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F9999	FINAL OBSERVATIONS STATE LICENSURE FINDINGS: 300.830b) If the staff member designated to provide social services is not a social worker, the facility shall have an effective arrangement with a social worker to provide social service consultation. 300.1030a)4) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: Toxicologic emergencies (for example, untoward drug reactions and overdoses).	F9999		

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300.1035a)3)4)5) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:

Procedures for providing life-sustaining treatments available to residents of the facility.

Procedures detailing staff's responsibility with respect to provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices.

Procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

300.1210b)2) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:

All treatments and procedures shall be administered as ordered by the physician.

300.3210a) No resident shall be deprived of any

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F9999	Continued From page 32 rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act) 300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility: 1. Neglected to provide cardiopulmonary resuscitation. 2. Neglected to follow physician orders to assess and monitor a resident. 3. Neglected to react to a resident's change in condition over a period of twelve hours. 4. Neglected to pursue alternative guardianship over a period of almost six months. 5. Neglected to provide treatment to a resident known to have a drug seeking/drug dependency problem. 6. Neglected to evaluate a resident's safety when gone from the facility on home visits for 1 of 3 sampled residents (R1). Findings Include: Admission face sheet indicates that R1 was admitted to the facility on 6/23/04 from an acute care hospital setting. MDS (Minimum Data Set) dated 10/03/04 shows R1 to be 62 years old. MDS documents R1 has short term memory problems, and her mental function would sometimes vary over the course of the day.	F9999		

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F9999	Continued From page 33 Diagnoses listed on the MDS are Alzheimer's Disease, Anxiety Disorder, Depression, Diabetes Mellitus, and Arthritis. Nursing notes on 12/11/04 at 6:00 PM documents the following: "Res. sitting at table in Dining Room with head between hands. When spoken to res. replied but speech was slurred, she was sweating profusely, eyes look 'glassy', gait was unsteady, when asked if she was ill res replied, "I'm just real tired ". Res. had been out with spouse and had returned approx. 5:15 PM prior to this nurse's arrival. BP 150/80, T 96.7, P (pulse) 48, blood sugar 174. Dr, Administrator et DON notified. No new orders at this time, suggestion to assess periodically. 11:00 PM sleeping, snoring loudly will continue to assess. 1:00 AM sleeping, respirations even et unlabored, still snoring. 4:00 AM still asleep no snoring. 5:30 AM Res found unresponsive no VS skin cold to touch." R1's death certificate states cause of death to be Hydrocodone Toxicity (overdose of narcotic painkiller). During interview with E3 (Licensed Practical Nurse) on 1/26/05 at 9:45 AM, E3 verified that she did not go to the room of R1 and evaluate her condition but based her documentation on the information provided to her by E5 (Certified Nurse Aide). E3 stated that when she referred in her nursing note of 12/11/04 at 6:00 PM of someone making the suggestion to assess R1 periodically, E3 was referring to Z1 (Attending Physician). The order to assess periodically was not found. E3 stated, "The Doctor said to check on her and keep her alive".	F9999		

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F9999	Continued From page 34 At 11:05 AM, E3 was interviewed regarding how R1 was checked on. E3 replied, "I had the CNA take her first set of vitals because I wasn't clocked in yet." E3 said, "I can't say exactly when she went to bed because I pass meds (medications) from 7 until 9 PM and she never came out. I did at times see her from the hall. At first she was sleeping in the chair and then she was sleeping while sitting on the bed." When E3 was interviewed regarding who assessed R1 at 11:00 PM, 1:00 AM and 4:00 AM per the documentation in the nurses notes and where else would documented assessments of R1 be written, E3 stated, "The CNAs checked on her at those times, and I charted what they told me in the nurses notes. It isn't written any where else. I did not do any neuro (neurological) checks. I thought if she was snoring she was ok." E3 was asked why, if snoring meant R1 was okay, then at 4:00 AM when the note says "no snoring" what did that mean. E3 stated, "I thought it meant that she was in a deeper sleep. I guess I should have gone in and done more checking." At 11:05 AM, regarding the Doctor's order, E3 stated, "He said, 'You know the drill, assess her and keep an eye on her'." Social service note for 6/25/04 documents Z10 (guardian/spouse) here and signed papers. "They do not wish DNR (Do Not Resuscitate) at this time." E3 was asked on 1/28/05 at 1:28 PM about R1's code status for CPR (Cardio Pulmonary Resuscitation), and E3 stated,"She was a full code." E3 was asked if resuscitation had been initiated on R1 and E3 replied, "No, she was cold	F9999		

