STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E245	A. BUILDING _____ B. WING _____	C 03/08/2006

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A R C OF JACKSONVILLE, LTD, THE	**1320 TENDICK, P O BOX 1115 JACKSONVILLE, IL 62650**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 490	Continued From page 58 adequate communication between shifts and with the Director of Nurses and each other regarding R1's behaviors and physical decline including her lack of eating/drinking and refusals of medications. The nurses failed to adequately and consistently assess and monitor R1 as her health deteriorated. 4. F331 - The facility failed to follow their policy on Psychotropic medications with behavioral management and drug monitoring. the facility neglected to ensure R1 who used antipsychotic drugs received gradual dose reductions and behavioral interventions when her Zyprexa was discontinued on 12/1/05 for her diagnoses of Schizophrenia. No medication was given in its place and the psychiatrist was not informed. The facility failed to implement behavioral tracking and hold IDT team meetings where R1's behaviors and condition changes should have been discussed when R1 exhibited life threatening behaviors and a deterioration of health status. 5. F354 - The facility failed to ensure they had a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. Review of the staffing schedules from 10/28/05 through 2/28/06 failed to reflect any registered nurses scheduled to work at anytime.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010(h) 300.1210(a) 300.1210(b)(3)	F9999		

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F9999	Continued From page 59 300.3240(a) Section 300.1010 Medical Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care a) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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These requirements are not met as evidenced by :

Based on interviews and record review, the facility neglected 1 of 8 residents on sample, (R1). The facility failed to ensure that R1 received necessary care and services to maintain the highest practical physical, mental and psychosocial well-being and failed to ensure that R1, who used antipsychotic drugs, received gradual dose reductions and behavioral interventions.

R1 was admitted to the facility on 11/18/05 with a primary diagnosis of Schizophrenia. R1 exhibited a decline in health beginning on 12/1/05 when her Zyprexa was discontinued. R1 received no medication for Schizophrenia, did not receive a gradual dose reduction of her psychoactive medication. On 12/10/05, R1's behaviors escalated and were not addressed appropriately by the staff.

Between 12/10/05 and 12/13/05, R1 was refusing to eat/drink, had fecal impaction, was throwing herself on the floor and exhibiting self abusive behaviors, had identified cognitive changes of confusion and lethargy and refused all medication. No nursing measures were implemented regarding her refusals and no facility staff identified this behavior as life threatening.

The facility failed to assess and monitor R1 when she began refusing to eat/drink or take her medications. They failed to assess and monitor R 1 for a possible Urinary Tract Infection and failed

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to follow physician orders regarding laboratory tests. They also failed to inform R1's Psychiatrist and primary Physician of R1's deterioration of mental and physical health.

These failures resulted in R1 deteriorating both mentally and physically, she was transferred to the hospital on 12/13/05, where she expired at 5: 28 p.m.with a diagnosis of dehydration, according to the autopsy.

Findings include:

Review of the Admission sheet, R1 was a 64 year old female admitted to the facility on 11/18/ 05 from a state operated mental institution with Schizophrenia. According to the pre-admission screening information, R1 had been Schizophrenic since age 16. According to the MDS (Minimum Data Set) dated 12/1/05, R1 required limited to minimal assist for all activities of daily living and was independent in ambulation . The MDS identified R1 as having insomnia daily or almost daily, moods are easily altered, verbally abusive, socially unacceptable behavior daily, and resisting care 1-3 days within the last 7 days.

According to the Admission physician's order sheet (POS), R1 was receiving only Zyprexa 20 mg q (every) hs (bedtime) for her schizophrenia and Celexa for depression. R1 had Haldol 5mg po (by mouth) or IM (intramuscularly) q (every) 6 hours prn (as needed) for anxiety or agitation.

