STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145680	A. BUILDING _____ B. WING _____	C 04/19/2016

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ROSEWOOD CARE CENTER OF MOLINE	7300 34TH AVENUE MOLINE, IL 61265

(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 000	INITIAL COMMENTS Original investigation of complaint #1621969/IL84742	F 000		
F 155 SS=G	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the advance directives regarding cardio-pulmonary resuscitation for one resident (R1) of three reviewed for advance directives in a sample of six. This failure resulted in facility staff not performing cardio-pulmonary resuscitation on R1, contrary to R1 ' s advance directive to be resuscitated as documented in the resident 's	F 155		

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

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medical record. R1 then expired in the facility.

FINDINGS INCLUDE:

The facility policy entitled "Code Status", revised 1/2016, documents,"(The facilty) will honor code status preferences as documented by the resident or their legally authorized representative...A physician's order will be obtained by the nurse, based on code status preference indicated by the resident, legally authorized Health Care Power of Attorney (POA), or legally authorized Health Care Surrogate...In the absence of a valid Do Not Resuscitate (DNR) order (including when no code status decision has been made or code status cannot be determined), CPR (cardiopulmonary resuscitation) will be initiated and emergency services will be called using 911."
R1's Facility Face Sheet, dated 4/8/16 documents R1 was readmitted to the facility on 4/8/16.
R1's Physician Order Sheet, dated 4/8/16 includes the following physician orders, "Advance Directives: Full Code."
R1's Do-Not-Resuscitate/Practitioner Orders For Life-Sustaining Treatment (POLST) Form dated 4/8/16 documents, "Cardiopulmonary Resuscitation; If patient has no pulse and is not breathing, attempt resuscitation/CPR" and is signed by R1's sister (Health Care Surrogate Decision Maker).
R1's Social Services Progress Notes, dated 4/8/16 document, "(R1) is a full code."
R1's Care Plan, dated 4/8/16 documents, "Full Code (current status). Will honor residents request for Full Code. If cardiac arrest, initiate CPR and call 911."
R1's Nurse's Notes, dated 4/13/16 at 7:50 A.M. document, "Noted (R1) to be sleeping, no S/S

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(signs/symptoms) of discomfort."
R1's Nurse's Notes, dated 4/13/16 at 9:15 A.M. document, "CNA (certified nursing assistant) approached writer and asked for writer to come to (R1)'s room. Writer immediately went to room and found (R1) with (no) apical/radial pulse, (no) BP (blood pressure), blue nail beds, rigor mortis (and) mottling noted. CPR not initiated d/t (due to) absence of vital signs, pulse, respiration, cyanosis noted around mouth. Body was cold at extremities, warm to groin."
R1's Nurse's Notes, dated 4/13/16 at 9:20 A.M. document, (E9) Registered Nurse assessed (R1) and also found (R1) (with) (no) B/P, respirations, pulse. Writer, ADON (Assistant Director of Nurses) returned to room for further assessment. (DON) (E2/Director of Nurses) entered room and all agreed absence of vital signs, cyanosis, mottling and rigor mortis present."
R1's Nurse's Notes, dated 4/13/16 at 9:35 A.M. document, "(R1) pronounced dead."
The facility form, Incident Investigation, dated 4/13/16 documents, "Res (resident) expired. Upon initial exam it was identified and confirmed by multiple nurses that the resident had no signs of life, no vital signs, (R1) was mottled and rigor mortis was noted. CPR not initiated R/To (related to) prior."
E11/Assistant Director of Nurses Incident Investigation statement, dated 4/13/16 documents, "I was sitting in the DON (Director of Nurses) office when (E6/LPN) nurse called to inform (E2/DON) that (R1) was unresponsive in (R1)'s room in bed. (E11/ADON) notified (E2/DON). (E11/ADON) went to (R1)'s room where CNA's were performing post mortem cares...(R1) was left to the care of the CNAs."
On 4/19/16 at 10:08 A.M., E5/Certified Nursing Assistant (CNA) stated, "(On 4/13/16) I had just

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cleaned (R1) up about 8:00 O'clock (A.M.) . (R1)'s eyes were open and (R1) was blinking (R1)'s eyes yes or no (answering questions). About 9:00 o'clock , (E10/CNA) went in (R1's room) and came out in the hallway and said, 'I think (R1) passed.' I got a stethoscope and checked for a heart beat and I couldn't hear anything. So I sent (E10/CNA) to get the nurse. (R1)'s fingers were blue. I did not start CPR. I did not see the nurses do CPR. I wasn't sure if I should (start CPR) or not."