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F9999	Continued From page 35 to touch and there were no vital signs." E5 was interviewed at 11:00 AM on 1/26/05 regarding the incident of R1 on 12/11/04. E5 stated R1 returned around 5:00 PM right after supper and looked like she was drunk. E5 stated the behavior that R1 was exhibiting was not like R1 at all. When R1 refused to talk with E5, E5 stated she went to E3 and told her something was wrong with R1. E5 stated she was asked to take R1's vital signs by E3 and as R1 went to her room "she was really wobbly." When E5 went to R1's room again later, E5 could tell R1 was "out of it." E5 stated she went to E3 again. E3 told E5 she (E3) had called the Doctor and there was nothing else she could do. The last thing I (E5) did before I left work was to go check on (R1). She was sitting on her bed, holding herself up with her arms behind her, and she was asleep. Her night gown was pulled way up to her chest and her legs were spread apart. This was not like her. I went to the nurse and told her I was really concerned; that I was really worried that she was going to go. They didn't tell us to check on her. I just took it upon my self as I knew something was wrong. I went to the nurse about it numerous times. I never saw the nurse go in or come out of (R1's) room." E3 stated on 1/25/05 in interview that she was aware of two other incidents when R1 came back from home visits with suspected ingestion of medications that were not ordered for her. Nursing notes document these dates to be 8/7/04 and 9/13/04. E3 stated no action was taken on 8/07/04 by the facility because R1 denied it happened, and that she (E3) had been told not to search residents' rooms. On 09/13/04, E3 stated	F9999		

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she called Z1 but documented no order from him because Z1 had said only to continue to assess and notify of any changes.

Z1's progress note dated 9/14/04 states: "Patient took her husband's Valium tablets last night and slept throughout the night rather deeply. However, she demonstrated no depression of her life signs, including respiration and blood pressure. This does confirm her history of drug dependence. Diagnosis: Valium overdose."

LOA (Leave Of Absence) sheets kept by the facility document that R1 was allowed to go home with Z10 on 98 home visits from the time of her admission until the date of her death.

Interviews and R1's record beginning at admission on 6/23/04 continuing through her death on 12/11/04 documents that the facility staff were aware of R1's concerns with Z10's behavior and the fact that Z10 was her guardian. These record entries and interviews also indicate that the staff neglected to do anything to correct the situation.

R1's medical record includes an Admission History and Physical signed by Z1 and documents the following:
This female is admitted to our facility after transfer from the psychiatric department. Her diagnoses include the following:
1. Depression with anxiety.
2. Polypharmacy problems .
3. Peptic ulcer disease.
4. History of hypokalemia.
5. Hypertension.
6. Impaired glucose tolerance.

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The patient has a history of drug dependency on narcotics and we have had many arguments about medicines with this lady. She signed out AMA (against medical advice) a few months ago when she was here because we refused to give her OxyContin.
Social History: She lives with her husband who apparently causes some problems when they are together.

A Letter of Plenary Guardianship indicates that Z 10 (spouse of R1) was appointed Plenary Guardian of both R1's person and estate on 3/27 /02.