Review of the Medication Administration record (MAR) on admission, dated 11/18/05, indicates her diagnoses as Schizophrenia paranoid type,

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depression, gastro-esophageal reflux, hypertension and hypothyroidism. According to the MAR, R1 was receiving Zyprexa 20mg q (every) hs (bedtime) for her schizophrenia and also had a prn (as needed) order for Haldol 5mg po (by mouth) or IM (intramuscularly) q 6 hours as needed for anxiety or agitation in addition to other medications. The MAR reflects an order for a CBC and CMP lab to be drawn on 11/21/05. Review of the Registered Dietician's assessment dated 12/2/05 indicates R1 weighed 231 pounds on admission and her estimated daily fluid requirements was 2775cc per day. Review of the care plan dated 12/1/05 reflect no medical concerns other than weight maintenance. The labs drawn on 11/21/05 showed a normal chem profile with an abnormal CBC.

Review of R1's care plan dated 12/1/05 reflects 3 behavioral problems - socially inappropriate behavior, episodes of sexual inappropriateness and injuries from behavior. An additional goal states resident will have no adverse reactions to psychotropic medications. The goal date is 3/1/ 06 and there had been no revisions, additions or deletions since 12/1/05. The RAP module for BEHAVIOR states R1 "may become verbally abusive with staff when she does not wish to comply c (with) ADL's or when she is anxious. R 1 is easily redirected by staff after she calms herself down. On a daily basis, R1 yells out - this is an attention seeking behavior that is redirected c (with) verbal cueing from staff. Occasionally res. is resistive to care - will refuse to eat/walk/ bath c/o (complaint) assistance from staff. This is also an attention-seeking behavior which is altered by verbal cueing from staff." The MOOD STATE RAP module comments state "exhibits a

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sad/worried facial expressions most - all of the time (furrowed eyebrows, turned down mouth, etc .) Res. is directed when approached by staff in a friendly manner. Res. enjoys socializing, singing + coloring - all work well as redirection."

In interview with R1's daughter (Z4) on 2/24/06 at 2:30pm Z4 indicated R1 was transferred to a state mental institution from a nursing home where she had lived for many years because she needed her toward the swallowing difficulty identified by the RD and no follow up to the speech therapy recommendation made bymedication adjusted. Z4 stated this happened every several years and stating her medications would be adjusted and she (R1) would return to the nursing home. Z4 stated she was transferred to this facility instead of the other nursing home as the people at the state operated facility wanted to be sure her behaviors were under control prior to sending her back to the long term care facility.

Review of the facility's policy: PSYCHOTROPIC MEDICATION MONITORING POLICY provided on 2/16/06 indicates the resident physician and/ or psychiatrist will address the usage of behavioral medications indicating that the diagnosis, dosage, duration, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate. The policy continues to state all residents will be assessed, and assessments updated as needed, for behaviors by the QMHP. The IDT (Interdisciplinary Team) will develop a care plan to meet the needs of the resident. The IDT team will update care plans as needed. The policy states all residents receiving psychotropic medications or medications used for

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behaviors, will be on monthly tracking sheets. The tracking sheets will include behavioral interventions, staff approaches to care and accommodating resident's environment. The monthly tracking sheets will indicate escalations and/or decreases in the residents' behavior. The tracking sheets are audited regularly, no less than three times a week. Residents exhibiting behavior problems will be reviewed within 24 hours by the IDT team. The QMRP is to review daily the resident's behavior through the use of the "Behavior coupons" and the 24 hour report. It continues to state "At the time of the regular care plan review, any resident not exhibiting behaviors for the prior three months, the physician will be consulted for a possible medication reduction. The resident's physician and/or psychiatrist will address the usage of behavioral medications indicating that the diagnosis, dosage, duration, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate. Should a resident refuse or miss any psychotropic medication, the physician must be contacted." The facility failed to follow this policy as no behavioral tracking or IDT meetings were held during R1's stay at the facility.

Review of the MONITORING RESIDENT BEHAVIOR PROCEDURE identifies Behavior coupons which are forms on which staff can document residents having escalated behaviors, isolated behaviors or behaviors not previously documented. The policy states the IDT will meet each morning to discuss any unusual resident behavior reported by the staff during the past 24 hours. It continues to state at the morning meetings, the IDT will review the resident's behavior care plan and make changes that are

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necessary. The facility has instituted a behavior-monitoring book for staff to use and a tracking sheet that is more informative.