On 4/19/16 at 11:10 A.M., E6/Licensed Practical Nurse (LPN) stated, "On the thirteenth, I gave (R1) a scheduled breathing treatment before 8:00 A.M. I noticed (R1) was grimacing, so I gave (R1) 650 MG (milligrams) of Tylenol (for pain). I went to the breakfast room from 8:00 until 9:10. (E10) CNA came and got me and said something is wrong with (R1). (R1) was gray. I had a stethoscope, I checked (R1)'s pulse. (There) was no pulse, no blood pressure, no respirations. (R1) was cyanotic and mottled. I immediately went to (R1)'s chart and saw (R1) was a full code. I called (E2/Director of Nurses). (E2/DON) wasn't in (E2)'s office. The ADON (Assistant Director of Nurses) (E11) came down and assessed (R1) and then (E2) DON came and assessed (R1). The group of us decided not to start CPR, (R1) was too far gone. (R1)'s groin was still warm, (R1)'s extremities were cool. (R1) did have a fan going on (R1), in (R1)'s room. I called (R1"s Power of Attorney), (R1's Power of Attorney) was in shock. (R1's Power of Attorney) didn't expect it (R1's death). I know quite a bit of time passed, from when (R1) was found and until we pronounced (R1) dead. (R1) was a full code. I did not perform CPR on (R1)."

On 4/19/16 at 1:00 P.M., Z2 (Physician) stated, "I saw (R1) the one and only time the day before

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F 155	Continued From page 4 (R1) passed away. I spent a great deal of time reviewing (R1)'s medical record from (R1)"s previous hospitalizations. (R1) had surgery a few months ago and suffered many set backs and complications...When (E6/LPN) called me about (R1)"s passing, I asked (E6/LPN) if (E6/LPN) instituted advance life support. (E6/LPN) told me repeatedly (E6/LPN) did not (do CPR) due to rigor mortis already setting in. Rigor mortis sets in , in two to four hours after death, but it is variable." On 4/19/16 at 2:55 P.M., E2/ Director of Nurses stated, "I did an investigation (into R1's death), because it was so bizarre. (R1) had only been here a short time...The nurses made the decision not to do CPR and the doctor had been called."	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		

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or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the physician of a change in a resident's condition for one of three residents (R1) reviewed for physician notification in a sample of six.

FINDINGS INCLUDE:

The facility policy, Reporting Significant Changes in Resident's Condition, dated 11/98 instructs staff, "Each charge nurse will be responsible for assessing the resident's condition on a continual basis. The charge nurse will notify the physician of any significant change in the resident's condition at the time the change is noted."

R1's current Physician Order Sheet, dated April 2016 includes the following diagnoses: Sepsis, Pneumonia, Respiratory Failure, Status Post Esophageal Perforation during repair of Diaphragmatic Hernia and Cholecystectomy with Abdominal Abscesses and Mediastinal Abscess, Cerebral Palsy.

R1's Nurse's Notes, dated 4/10/16 at 12:00 P.M.

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F 157	Continued From page 6 document, "(R1) was asked if in any pain, (R1) looks at nurse. Alert, but does not say anything. (R1) was asked if in any pain, blink twice. (R1) blinked twice. (R1) warm to touch. Temp (temperature) was taken and it is 101.8 degrees. Tylenol 650 MG (milligrams) given PRN (as needed) via J (jejunostomy) tube. No complaints. (R1) repositioned every two hours. Continuous feeding present and oxygen. Will continue to monitor." R1's Vital Sign Flow Sheet documents R1's Temperature as 97.9, 98.1, 97.1 and 97.4 on 4/8/16 and 4/9/16. On 4/19/16 at 9:50 A.M., E4/Licensed Practical Nurse (LPN) stated, "(On 4/10/16) a CNA (certified nursing assistant) came to me and said (R1) was feeling warm. When I went to the room, (R1) was sweaty. (R1) had sweat on (R1)'s face and (R1)'s hair was wet. (R1)'s temperature was 101.8 (degrees). I gave (R1) some tylenol. I called the doctor about something else, but I had to leave a voice mail. So I didn't get a chance to tell (the doctor)." On 4/19/16 at 12:50 P.M., E2/Director of Nurses verified that a nurse is to call the physician with a change in a resident's condition, including an elevated temperature.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to cover a stage two pressure ulcer and failed to perform incontinence care to prevent contamination of a stage two pressure ulcer for one of three residents (R3) reviewed for pressure ulcers in a sample of six.

FINDINGS INCLUDE:

On 4/18/16 at 1:05 P.M., E3 and E12 Certified Nursing Assistants (CNAs) and E13 Rehab/Restorative Aid prepared to transfer R3 from the wheel chair to bed via a mechanical lift. After transferring R3, E3 and E12/CNAs, removed R3 pants and adult incontinence brief. There was a large amount of brown stool in the brief. A 2 CM (centimeter) X 1 CM X 0.4 CM deep pressure ulcer was present to R3's coccyx. The pressure ulcer had a pink wound bed with a white macerated area surrounding the wound. No dressing was in place, covering the wound. Using a disposable wipe, E3/CNA cleaned R3's buttocks, including the pressure ulcer. Wiping the wound with the soiled cloth. E3 and E12/CNAs then applied a clean disposable incontinence brief on R3, repositioned R3's covers, handed R3 the remote control and left R3's room.

