| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **PROVENA COR MARIAE CENTER** | **3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114** |

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|---|---|---|---|---|
| F 333 | Continued From page 19<br>(E3) was taught to record administration of medications prior to taking to resident and was asked to abide with the facility's policy to record after administration."<br><br>E2 (Director of Nurses) was informed of the Immediate Jeopardy on 9/14/06 at 1:45 PM. The surveyor confirmed the facility took the following actions to remove the immediacy of the situation:<br><br>A. All licensed nursing staff have been provided 1:1 in-servicing regarding the Medication Administration -General Guidelines and Medication Occurrence policies prior to providing direct patient care, effective 9/14/06. All licensed nursing staff have documented that they have read and understand the Blood Sugar Monitoring policy.<br><br>B. The Medication Administration Records of all patients will be monitored daily effective 9/15/06 to monitor medication administration.<br><br>C. The Administrator and the Director of Nursing shall be responsible for ensuring continued compliance and will be responsible for overseeing the implementation of this plan of abatement | F 333 | | |
| F9999 | FINAL OBSERVATIONS<br><br>Licensure Violations<br><br>300.610 a)<br>300.1010h)<br>300.1030a)1<br>300.1030a) 2<br>300.1210a) | F9999 | | |

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|---|---|---|---|---|
| F9999 | Continued From page 20<br>300.1210b)1)<br>300.1210b)2)<br>300.1610a)1)<br>300.1620a)<br>300.1630c)<br>300.3220f)<br>300.3240a)<br><br>300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>300.1010 Medical Care Policies<br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest deubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification<br><br>300.1030 Medical Emergencies<br>a) The advisory physician or medical advisory | F9999 | | |

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|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F9999 | Continued From page 21<br>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:<br>1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).<br>2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).<br><br>300.1210 General Requirements for Nursing and Personal Care<br>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br>1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.<br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>300.1610 Medication Policies and Procedures<br>a) Development of Medication Policies<br>1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with | F9999 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F9999 | Continued From page 22<br>the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.<br><br>300.1620 Compliance with Licensed Prescriber's Orders<br>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.<br><br>300.1630 Administration of Medication<br>c) Medications prescribed for one resident shall not be administered to another resident.<br><br>300.3220 Medical and Personal Care Program<br>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)<br><br>300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced | F9999 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F9999 | Continued From page 23<br>by the following:<br><br>Based on interview and record review the facility failed to :<br><br>1. Ensure that R1 received the medications ordered by her physician during the morning medication pass on 9/5/06. This failure resulted in R1 taking 9 medications ordered for another resident, including Glypizide and Cozaar, and having periods of significant hypoglycemia for approximately 13.5 hours.<br><br>2. Provide care and services for R1 by not monitoring blood glucose levels and blood pressure every 4 hours on 9/5/06 as ordered by the physician after a R1, a non-diabetic resident, received a dose of Glipizide, a medication used to lower blood sugar in patients with Diabetes Mellitus. These failures resulted in R1 not receiving additional treatment because the physician had not been made aware of 2 blood glucose readings below 60 milligrams/(per) deciliter at 4:15pm and 8PM on 9/5/06. The staff also did not measure the 8:00 PM,12:00 AM and 4:00 AM blood pressures as ordered.<br><br>3. Initiate Cardio Pulmonary Resuscitation when a resident had no vital signs or respirations. The resident had made the decision to be a Full Code in case of cardiac arrest on 9/2/06. The resident was found unresponsive at 5:00 AM on 9/6/06. No resuscitative efforts were initiated by facility staff.<br><br>The findings include:<br><br>1. R1 has diagnoses of Closed Cervical Fracture with Cord Injury, Fracture Distal Ulna, Coronary | F9999 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PROVENA COR MARIAE CENTER** | **3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114** |