Review of the nurses notes dated 11/27/05 at 10 am, E3, LPN wrote "urine dark in color c (with) strong odor. Slight c/o (complaint of) burning." At 10:15, E3 wrote that Z1 (primary physician) was paged and returned his call at 10:45am with an order to "obtain UA (Urinalysis) for am p/u (pick up)... dx (diagnosis) Poss. (possible) UTI (Urinary tract infection)." Review of the lab sheets reflect only a culture was done not a urinalysis as ordered. The culture results shows a 10,000 to 50,000 colony count of Enterococcus species with a sensitivity which was faxed to Z1 two days later on 11/30/05. Review of the nurses notes reflect no followup on the culture and/or R1's symptoms of a UTI. Interview with E3, LPN, on 2 /23/05 at 10:46 am indicates she should have clarified the order for the UA not being done as she filled out the requisition slip in error.

On 11/29/05, R1 saw Z1 in his office. E5's nurses notes indictate that R1's blood pressure was up and a new medication was added. Again, there is no followup/assessment to the UTI symptoms R1 was complaining about two days prior and no follow up toward her blood pressure being elevated.

On 12/1/05 at 2pm, E3, LPN, wrote in the nurses notes that she spoke with Z2, psychiatrist/ medical director, "regarding Zyprexa order." The Zyprexa was discontinued and Vistaril 100mg at bedtime was ordered in it's place. On 2/16/06 at 11:20am, E3 said she called Z2 because Public Aid wasn't going to pay for Zyprexa and she

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needed it changed to something else that Public Aid paid for. The nurses notes dated 12/2/05 at 2 pm then state Z2 was notified by E3 that R1 had an allergy to Benadryl and may also be allergic to Vistaril so Z2 then discontinued the Vistaril. E3 stated she didn't notify Z2 that R1 was on no medication for her schizophrenia because "it was a doctor's order" to discontinue both medications. E3 also stated Z1, R1's primary physician would not have known about the Zyprexa as he was her medical doctor. Review of the MAR (Medication Administration Record) for December shows that R1 was receiving no medication for her Schizophrenia. There is no indication the nurses identified the abrupt discontinuation of the Zyprexa as a concern and no evidence that the nurses were monitoring/assessing R1 for possible adverse effects or complications of the discontinuation of the drugs.

Review of the Registered Dietician's (RD) assessment dated 12/2/05 states "Diet remains appropriate used for wt (weight)control. Observed res (resident) at lunch, very difficult time swallowing. St (speech therapy) eval (evaluation) recommended. (change) diet to Gen/ M Soft (general/mechanical soft)."

Review of the nurses notes dated 12/4/05 at 1:20 am states R1 set the alarm off on C hall and was put on 15 minute safety checks for exit seeking behavior which the nurses continued to document. On 2/16/06, E1, Administrator, was asked about the BEHAVIOR COUPON for this incident and provided only one BEHAVIOR COUPON for R1 dated 11/22/05 which identifies R1 throwing herself on the floor and aggressing against staff. There were no other coupons

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F9999	Continued From page 67 completed according to their protocol. On 12/5/05, nurses notes written at 2:30pm by E 3 state R1 refuses some to feed self "staff encourage eating per self. received new diet order + processed." There is no monitoring or nursing assessment the RD. R1 is still on exit seeking precautions. On 12/6/05 at 5:30pm, E5, LPN writes that R1 had not eaten or voided all day but did have a small bowel movement. There is no indication that R1 was assessed at that time. Z1 was called and returned his call at 5:40pm and ordered "give liquids. Call dr. tomorrow if resident hasn't voided ." R1 is documented as voiding in her bed at 9 pm. There is no evidence the nurses encouraged or monitored R1's intake to ensure it was sufficient and no indication that R1 was assessed, including vitals, at the time. On 12/7/05 at 5am, E3 writes R1 had had no bowel movement and was checked for impaction which was manually removed. R1's safety checks continue for her exit seeking behaviors. Again, there is no indication the nurses assessed R1 or monitored her fluid intake as directed by the physician the day before. At 4:40pm on 12/7 /05, R1 fell to the floor. Vitals were taken and recorded as 130/90, Respirations 19, Pulse 72 and temperature 97.4. On 12/8/05 at 12:30pm, E4's nurses notes state R1 is up ad lib and requires verbal cues to eat. Appetite is poor and vitals are recorded. On 12/10/05 at 2pm, E3, LPN, writes R1 requires much encouragement with meals and at 2:30pm,	F9999		

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writes both meals refused. There is no assessment documented on R1 and no vitals recorded.