R3's Pressure Ulcer Risk Assessment, dated 3/9/16 documents R3 is at High Risk for the

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development of pressure ulcers.

R3's current Care Plan, dated 3/6/16 documents, "Problems: Stage 2 Coccyx Wound. Interventions: Assess wound weekly. Monitor for signs and symptoms of infection. Provide treatment as ordered. See Treatment Administration Record. Use caution to protect area."

R3's current Physician Order Sheet, dated April 2016 includes the following treatment orders: Cleanse wound to sacral area with Normal Saline, apply Wound Gel. Cover with (non-adherent dressing) and tape.

On 4/18/16 at 1:15 P.M., E3/CNA stated, "I didn't mean to wipe over (R3)'s bed sore with it (disposable wipe). I don't know why (R3) didn't have a dressing on (R3)'s wound. I didn't get (R3) up this morning."

On 4/18/16 at 1:25 P.M., Z1/Certified Nursing Assistant (CNA) stated, "I am an Agency CNA. This is my first time working here (the facility). I got (R3) up before 8:00 A.M. I don't remember (R3) having a dressing on (R3's coccyx) when we got (R3) up. Nobody told me (R3) had a pressure ulcer."

On 4/19/16 at 12:50 P.M., E2/Director of Nurses confirmed (R3) should have a dressing in place to (R3)'s coccyx at all time. E2/DON also confirmed a pressure ulcer wound should not be cleaned with a soiled, disposable wipe. Despite repeated requests, E2/DON did not provide a policy for wound cleansing or application of a wound dressing.

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a physician-ordered medication for pain for one of three residents (R1) reviewed for pain in a sample of six.

FINDINGS INCLUDE:

The facility policy, Physician Orders, dated (revised) 3/15/2013 directs staff, " Section 111. Telephone Orders: For orders given by the prescriber to the nurse over the telephone, the nurse will: Repeat the order back to the

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prescriber to ensure accurate understanding. Write the order onto the Telephone Order form; include date and time order was received. Transcribe the order onto the POS (physician order sheet) in proper format, noting a telephone order. Record the medication or treatment onto the MAR (medication administration record) or TAR (treatment administration record). Carry out the orders as appropriate."

R1's Physician Order Sheet, dated April 2016 includes the following diagnoses: Sepsis, Pneumonia, Respiratory Failure, Status Post Esophageal Perforation during repair of Diaphragmatic Hernia and Cholecystectomy with Abdominal Abscesses and Mediastinal Abscess, Cerebral Palsy. Also included is the following order: Hydrocodone 7.5 MG (milligrams)/325 MG per 15 ML (milliliters). To receive 10 ML per J-Tube (jejunostomy tube) every 6 hours scheduled at 6:00 A.M., 12:00 P.M., 6:00 P.M. and 12:00 A.M.

R1's Nurse's Notes dated 4/12/16 at 1:30 P.M. documents, "(R1) crying and shaking head 'Yes' when asked about pain. Medicated with PRN (as needed) Tylenol per J-Tube. Family at bedside and stating resident is definitely having 'a lot of pain'. Immediate call placed to Z2 (R1's Physician) with report of the above. New orders received/noted for Hydrocodone Elixir 7.5/325 MG per 15 ML, to receive 10 ML per J-Tube every six hours scheduled at 6 AM-12 PM-6 PM-12 AM. Family, including (R1's sister) aware. Spoke with pharmacy, she is going to call (Z2) on (Z2)'s cell phone to obtain emergency supply."

R1's Medication Administration Record, dated April 2016 includes the following medication:

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"Hydrocodone Elixir 7.5/325 MG per 15 ML. To receive 10 ML per J-Tube every six hours." No staff initials are noted to indicate R1 received this medication on 4/12/16 at 6:00 P.M. or at 12:00 A.M. on 4/13/16.

On 4/19/16 at 11:10 A.M., E6/Licensed Practical Nurse (LPN) stated, "(Z2) ordered Hyrocodone liquid (On 4/12/16). (Z2) said to put (Z2)'s cell phone number on the telephone order and have them (Pharmacy) call (Z2). You can get an emergency supply (of medication) if they talk to the doctor. The medicine was not here when I left at 2:15 P.M. The next day I came in (4/13/16) the medicine was not here, so I called the pharmacy. They said they missed the phone number to call the doctor, but they would call right away. The pharmacist then called me back and said the doctor had changed it (Hydrocodone liquid) to PRN (as needed). I had asked them (the day before) to 'Stat it' (emergency) it to me from (a local pharmacy), but they said they couldn't do that. The medicine never came in. (I called the doctor) on (April) twelfth because (R1's family) wanted me to call for scheduled Morphine. That is what (R1) had been receiving around the clock at the hospital before (R1) got here."

On 4/19/16 at 12:50 P.M., E2/Director of Nurses (DON) stated, "There is a (facility) policy for staff to follow when a doctor orders a narcotic medication. If a medicine is not available for staff to give a resident, the staff should call the doctor and let them know."