invited to attend the meetings. The Immediate Jeopardy was identified on 4/4/08, began on 4/2/06 when unnecessary drugs were used. Immediate Jeopardy called on 4/4/08 to EI. Removed on 4/7/08. The facility took the following actions to reduce severity to Level 2 in order to allow time to implement and evaluate new policies and procedures. 1. The DON has been removed from her position as of 4/4/08. 2. All residents potentially affected identified . 3. Registered Nurse assumed position of Acting DON as of 4/4/08. On 4/4/08 Nurse Consultant was contractedc and new Director of Operations scheduled routine facility visits to provide administrative oversight. On 4/5/08 Nurse Consultant educated Acting DON and implemented new policies and procedures. A form was developed and implemented 4/7/08	F 490		

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F 490	Continued From page 123 where staff members can anonymously submit concerns. Social service Director will route to appropriate Administrative staff. Management concerns go to Director of Operations, Director will audit all forms for system failures. Monthly meetings will be conducted with staff for minimum of 3 months. 4. Nurse Consultant and Director of Operations will attend monthly QA and review for trends. Effective April 7, 2008.	F 490		
F 492 SS=H	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify local law enforcement of possible criminal activity involving the potential missuse of Morphine Sulfate by (E14 LPN). This failure to report this allegation contributed to four other suspicious deaths related to the use of Morphine Sulfate after 1 resident expired on 4/2/06. This applies to 5 of 6 residents receiving hospice care at the facility (R7, R28, R29,R30 and R31). The examples include: 1. The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 reported that E14 (LPN) said, "Those people aren't meant to live that long. They are	F 492		5/1/08

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F 492	Continued From page 124 meant to die in their teens and I'm going to help him along." The report further states, "E6 recalled that approximately forty-five minutes later, she observed E14 leaving R27's room. E6 thought this was odd because R27 should not have been given any Morphine for at least another hour and a half....E6 said that she compared the narcotics book with R27's Morphine bottle. E6 explained that the amount remaining in a morphine bottle could be determined by lines along the bottle. E6 put forth that she discovered that 160 mg of Morphine was missing." R27 expired on 4/2/06. 2. The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). The report states, "E6 recalled R28 suffered from Dementia, was easily agitated, and would often hit people. E6 stated she came to the facility on Saturday, and had a conversation with E14 (LPN) in the smoking area. According to E6, E14 told her, R28 is "going to die in half an hour." E14 then told E6 that she had given her 30 mg of Morphine. When E14 noticed the shocked expression on her (E6) face, E14 later said that she gave her 20 mg..." E6 further states in the report, "E7 (RN) took over the care of R28 that night. E6 professed that E7 did not dispense any Morphine to R28 because she was unconscious....E6 stated she determined that one Morphine bottle belonging to R28 had 160 mg of Morphine missing....E6 stated she knew that E14 was overheard bragging about over-medicating R28 in the smoking area in the back of the facility on that Saturday and Sunday. E6 explained E12 (LPN) and other CNA's overheard E14 state," I can't believe she's still alive with all the Morphine I've given her." R28 expired in the facility on 9/10/06.	F 492		

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F 492	Continued From page 125 3. The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 stated, R29 a resident suffering from liver failure, had just been put on Hospice. E6 indicated that R29 had been sitting upright in his wheel chair, was alert, and was even smoking. E6 stated E14 (LPN) gave him (R29) his first dose of Morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered the Morphine. E6 indicated that she later discovered that 40 mg of Morphine was missing. R29 expired at the facility on 9/18/06. 4. Two other residents died in the facility after receiving liquid Morphine Sulfate (R30 and R31) per the Illinois State Police Investigative Summary (Synopsis) dated 12/12/06. R30 received an order dated 8/14/06 for Roxinal liquid (Morphine) 10 to 20 mg sublingual every 2 hours as needed. An order for Morphine was received at 1:51 PM from R30's physician. At 6:50 PM, R30 was found to have no pulse or respirations. The Illinois State Police Investigative report dated 7/10/07 documents that E14 approached E2 (Director of Nursing) and stated that R30 was just prescribed Morphine but it had not been delivered from the pharmacy yet. E2 instructed E14 to use Morphine from a deceased resident R31 who expired on 4/8/06. There was no documentation in R30's chart showing R30 received Morphine. The bottle of Morphine that was given to E14 could not be found the day after R30 expired. R31 died on 4/8/06. The Illinois State Police Investigative Report dated 10/31/06 documents an interview with E13 (LPN). 'E13 related that	F 492		