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|---|---|---|---|---|
| F9999 | Continued From page 24<br>Atherosclerosis, Atrial Fibrillation, Deficiency Anemia, Syncope and Heart Disease Postcardiac Surgery per the clinical record Face Sheet dated 9/6/06. R1's Admission Assessment dated 9/2/06 documents that R1 is fully conscious and is oriented to person, place and time.<br><br>During an interview conducted on 9/13/06 at 10:10 AM, E3 (Registered Nurse) stated, "I was in the habit of getting medications set up for R2. R2 was in the bathroom and I did not want to invade her privacy so I set them in the drawer. I pulled the medication for R1 and marked the portion cup with an 'S.' I took R2's pulse and O2 saturation. R2 refused to take her pills because of the Lasix. I placed her medications on the med cart. I got distracted and picked up R2's medications and gave them to R1 in applesauce. I walked out (to the hallway from the resident's room) and started to get the next resident's medication ready and I opened the drawer and saw R1's medications in the portion cup. I knew immediately what I had done."<br><br>On 9/13/06 at 11:00 AM, E3 verified that he gave R1 the following wrong medications: Oxybutynin 5mg, Furosemide 40mg, Cozaar 50mg, Vitamin B-6 1000mg, Aspirin 325mg, Clopidogrel 75mg, Potassium CL 10meq, Glipizide 10mg and Docusate Sodium 100mg.<br><br>R1's medications listed on the Physician Order Sheet for September 2006 are Warfarin sodium 2.5mg daily, Levoxyl 88mcg daily, Diltiazem 180mg daily, magnesium oxide 400mg twice a day, Nexium 40mg twice a day, Doxycycline 100mg twice a day, Digoxin 125mcg daily, Amiodarone HCL 200mg three times day, Duragesic patch 12 mcg every 72 hours. | F9999 | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F9999 | Continued From page 25 | F9999 | | |

Physician's Orders dated 9/5/06 state, "Per Z1 give normal medications. Hold Digoxin for today. Monitor every 4 hours x 24 hours blood pressure and blood glucose. Notify if blood pressure (systolic) is less than 100 or if blood sugar is less than 60."

Departmental Notes for Nursing dated 9/5/06 state, "At 9:54 AM notified Z1 (Physician) via phone and the family at the bedside about the wrong medications given this resident....Received orders per Z1, assessed R1 as ordered, B/P 128/80 and blood sugar was 113. Spoke about the patient's (R1) appetite and offered a health shake for assist with nutritional status..." The Departmental Notes document on 9/5/06 that R1's blood glucose level was 48 at 12:43 PM, 49 at 4:15 PM, 45 at 8:00 PM and 67 at 12:25 AM.

R1 had fluctuations in her blood glucose levels for a period of 13.5 hours after receiving Glipizide 10mg at 9:30 AM on 9/5/06.

The facility's Medication Administration General Guidelines Policy and Procedure effective 2/12/02 states, "Medications will be administered at the time they are prepared. Doses will not be pre-poured. Residents are identified before medication is administered. When in doubt: Check identification band. Check photograph attached to the medical record. Call resident by name. If necessary, verify resident identification with other facility personnel. Medications supplied for one resident are never to be administered to another resident. For residents unavailable to receive medication on the pass, the MAR (Medication Administration Record) is flagged with tags, colored plastic strips, paperclips, or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PROVENA COR MARIAE CENTER** | **3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114** |

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|---|---|---|---|---|
| F9999 | Continued From page 26 | F9999 | | |

similar system. After completing the medication pass, the nurse returns to the missed resident to administer the medication." The facility's Medication Administration General Guidelines Policy and Procedure lacks any instruction on what should be done with medications once they are placed in the medication cup.

During an interview conducted on 9/14/06 at 12:30 PM, E3 said that he could not remember if the facility went over their policy and procedure for medication administration. E3 said that his orientation was approximately two days long.

During an interview conducted on 9/14/06 at 9:35 AM, E2 (Director of Nurses) verified that E3 did not follow the facility's Policy and Procedure for administering medications.

A report submitted to E1(Administrator) on 9/12/06 by the Pharmacy Consultant states, "He (E3) was taught to record administration of medications prior to taking to resident and was asked to abide with the facility's policy to record after administration."

2. R1 has diagnoses of Closed Cervical Fracture with Cord Injury, Fracture Distal Ulna, Coronary Atherosclerosis, Atrial Fibrillation, Deficiency Anemia, Syncope and Heart Disease Postcardiac Surgery per the clinical record Face Sheet dated 9/6/06. R1's Admission Assessment dated 9/2/06 documents that R1 is fully conscious and is oriented to person, place and time. The last fasting blood sugar on record for R1 was done on 8 24 2006 was 77 (normal is 70 -99)

On 9/13/06 at 11:00 AM, E3 (Registered Nurse) verified that he gave R1 the following wrong

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PROVENA COR MARIAE CENTER** | **3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114** |