Neuropsychological screening done by Z12 (Ph. D., hospital counselor) on 6/21/04 at the hospital documents the following:
"According to the medical records, the patient has indicated that her husband is mean to her. There is also concerns about possible abuse and neglect by the husband in the home by social work, (Z3). It was also noted by social work there may be concern about the patient going back to the local nursing home because in the past apparently the patient's spouse had her come home and do housework and then return to the nursing home."

Z3, SSD (Social Service Designee at the admitting hospital) was interviewed on 1/28/05 at 12:50 PM. Z3 stated, "I talked extensively with (R1). She was afraid of her husband. He was very controlling, very mean to her and I think it was physical as well as emotional. She was a very humiliated woman. She did tell me that she did want to get her guardianship changed." Z3 was asked if the nursing home or anyone had

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attempted to get the guardianship changed. Z3 stated, "I did. I made a referral on this and I told the nursing home about it and that the counselor here had offered to see the resident after discharge When it came time to discharge her, the hospital was concerned about sending her with her husband so a private transport was hired to take her to the nursing home, while the husband followed in his own vehicle. We were concerned because he was very angry. I spoke to the SSD at the nursing home and reported all of this to her."

E4 (Social Service Designee) documents on 8/9/ 04 that R1 is concerned with how Z10 is treating her (calls her names, screams and throws things at her). E4 documents that R1 wants to stay in the facility permanently and R1 wants to talk with her son (Z2) regarding her guardianship. R1 would like to get it changed.

E4 was interviewed on 1/26/05 at 1:45 PM regarding the above social service note. E4 was asked if the facility had taken any action to seek out a change of guardianship for R1. E4 stated, " That August ninth note was probably the first I knew about her wanting to change. (Z10's) son's wife worked here at the time and they wanted to help her. They had an appointment for the next week. I took it, it was a lawyer to get it changed. Maybe it was her other son." E4 was again interviewed on 1/28/05 at 11:20 AM regarding who the lawyer was in the 8/9/04 social service note. E4 stated, "I don't know who the lawyer was . No one in the facility helped to set this up or take action. I came back on Monday and she was with him (Z10). That was it, nothing was done. I talked with the Social Service person (Z3) at the

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hospital before we admitted her. She said (R1) had talked to a counselor there about changing her guardian. (Z3) said that the hospital staff were worried about her husband (Z10) driving (R 1) to the nursing home. So the hospital transported her here with him (Z10) following in his own vehicle."

On 1/25/05 E1 (Administrator) was interviewed at 10:30 AM. E1 was asked if anyone at the facility had attempted to seek an alternate guardianship for R1. E1 stated, "There was nothing we could do about it. Our hands were tied. R1 was in and out of here three times. There was abuse at home. She was noncompliant with her medications." On 2/1/05 at 12:00 PM, E1 was interviewed regarding whether or not anyone at the facility had arranged for any psychiatric treatment for her at the facility or outside the faculty. E1 stated, "No, family may have." E1, (Administrator) was interviewed on on 1/28/05 at 10:40 AM regarding R1 leaving the facility to do work at Z10's home. E1 replied, "The stories of his working her to death are all true, mowed the yard, worked her hard. You know he has guns in his house and open access to a drug safe."

On 8/9/04 E4, SSD (the facility's Social Services Designee), documented in R1's Social Service Progress Note the following:
(R1) voiced concerns regarding how he (Z10) is treating her. He is controlling, calls her names, screams at her, throws things. Today she states that she wants to stay here permanently. She wants to talk with her son (Z2) regarding her guardianship. She would like to get it changed. She was tearful, wants to return home but realizes she can't if (Z10) continues to treat her

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this way. She thinks he is getting worse and sees no hope for improvement in his behavior.

E4 was again interviewed on 1/28/05 at 11:20 AM regarding who the lawyer was in the 8/9/04 social service note. E4 stated, "I don't know who the lawyer was. No one in the facility helped to set this up or take action. I came back on Monday and she was with him (Z10). That was it, nothing was done. I talked with the Social Service person (Z3) at the hospital before we admitted her. She said (R1) had talked to a counselor there about changing her guardian. (Z3) said that the hospital staff were worried about her husband (Z10) driving (R1) to the nursing home. So the hospital transported her here with him (Z10) following in his own vehicle".