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F 492	Continued From page 126 E14 told her that she gave R31 Morphine. E13 explained that R31 was already unconscious, and could not be in any pain. E13 put forth that E14 then told her, "She won't make it through the day. I made sure of that." E13 indicated R31 died at noon that day.' The facility was unable to provide any documentation showing that the local police were ever informed of E14's alleged misuse of Morphine Sulfate for resident's receiving end of life care. On 2/21/08 at 12:10 PM E1 (Administrator) confirmed to surveyors that the police were never notified about any allegation concerning E14 (LPN). The facility was unable to provide a policy and procedure on when local law enforcement is to notified about alleged criminal activity.	F 492		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain records for each resident accurately and according to professional	F 514		5/1/08

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F 514	Continued From page 127 standard and practice. This involved records for 6 residents: R27, R28, R29, R30, R31 and R33. Finding includes: During the initial tour, surveyor requested all the medical records pertaining to R27, R28, R29, R30, R31, R32 and R33 from E1, Administrator. E1 indicated that the facility had no documentation of any of those residents as they were all taken by Illinois State Police (ISP) as part of an investigation. The facility provided only the partial chart of R32 and the care plan from R33. Surveyor again requested any additional documentation such as Hospice notes, Care Plans, and any assessments done in the facility. The facility then provided R31's hospice documentation, but no other medical documentation for R27, R28, R29, R30, R31 and R33. Review of R27, R28, R29, R30, R31, R32 and R33 ' s subpoenaed records were done on 1-9-08 and 1-10-08 at the ISP center. Records that were subpoenaed for R28, R29 and R 31 did not have any care plans and MDS (Minimum Data Sets) attached. R27, R28, R29, R30, R31 and R33 ' s record did not have any initial assessment for pain, pain management and monitoring of pain medication documentation. R27, R28, R29, R30 and R33 ' s records also did not reflect Hospice documentation and care planning to show what care needs were addressed by Hospice and the facility staff and the charting of the care provided by the Hospice. During the annual survey, surveyors asked E1 to show any other documents that each of the above residents may have that were not included on the subpoenaed records sent to ISP. E1	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. BUILDING ____ B. WING ____	04/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTOCK RESIDENCE	**309 MCHENRY AVENUE WOODSTOCK, IL 60098**

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F 514	Continued From page 128 stated that whatever the facility had as medical records for the residents was in the subpoenaed records and not available in thr facility. Since the assessments were not in the records compiled by ISP and could not be provided by the facility, there was no evidence that they had been done.	F 514		
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the active participation of a quality assessment and assurance committee	F 520		5/1/08

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. BUILDING ______ B. WING ______	04/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTOCK RESIDENCE	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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F 520	Continued From page 129 that includes the participation of a physician on the committee. Findings include: On 2/21/08, a list of the QA committee members was requested from E1. When the list was presented, there was a lack of a physician listed. The list provided indicated that the committee had met on 11/14/07 with no physician and also on this day no director of nursing present. It met again on 12/5/07, with no physician, and on 1/2/08 with no physician present. When interviewed, E1 stated that the medical director never attends the meetings. Upon further inquiry, E1 stated that the Medical Director (Z4) had not been invited to attend the meetings. Based on this, there is no exchange of information between the medical director or any other physician to enhance the functioning of the QA committee and allow for better development or revision of clinical protocols based on current standards of practice, revision of policies and procedures, training for staff concerning changes, and standards for evaluating staff performance.	F 520		