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F9999	FINAL OBSERVATIONS STATE LICENSURE FINDINGS: Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician.	F9999		

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F9999	Continued From page 32 Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These REGULATIONS are not met as evidenced by: Based on record review and interviews, the facility intentionally removed the oxygen from one of one sampled residents (R1). The facility staff physically held down one of one sampled residents (R1) so an injection of an anti-psychotic medication could be administered. R1 was admitted to the hospital with a subdural hematoma and died. The facility also failed to assess and monitor the condition of 1 of 2 residents sampled insulin	F9999		

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dependent residents (R13). Facility failed to notify the R13's physician that insulin was being held and not given as ordered. This failure could place the resident at risk for a diabetic reaction.

Findings include:

I. The facility "Incident Report" dated 7/5/05 at 5: 17 am by E5 (unlicensed person working as a nurse)states: "I walked up hall and heard a noise. E7 (Certified Nursing Assistant/CNA) and I walked in (R1's) room and found him on floor on back. (R1) had cut above right eye and right hand was bruised. Pressure applied to wound. Resident alert and knew name. Full ROM (range of motion) with pain at right hand and wrist. 911 called."

Hospital record for R1 show emergency room (ER) admission at 5:03 am on 7/5/05. A Computerized Tomography (CT) scan of the brain was done on 7/5/05 at 7:43 am. This report under the category "Impression" states, "Patient has an acute subdural hematoma on the right which produces mass effect on the right cerebral hemisphere."

Z1 (physician) states in his hospital admission note dated 7/5/05, "Discharged yesterday to a nursing home. This morning he was found unresponsive after falling and hitting his head on a fan. He sustained a laceration to the left forehead and on the way to the hospital he was combative and restless. He was confused in the ER.....He was unresponsive at the time I saw him . He would withdraw to pain but did not follow any commands." Under the section "Physical

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Examination" Z1 states, "He does not respond to voice commands. He does withdraw to pain with the right hand but not the left hand. He does have some Cheyne-Stokes breathing. Pupils are fixed, constricted. No corneal reflex." Under " Prognosis" Z1 states, "Grave and I do not think he will survive this subdural hematoma.....(previous medication) may be accelerating his subdural hemorrhage given his current neurologic findings and Cheyne-Stokes breathing ."

The "Preliminary Investigation Report by the County Coroner" dated 7/7/05 shows cause of death for R1 was "Acute Subdural Hematoma received in a fall."

On 7/8/05 at 10:05 am Z4 (family member) stated, "They said (R1) fell on a fan. He was on oxygen continuously at home for the past year. (Z 5, physician on call) said no one called. (R1) was unable to walk at all. We asked them to put a bed alarm on and they didn't. My sister went into the facility and there was blood all over his room. Why didn't they just put him in a (recliner chair) at the nurses desk to watch him or call us to come in?"

(Z1's) admission orders to the facility dated 7/4/ 05 at 2:30 pm show R1 as a 74 year old resident with diagnoses including: Shortness of Breath, Chronic Obstructive Pulmonary Disease (COPD), Recent Heart Attack with open heart surgery and placement of stents (MI), Chest pain, Coronary Artery Disease (CAD), Type II diabetes-insulin dependent (DM), Pacemaker and Depression.

Admission nursing notes by E30 (Licensed

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Practical Nurse) at 2:30 pm show R1 as,"Alert and oriented to person, place and time. (Zero) confusion noted." Nursing notes by E30 at 4:00 pm state, "Oxygen at 3 liters due to shortness of breath." At 6:00 pm, E30's notes state, "Family here with resident."

The "Consultation" report dated 6/28/05 provided to the facility by the hospital by Z2 (physician) upon transfer states, "He is alert and oriented to person, place and time. History of Coronary bypass grafting. Severe diffuse coronary disease with multiple previous stents. Most recent stent was in April. Chronic obstructive pulmonary disease. Oxygen dependent."

The hospital transfer sheet dated 7/4/05 from a local hospital to the nursing facility states " Oxygen at 3 - 4 liters."

Z1 (physician) stated in interview on 7/8/05 at 9: 30 am,"(R1) was alert and oriented. He knew what was going on."

At 10:00 pm on 7/4/05 nursing notes for E30 state, "Quiet at present. No other complaints offered."

Nursing notes by E5 at 10:30 pm on 7/4/05 state, "(R1) very angry and combative. Telling aids how he is going to blow up the facility with his oxygen tank. Oxygen tank removed from room. Talked with resident until he calmed down." Another entry in the nursing notes by E5 for the same time conflicts with this by stating, "Tried to calm resident to no prevail."

At 10:45 pm on 7/4/05, E5's nursing notes state, "

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Haldol 0.5 milligrams (mg) given IM (intramuscular) for severe agitation." Subsequent investigation conducted by E2 (Acting Director of Nursing) shows the actual amount of Haldol injected was 5.0 mg (10 times the amount E5 initially documented). This report states, "It was reported ..... (E5) administered Haldol 5 mg IM to (R1) on 7/4/05. (E5) stated that she did not obtain an order for the Haldol prior to administration."