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|---|---|---|---|---|
| F9999 | Continued From page 27<br>medications: Oxybutynin 5mg (for bladder spasms), Furosemide 40mg (diuretic), Cozaar 50mg (anti-hypertensive), Vitamin B-6 1000mg, Aspirin 325mg, Clopidogrel 75mg (to prevent blood clots), Potassium CL 10meq, Glipizide 10mg (anti-hyperglycemic) and Docusate Sodium 100mg (stool softener).<br><br>R1's Physician's Orders dated 9/5/06 state, "Per Z1 (Physician) give normal medications. Hold Digoxin for today. Monitor every 4 hours x 24 hours blood pressure and blood glucose. Notify if blood pressure (systolic) is less than 100 or if blood sugar is less than 60."<br><br>Departmental Notes for Nursing dated 9/5/06 state, "At 9:54 AM notified Z1 (Physician) via phone and the family at the bedside about the wrong medications given this resident....Received orders per Z1, assessed R1 as ordered, B/P 128/80 and blood sugar was 113. Spoke about the patient's (R1) appetite and offered a health shake for assist with nutritional status..." The Departmental Notes further document on 9/5/06 that R1's blood glucose level was 48 at 12:43 PM, 49 at 4:15 PM, 45 at 8:00 PM, and 67 at 12:25 AM.<br><br>Departmental Notes for Nursing dated 9/5/06 at 9:26PM show, "Resident c/o (complaint) of being sweaty and cool to touch. Accucheck taken at 8PM, and was 45mg/dl. Health Shake given and ice cream eaten, at 20:45 (blood glucose) was 207mg/dl. Skin warm and dry to touch and patient more alert and oriented. No shakyness noted."<br><br>Departmental Notes for Nursing do not show any documentation of blood pressure after 4:15 PM | F9999 | | |

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|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F9999 | Continued From page 28<br>on 9/5/06. There was no documentation of vital signs including blood pressure on 9/6/06. These notes were reviewed with E2, Director of Nursing on 9/13/06. E2 provided no further information. On 9/14/06, E2 was asked if there was another place where blood pressures would be recorded? E2 replied No.<br><br>The facility's Medication Occurrence Policy and Procedure effective 4/17/02 states, "A medication occurrence is defined as a resident receiving the wrong medication... The medication occurrence and treatement must be documented in the resident's clinical record. The resident should be monitored for 72 hours or as directed."<br><br>During an interview conducted on 9/13/06 at 11:30 AM Z1 (Physician) referred to the Blood Glucose monitoring sheet and stated, "I was not notified of the low blood sugar levels documented for 5:30 PM and 8:00 PM on 9/5/06. If I had been made aware I would have possibly ordered IV Dextrose, possibly D-10 if it were available. If R1 was asymptomatic, I would have stepped up the frequency of monitoring. I would have changed my management of the case."<br><br>During an interview conducted on 9/14/06 at 9:35 AM E2 (Director of Nurses) stated, "I know that the nurse gave graham crackers at 12:25 AM for a blood sugar of 67 but she did not re-check R1's blood sugar after that. I don't know why she didn't re-check her after giving her something to eat. We asked her that. I think she felt that she was out of danger." When the surveyor asked E2 what she would have done after R1's blood sugar dropped from 207 to 67 in 3 hours and 40 minutes E2 said, "I would have went back and re-checked the blood sugar." | F9999 | | |

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|---|---|
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|---|---|---|---|---|
| F9999 | Continued From page 29<br><br>The facility's Policy/Procedure for Blood Sugar Protocol approved March 22, 2002 states, "If blood sugar is below 60 MG/DL call Physician and continue (treatment) until blood glucose is greater than 70 or new orders received."<br><br>During an interview conducted on 9/14/06 at 9:35 AM E2 (Director of Nurses) said that the policy was reviewed yesterday and it is not clear what nursing should do when blood sugars are over 60 but below 70. We will have to discuss with our medical director and our clinical nurses to determine what needs to be changed.<br><br>During an interview conducted on 9/13/06 Z3 (Registered Pharmacist) said that Glipizide 10 mg can lower blood sugar for up to 24 hours after the medication has been administered.<br><br>In Krause ' s Food Nutrition and Diet Therapy, 2004 on page 825 in Box 33-7 common causes of Hypoglycemia, lists medication errors first. Under the section on Acute Complications of Hypoglycemia, "In general, a glucose of 70mg/dl or lower should be treated immediately (Cryer et al, 1994). Even a level of 60 -80 mg/dl may require a management decision (e.g., carbohydrate ingestion ...) ...Although any carbohydrate will raise glucose levels, glucose is the preferred treatment ... Initial response to treatment should be seen in 10 - 20 minutes; however, blood glucose should be evaluated again in about 60 minutes because additional treatment may be necessary."<br><br>The text Mastering Geriatric Care,1997, p 249 under Complications states that " Older adults are more sensitive to low blood glucose levels | F9999 | | |