Review of E3's nursing note for 8/7/04 indicates that R1 went on home visit with her spouse/ guardian and after returning her to the facility, Z 10 notified the facility that R1 had taken his Valium. Review of R1's record failed to provide evidence that this was investigated, nor that the Doctor had been notified.

E3 was interviewed at 9:45 AM on 1/26/05 regarding whether or not the Doctor was notified about the 8/7/04 incident. E3 stated, " I didn't call the Doctor because she (R1) said it was not true. I didn't investigate or search for the Valium because E1 said that would be a violation of her resident rights. I didn't want to over react".

E3's 9/13/04 nursing note indicates R1 again went on home visit with Z10 and on return, Z10 again notified the facility of R1 taking his Valium. The Doctor's progress note made on the

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following day lists a diagnosis of Valium overdose. Both the 9/13/04 and the 12/11/04 nursing notes signed by E3 indicate R1 came back from home visit sweating profusely, speech slurred, and extremely lethargic (tired).

During interview on 2/2/05 at 10:35 AM regarding the 12/11/04 incident, E3 stated "no" when asked if R1 was just tired that night. When asked if R1 seemed a little better this time than she did during the September incident, E3 replied, "No, she was way worse than she was in September".

Nursing notes from 6/23/04 through 12/11/04 document information of R1 ingesting overdoses of pain medications on three separate occasions.

On 8/7/04 at 9:00 PM the nurse documents: "Res (resident) had been out (with spouse) and returned 6:00 PM. Husband called at 8:45 PM et (and) stated, 'I have 6 Valium missing et (R1) says she took 4 of them - that's 40 mg and if she takes the other two it could stop her heart'. Res was questioned et stated, 'I didn't take any - he's lying'. Vitals taken T (temperature) 97.8, BP (blood pressure) 118/60, P (pulse) 80, R (respirations) 20, will continue to assess." Signed (E3), LPN (Licensed Practical Nurse).

On 1/26/05 at 10:05 AM, E3 was interviewed regarding her 8/7/04 entry in R1's nursing notes. When questioned if the other two pills were found or if the Doctor had been notified, E3 stated, "No, I have been told not search residents rooms. I didn't call the Doctor because she (R1) said it was not true."

Nursing note for 9/13/04 6:40 PM, E3

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documented, "Res' husband called, "I'm dropping (R1) off and someone will need to help her into the building." Res returned et was assisted inside, sweating profusely, extremely lethargic, speech slurred. VS (vital signs) BP 153/92, P 91, R 19, T 96.6, blood sugar 168. Dr. (Doctor) notified as well as (E1-Administrator) and (E2) DON (Director of Nursing). Res husband called again 'She got in my safe et took a bunch of pills - Valium - but I'm not sure how many - I will have to quit bringing her home if she keeps doing this' ."

Physician progress note dated 9/14/04 documents, "Patient took her husband's Valium tablets last night and slept throughout the night rather deeply. However, she demonstrated no depression of her life signs, including respiration and blood pressure. This does confirm her history of drug dependence. Diagnosis: Valium overdose."

E3 was interviewed on 1/26/05 at 9:45 AM. During the interview when questioned if the doctor had given any orders when she notified him of the 9/13/04 incident, E3 stated, "He said to continue to assess and notify of any changes." Physician order sheet contained no order on this date. E3 stated, "No I didn't write the order 'cause' he just said to do that. I did suspect she had taken pills at home because she had a history of taking her husband's pills. She had told me about it before. This wasn't the first time she came back like that".

During interview with E3 on 1/26/05 at 9:45 AM, E3 stated that when she referred in her nursing note of 12/11/04 at 6:00 PM of someone making