E7 (Certified Nursing Assistant/CNA) was interviewed on 7/8/05 at 4:45 am and stated, "He was confused and trying to throw his bedside table at his oxygen. The nurse took the oxygen concentrator out of his room. We heard him throwing things. We even had to pull an extra CNA to help hold him for the Haldol shot. The nurse had the shot behind her back and came in after we had him still enough to give him the shot. His pulse was 48 at around 2:30 am when he was asleep. When he woke up, his vitals went back to normal. At about 4:15 - 4:30 am, (E5) heard a noise and couldn't see him in his room. (E5) called me and then I heard her scream. There was a lot of blood. His hand was black from about the wrist down. There were clots on the floor and clots on his head."

In interview with E6 (CNA) on 7/8/05 at 5:05 am she stated, "(R1) was confused when I first saw him about 10:20 pm. He told us to get out and tried to hit us. The nurse took the oxygen concentrator from him after he tried to throw a fan at it. He didn't want to stay here. [When found], (R1) was laying on the floor by the other bed. His head was on the fan. He didn't understand when we told him to stay on the floor. His hand was full

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F9999	Continued From page 37 of blood. The cut was on his left forehead. It looked like a flap of skin you could pull back. There was a lot of blood in his room and clotted blood as well. I was one of the people who helped hold him so the nurse could give him Haldol." In written statement provided on 7/11/05 shows, "(E18-CNA) stated she was instructed by (E5) to assist with administration of shot. (E18) stated she did assist with holding (R1) 'over' in order for the nurse to administer medication." The ambulance report dated 7/5/05 at 4:44 am states: "R1 was placed on 6 liters of oxygen by ambulance personnel." II. Admission sheet states R13 is 45 years old and has resided in the facility since 08/16/04. The current physicians order sheet on the record of R 13 lists Diabetes Mellitus among the resident's many diagnoses. This physicians order sheet also contains a current order for Novolin 70/30 Insulin 40 Units to be given daily at 6 AM and 4 PM and an order for an accucheck to be done at these times.. Medication Administration Record (MAR) for the month of June 2005 indicates that the 4 PM dose of the Novolin 70/30 insulin was "held" (not given) for 4 of the 30 evenings in June (6/19/05, 06/26/05, 06/27/05, and 06/28/05). This documentation is recorded by E38 (Licensed Practical Nurse). Complete record review shows that this MAR sheet is the only place in the record where it is	F9999		

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indicated that the insulin was not given. No other reference to this lack of insulin administration was found in the record or provided.

The MAR is also the sheet where the ordered accuchecks are recorded. Accuchecks for these four evenings were observed to be documented as 06/19/05--83, 06/26/05--143, 06/27/05--123, and 06/28/05--88.

During interview on 07/26/05 at 1:55 PM, E38 stated she held the insulin because of her "good sense." E38 stated no one is going to give 40 Units of insulin to someone with blood sugars that low. E38 stated she did not notify the physician of the insulin being held. E38 stated she did not record this information anywhere else in the record. E38 stated she did not know if the accucheck readings were obtained before or after R13 ate her evening meal. E38 stated "she is not at the beginning of my list (for residents requiring accuchecks done). Sometimes she eats and sometimes she doesn't. Sometimes she has eaten before I do the accucheck and sometimes she hasn't." E38 stated she would usually pass on to the next shift in report that she had held a resident's insulin. E38 was not sure if she did so on these dates or not. E38 stated the next shift should "look at the MAR." There was no assessment in the record of R13 for the remainder of the evening on the evenings that her insulin was held. When provided with R13's record, E8 could provide none.

Current physicians order sheet contained an order for Novolin R insulin to be given to R13 at 7 AM and 4 PM on a sliding scale basis depending upon the results of the accucheck. If the test

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reads over 401, R13 is to receive 15 Units of this insulin. On 07/24/05, the accucheck read 488. E 38 did not follow the sliding scale but called the physician who then ordered 15 Units of the insulin to be given. E38 stated she did not follow the sliding scale order because she did not interpret it to mean 15 Units of insulin should be given. E38 stated the reading "was high so I called the doctor."

During interview on 07/26/05 at 2:40 PM, Z3 (physician of R13) stated that he would expect to be notified when an insulin order could not be administered to his patient. Z3 stated he would make the determination to "hold" the insulin if needed.

Section 300.650 Personnel Policies

c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.

d) The facility shall check the status of all applicants with the Nurse Aide Registry prior to hiring.