On 12/11/05 at 1pm, E3 again writes R1 refused both meals and "refused to drink. Is off falls V/S (vital signs). Voided very large amt (amount) 12 n (noon) prior to meal." Again, there is no assessment done and no vitals recorded. At 2:30 pm on 12/11/05, E3 writes R1 was checked for impaction, "hard stool felt (high) up tolerated procedure well. Last BM (bowel movement) recorded on 12/7/05. Did give fleets enema at this x (time). Resident confused and lethargic. Does not follow verbal commands." There is no indication that E3 assessed R1 for her confusion and lethargy. There are no vitals recorded. On 2 /23/06 at 10:46am, E3 stated R1's confusion and lethargy was a definite change in condition and she called the physician at 2:45pm hoping he would send her out to be checked. E3 stated Z5, the physician on-call for Z1, returned the call and gave her an order for Bactrim due to a possible UTI and to repeat the fleets enema. Review of the MAR for 12/11/05 also indicates she took no medications. There is no indication that the physician was aware that R1 was not taking any medications at the time the Bactrim was ordered. Interview with E3 on 2/23/06 at 10:46am indicates E3 was very concerned regarding R1's condition change and indicated she kept E2, DON, informed. E3 stated she thought about the Zyprexa being discontinued but stated it was a physician's order and she didn't think she needed to notify the psychiatrist. E3 stated she gave a detailed report to E14, LPN, on the 2:30pm to 11 shift and kept E2, DON, well informed of R1's condition but E2 kept saying it was behavioral.

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F9999	Continued From page 69 There is no indication that the nurses identified R 1 as having a decline/deteriorating and there was no evidence that she was evaluated by the IDT to determine whether the discontinuation of the Zyprexa could be a causative factor. E14 wrote in the nurses notes dated 12/11/05 at 7pm that R1 received an enema and had no complaints. There is no documentation regarding R1's physical and/or mental status during this shift. No vitals are recorded and there was no evidence that the nurse was monitoring her refusing to eat or drink. At 10pm, E14 then documents R1 had no results from the enema and states "res (resident) hasn't even urinated all shift. Will continue to monitor." There is no evidence that E14 assessed R1's lack of urinating and no indication as to whether he was aware that she ate or drank anything. In addition, there is no followup to her confusion and lethargy previously documented earlier in the day. Review of the MAR indicates she refused her medications and supper is documented as "O" intake. On 2/2/06 at 12:40pm, E14 was questioned about the enema and stated " Actually, I didn't give it." E14 stated he gave the enema to a CNA to give and it must have been reported to him that R1 had no results from it. E 14 stated he really didn't remember the situation and didn't know why the enema was given anyway. E14 stated he didn't know if he knew about the Zyprexa being discontinued and R1 taking no medications. E14 stated he did remember some of R1's behaviors such as putting herself on the floor but she usually took medication for him. E14 was asked about the shift report and stated he doesn't listen unless it's regarding care but doesn't recall any information	F9999		

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being passed on to him regarding her condition. E14 was asked if he felt something was wrong with R1 and stated "Obviously, something was, she didn't urinate all shift." E14 added that he didn't know if that was usual for her but would assume most people would urinate during the shift. Asked if R1's condition seemed to be an issue that evening, E14 stated "No." E14 was unaware that R1 hadn't eaten/drank or taken any of her meds that day and didn't remember any behaviors in specific although he circled her medications as refused and the intake sheet indicated nothing taken for supper.