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|---|---|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 30 | F9999 | | |

than younger adults. Their hypoglycemic symptoms may range from mild to severe and may go unrecognized until the condition is life-threatening ."

3. Departmental Notes for Nursing dated 9/6/06 show that R1 was checked at 12:25 AM by E4 (Registered Nurse). R1 was not checked again by E4 until 5:00 AM. R1 was found to be cyanotic, pulseless and had no respirations. R1 was not reassessed by E4 at that time.

During an interview conducted on 9/19/06 at 11:45 AM, E1 (Administrator) said that CNA staff went into R1's room at approximately 3:30 AM on 9/6/06 to answer her roommate's call light.

E4's written statement dated 9/12/06 states, "At 3:30 AM resident was checked , no signs and symptoms of respiratory distress, she was resting comfortably in an upright position. Appeared to be within normal limits for herself." In a statement dated 9/6/06 E5 (Certified Nursing Assistant) said he was in R1's room at 10:30 PM, 11:25 PM, 12:30PM, 2:30 AM and 3:30 AM. There is no evidence that vitals including blood pressure were done at those times. (According to R1's physician order dated 9/5/06, the facility was to monitor every 4 hours x 24 hours blood pressure and blood glucose). There is no evidence to show blood glucose monitoring was done at 4:25 AM (The next 4 hour interval after 12:25 AM check). On 9/14/06 E2 (Director of Nursing) verified there were no other blood pressures documented after the 4:15PM on 9/5/06.

The medical record face sheet located in the front of R1's chart shows under Code Status: Full

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PROVENA COR MARIAE CENTER** | **3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114** |

| (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 |
|---|---|---|---|---|
| F9999 | Continued From page 31<br>Code. R1's New Resident Check-off List dated 9/2/06 documents that R1 is a full code and code status is identified on the chart.<br><br>From the Departmental Nurses Notes dated 9/6/06 at 5:00 AM, "R1 found with no vital signs and cyanotic. Informed Z4 (family) on phone that resident had expired. At 5:10am, Z1 (physician) was notified that R1 expired." In a written statement dated 9/12/06, E4 (Registered Nurse-RN) stated, "I entered the resident's room, noted patient was cyanotic. I shook patient to arouse resident and no response. No respirations noted, no pulse palpable, patient cool to touch. Returned to the phone, and reported to Z4 (family) resident was expired."<br><br>Information received from E1 on 9/19/06 show that E4 had been inserviced on the Code Blue Policy and Procedure on 7/26/06. On 9/14/06 at 9:35AM E2 said that all licensed staff are CPR certified.<br><br>The facility's Policy for Code Blue effective 1/30/04 states, "The staff discovering a full code resident in a cardiopulmonary arrest or a resident with a modified code who's heart is still beating, will stay with the resident, and call for help. This employee, if CPR certified, will initiate CPR immediately. Code Blue and location will be announced overhead so that CPR certified staff will immediately go to resident location. The first responder will assure that 911 has been called and will assist with CPR. CPR will be continued until the paramedics arrive and take over care of the patient. When designated a full code, the patient, with either a witnessed or unwitnessed arrest, will have CPR continued until the paramedics arrive. Staff will respond with crash | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145972 | A. BUILDING _____ B. WING _____ | C 09/28/2006 |

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|---|---|---|---|---|
| F9999 | Continued From page 32<br>cart and/or appropriate supplies. The nurse on duty will assess the resident's vital signs, responsiveness and take charge of the code until paramedics arrive." This policy and procedure does not give the nurse the right to decide if resuscitation efforts should be initiated.<br><br>During an interview conducted on 9/19/06 at 11:45 AM E1 (Administrator) verified with this surveyor that E4 did not initiate CPR on R1 when she found her on 9/6/06 at 5:00 AM. E1 said that the facility's policy is clear, CPR should have been started on R1.<br><br>(A) | F9999 | | |