Section 300.660 Nursing Assistants

a) A facility shall not employ an individual as a nurse aide unless the facility has inquired of the Department as to information in the Registry

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F9999	Continued From page 40 concerning the individual. (Section 3-206.01 of the Act) The Department shall advise the inquirer if the individual is on the Registry, if the individual has findings of abuse, neglect, or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act, and if the individual has a current background check. (See Section 300.661 of this Part.) Section 300.661 Health Care Worker Background Check f) Beginning January 1, 1996, when the facility makes a conditional offer of employment to an applicant who is not exempt under subsection (w) of this Section, for a position with duties that involve direct care for residents, the employer shall inquire of the Nurse Aide Registry as to the status of the applicant's Uniform Conviction Information Act (UCIA) criminal history record check. If a UCIA criminal history record check has not been conducted within the last 12 months, the facility must initiate or have initiated on its behalf a UCIA criminal history record check for that applicant. (Section 30(c) of the Health Care Worker Background Check Act) These REGULATIONS are not met as evidenced by: Based on record review and interviews, the facility: 1. Failed to verify current licensure status for one of three sampled Registered Nurses prior to employment (E5). 2. Failed to confirm current licensure status for	F9999		

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F9999	Continued From page 41 two of three sampled Licensed Practical Nurses (E11, E12). 3. Failed to verify certification for thirteen of sixteen sampled nursing assistants prior to employment (E13 - E28). 4. Failed to obtain healthcare worker background checks for three of nineteen sampled employees (E5, E22, E25). This failure resulted in the hiring of one employee as a Registered Nurse who is not licensed with the Illinois Department of Professional Regulation . This failure placed all residents within the facility at potential risk for abuse and improper nursing care by allowing an unlicensed person to practice as a professional nurse. Findings include: According to the personnel file of E5 (unlicensed person working as a nurse): E5 was hired on 3/ 10/05 as a Registered Nurse, License Pending (RN/LP). The personnel file for E5 shows a diploma indicating she graduated from nursing school in May 2004. The application shows prior employment as a Certified Nursing Assistant (CNA). CNA registry verification, current Registered Nurse license and Healthcare worker background check were not in her personnel file. E1 (Administrator) was unable to provide this information on 7/7/05 and 7/8/05. The facility nursing schedule shows E5 began working as an RN/LP on 3/10/05. E5 worked 13 days (6:00 am - 2:00 pm) in March as an RN/LP, 17 days in April as an RN/LP, and 23 days in May as an RN/LP. While working day shift, E5 worked all the units within the facility. In June of	F9999		

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2005, E5 began working third shift (10:00 pm - 6: 00 am). In June E5 worked 17 nights and 4 nights in July. While working nights during June and July, E5 was responsible for a wing with four halls housing residents including Medicare recipients. On the night 7/4/05, E5 was directly responsible for 67 residents including six Medicare residents and a house census of 129 including 3 additional Medicare residents. E5 would have been the only RN working in the facility after transferring to this shift.

On 7/8/05 at 10:00 am, the CNA registry was contacted. E5 is not listed as a CNA on the registry. The Department of Professional Registration was contacted on 7/8/05 at 10:30 am. E5 is not currently licensed as a Registered Nurse (RN).

E1 (Administrator), E2 (Director of Nurses/DON) and E4 (Corporate RN) were notified of these findings on 7/8/05 at 11:15 am. At that time E1 stated, "I didn't know she was not a Registered Nurse or CNA. The previous (E31) and (E32) were responsible for checking that." E1 was unable to explain at this time how E5 was allowed to work as an RN/LP and RN for 4 1/2 months.

The facility "Abuse and Neglect Detection and Prevention Program" dated 9/2/02, under the heading "Screening" states: "All employees will have criminal background checks and license/ certification confirmation." The facility policy is in compliance with federal regulation 483.12(c)(1)(ii)(A) and (B). On 7/7/05 at 10:00 am, E1 stated,"If the employee was a CNA we check the registry as well."

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F9999	Continued From page 43 In written documentation presented as part of immediacy removal plan to the Illinois Department of Public Health, E1 stated,"7/8/05 - 1:00 pm - 100% audit of employee files completed for accuracy to ensure that all appropriate licensure verifications had been completed for current professional staff. 100% audit completed to ensure that background checks had been completed on all CNA's currently employed. Random employee records were inspected for compliance with federal and state law on 7/11/05. E5 did not have any license or certification on file with the facility. E11's (Licensed Practical Nurse/LPN) license currently on file expired 1/31/05. E12's (LPN) license currently on file expired on 1 /31/05. E13 - E25, All certified nursing assistants were hired before CNA registry verification was completed. E1 was unable to give a reason the CNA registry checks were not done according to federal and state law as well as their policy when informed on 7/11/05. Healthcare worker background checks were investigated on 7/11/05. E5 was hired 3/10/05. No background check available. E22 (CNA) was hired 3/23/05. No background check available. E25 (CNA) was hired 9/27/04. No background	F9999		

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F9999	Continued From page 44 check available. E1 was unable to provide an explanation as to why the healthcare worker background checks were not on file when informed on 7/11/05. E10 (Business Office) stated, "I think the previous employee responsible for doing these (CNA registry) checks and initiating the healthcare worker background checks did not know she was to do them or put them on file. I think when she saw a background check done, she didn't know it had to be within twelve months to be current."	F9999		