The next entry in the nurses notes is dated 12/12/05 at 6am by E16, LPN, and states "res has been having two episodes of light brown mucous bowel movements thru noc (night) Res has not urinate all noc. Res temp 97.6." There is no assessment documented and no vitals other than the temperature. There is no followup to the possible impaction/two enemas and nothing regarding her mental/cognitive status or behaviors. On 2/23/06 at 11:44am, E16 stated she gets very little report from E14 and didn't know she (R1) wasn't eating/drinking or taking her medications and didn't know if she was told about the enemas or not. If she knew, it was because it was in the nurses notes. E16 stated R 1 had a definite condition change as she usually responded when asked a question. Asked whether R1 took fluids, E16 stated they usually don't wake them up in the night if they are sleeping. In regards to the Zyprexa being discontinued, she stated she did not know that and would have wanted to know that it had been stopped abruptly as it would be very important to know that. E16 did not notify the physician even

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F9999	Continued From page 71 though she identified a definite change in R1. On 12/12/05 at 11:30am, E4, LPN, writes she left a message for Z2 regarding R1's refusals of meds for two days and no appetite for past 3 days. The notes also indicate no bowel movements with enemas given. There is no documentation on R1's behaviors and what she is doing during this time. The note states R1 is " not verbal much of the time. Needs much encouragement to do anything." There is no assessment and no vitals recorded. At 12:25pm, Z2 returned the call and ordered Remeron Solutabs 30 mg every bedtime. At 2:10pm, Z1 is notified of the previous notes and orders no new orders at that time. On 2/16/06 at 1:30pm, E4 stated Z2 was informed that she was taking no medications and that is why she ordered the Solutabs as they melt in the mouth. E16 did not indicate at that time, although she wrote three entries into the nurses notes, that she did any assessment at all on R1. On 12/12/05 at 3:30pm, E5 documents Z1 " ordered push fluids monitor po input monitor urinary output" and he will see in facility on 12/14/ 05. At 8:10pm, E5 writes R1 "kept putting herself on the floor had diarrhea x 2" and at 8:15pm R1 was put on 15 minute safety checks. At 11pm, E 5 writes R1 remained on safety checks and had x 2 diarrhea. There is no indication that E5 assessed R1's physical condition, behaviors or cognitive status. There are no BEHAVIOR COUPONS filled out according to their policy. . On 2/24/06 at 1:20pm, E5 stated she didn't really remember knowing that R1 was refusing to eat/ drink and take medications although she was the nurse that called the physician on 12/6/05 to	F9999		

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report no food or fluids and received an order to " give liquids" at that time. E5, after reviewing the nurses notes, was unable to state whether R1 had 4 episodes of diarrhea or 2 or if she just documented the same 2 episodes twice. E5 stated she didn't take the order to monitor intake and output and stated E2 may have. E5 stated her behavior definitely had changed and didn't realize her Zyprexa had been discontinued and she was receiving nothing for her behaviors. E5 stated R1 was putting herself on the floor and was digging and scratching at herself which were both new behaviors. On 2/24/06 at 1:20pm, E5 stated R1's eyes were different and she didn't talk much. No physician notification occurred and no IDT meetings were held.

On 3/2/06 at 10:15am, E2 stated no intake and output sheet was started therefore no monitoring was done per physician's order by E5 even though she documented it in the nurses notes that evening.

At 6am on 12/13/05, E16 writes "res awake all noc rolling on floor. Res has numerous bruising et scratching all over her body. Res was given prn Haldol 5mg/IM (not) effective... will pass on to next shift." Again, there is no indication any assessment was done on R1 and no indication that either the psychiatrist or primary physician were notified. There is also no indication R1's intake and output was monitored or that the nurses were aware of th extent of her refusals. On 2/23/06 at 11:44am, E16 stated R1's behavior was a different story. E16 stated she was screaming and hollering all night, kicking the walls, was on the floor, she wouldn't sit up or stand up, and wouldn't stay on the mattress

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which they placed on the floor for her protection. E16 stated they had to remove R1's roommate from the room due to R1's behaviors. E16 stated R1 would normally respond back when spoken to but that night R1 would just look at her. R1 was unable to be redirected at all. E16 stated this was very unusual for R1 and she called E2, DON, that night and was asked to read the PRN medications to her which she did. E16 stated she told E2 that she was concerned about R1's wellbeing and was told to give the Haldol and see what happens. E16 stated she was told at shift report that night by E5 that R1's behaviors had increased and be sure to watch her. She wasn't told that R1 wasn't eating/drinking or that she was taking no medications or about the order to monitor intake and output. Therefore E5 didn't know she was supposed to do it. Again, the nurse neglected to assess R1's physical/mental status and neglected to notify either the psychiatrist or primary physician of this change.

At 11:30am on 12/13/05, E4 documented in the nurses notes that R1 was in her room on the floor with pillow and blanket, resident refused to get up off floor, several bruises + scratches noted over all body parts possibly from rolling around on floor. She continues to document res will not stay on mattress and that she refused to eat or drink anything. She also documents that she refused all medications. Vitals were 120/60, Pulse 80, Respirations 22 and temperature 97.6. The note continues to state R1 "throws head back + forth". Haldol PRN was given. The note states "res only shakes head "yes" or "no" to questions but doesn't answer appropriately... circ (check) ok, nail beds blanch immediately. Shakes head no when asked if any c/o pain." At 2pm, E4

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F9999	Continued From page 74 writes "ref (refuses) any po intake today. Also (no) output noted today." There is no indication that either physician was notified and no physical assessment done by E4. There is no indication that either physician has been notified of her self abusive behaviors/condition change and the use of the Haldol which is required by the facility's policy. There is no indication that R1 was assessed for her behaviors and no indication that R1 had been reviewed by the IDT team. At 2:40pm on 12/13/05, E5's nurses notes state " residents hand turning blue also not eating - taking liquids will not stay in bed gets on floor mattress was placed on floor B/P 100/80 P 38 R 24 temp 96.7." At 2:45pm, Z1 was called and an order to send to the hospital was obtained. At 3 pm, R1 was transported to the hospital by ambulance. At 5:40pm, the nurses notes state the hospital was called and the nurse was informed that R1 had expired at 5:28pm. The last entry into the nurses notes is dated 12/ 14/05 and is a back note dated 12/12/05 at 2pm. It states "res had med (medium) BM + voided sufficient amt (amount) on toilet res required assist for ADL's (activities of daily living) Res alert ?oriented not answering any questions. (No) intake, skin turgor good mucous membranes moist mouth care often Nailbeds blanch well, denies any c/o of pain or distress, shaking head 'no' food and fluids offered regularly, refused everytime, would not open mouth at all several attempts made by several diff (different) staff members." The note is initialed under the date by E4 and is not signed. Interview on 2/23/06 at 2:10pm indicates E4 went down to the room with E2 as she told her she needed to do a complete	F9999		

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assessment. E4 stated E2 did not go into the room with her when she did the assessment on R 1. E4 stated she forgot to write the note and probably wrote it on the 24 hour report sheet but review of the report sheet did not reflect any information. E4 stated she opened R1's mouth to check her mucous membranes even though she charted that R1 wouldn't open her mouth "at all." E4 stated she only looked in her mouth and it looked moist. E4 stated she checked R1's skin turgor on her arm. E4 stated she documented oral care was provided although interview with E 10, CNA, (certified nurses aide) on 2/24/06 at 4 pm indicated he did not provide any oral care as he took care of R1 that day. E4 stated she wrote the note when called to the Administrators office on 12/14/05. E4 was asked if she was told what to write and responded "basically." E4 stated she wrote the note to the best of her knowledge and that she shouldn't take the CNA's words for anything. On 3/2/06, E4 stated she wasn't sure the information provided in the backnote actually happened on the 12/12/05 as she was pulling it from her memory.

The death certificate lists "Dehydration" as the cause of death with contributing factors listed as severe coronary artery atherosclerosis. The Autopsy report indicates contusion hemorrhage and abrasions present on the anterior surfaces of the lower extremities and in both patellar regions, none of any particular pattern. Also present are abrasions on the dorsal surface of both feet and toes. There is scant vital reaction in association with these abrasions over the feet. There are ecchymoses on the shoulders bilaterally and dorsal surfaces of both arms of no particular pattern with yellow discoloration ranging from 1 -

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F9999	Continued From page 76 3.5 cm. All injuries are compatible with the history of self-inflicted injuries. The Final Autopsy Data Summary indicates R1 had a clinical history of schizophrenia with poor nutrition and hydration , 3-4 days duration. It continues to state "orbits sunken on gross examination, compatible with dehydration and Vitreous chemistry compatible with dehydration." On 2/17/06 at 10:25am, Z2 stated she had not seen R1 yet and was unfamiliar with her psychiatric and medical history. When asked about the Zyprexa, Z2 stated didn't think she ordered the Vistaril in place of the Zyprexa because they were in two different drug classifications and added that they usually get prior authorization for the Zyprexa. However, telephone orders for both drugs being discontinued are signed by Z2 and on the clinical record. Z2 stated she would not have discontinued it like that if she would have realized it was. Z2 agreed that discontinuing the Zyprexa and the lack of it contributed to R1's decompensation. Z2 stated she did not intend on stopping all medication for her Schizophrenia. Regarding the phone call on 12/12/05 at 12:25pm where she ordered the Remeron, she stated she was told R1 was refusing medication and the staff suggested she was more depressed. Z2 stated that was why she ordered the Remeron in a Solutab form. Z2 stated she didn't realize R1 wasn't getting any meds for her behavior and probably didn't know the extent of her refusals of food and fluids. On 2/17/06 at 10:18am, Z1 stated he saw R1 on 11/27/05 and remembered ordering a new blood pressure medication. Z1 said he had no	F9999		

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information provided to him regarding R1's medical history when he saw her and was unfamiliar with her history. Z1 stated E2 called him the day before she died and told him that R1 was drinking and urinating. Z1 stated he was unaware of the Zyprexa being discontinued and would not necessarily be made aware since that was the psychiatrist's order and he leaves that up to her. Z1 stated he was waiting for her to improve mentally then he would deal with health issues. Z1 stated "Things should have been done, looking back."

Review of the MOSBY'S 2005 DRUG CONSULT FOR NURSES identifies Zyprexa as a Anti-psychotic medication. It identifies the dose range for elderly residents as being 2.5mg to 10 daily. Patient instructions include telling the patient to avoid dehydration, instruct patient to take drug as ordered and caution patient against abruptly discontinuing the drug and suggest sips of tepid water and sugarless gum to relieve dry mouth among others.

On 2/24/06 at 9:10am, E15, RN (Registered Nurse), Care Plan/MDS Coordinator, stated R1 was very difficult to talk to when she first came in but could answer questions when asked. E15 states she does not do direct care of residents, was aware that R1 was refusing meals but not to the extent that she was. E15 stated she remembered the morning of 12/13/05 because E 16 came to her and wanted her to look at R1 as she had been on the floor all night and had scratches/bruises all over her. E15 stated she went to the room and R1 was on a mattress on the floor. E15 stated E2 was aware and attributed all her problems to "behavior." E15

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stated R1 would follow commands to roll from side to side but wouldn't get back on the mattress . E15 was asked about care planning for Behaviors and stated the staff are to fill out coupons which the IDT team reviews daily. E15 stated there were no IDT team meetings between the end of October to the end of December but didn't know why. E15 agreed that was why R1's behaviors had not been assessed by the IDT during her stay at the facility. E15 made no changes in R1's care plan or behavioral interventions from 12/1/05 on and was provided no prior medical or psychiatric history.

On 2/23/06 at 9:20am, E2, DON, stated the nurses do not get followup and they are very task oriented, have trouble thinking out of the box. E2 was asked about the 24 hour report and stated her, E1 (Administrator) and Z6 (Corporate) have reviewed it and found no information in it to support any nursing observations or assessment regarding R1's behaviors and/or physical condition.

On 3/2/06 at 9:35am and on 2/23/06 at 9:20am, E2, DON, agreed that the order from Zyprexa to Vistaril was unusual as they were in different categories of drugs. E2 stated based on her pre-admission screening, she thought R1's behaviors were attention-seeking. E2 stated when R1 first arrived at the facility, she would run up and down the hall, holler and scream at times, could carry on a conversation sometimes and not others and would appear weak and require assistance.

On 3/2/06 at 11:15am, E2 stated the nurses did not keep her well informed even though they have been repeatedly told to. E2 also stated

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communication between shifts, nurses and the aides is a problem. E2, when asked why R1 died from dehydration, stated because R1 was not properly assessed by the floor nurses and because they did not communicate with the physicians and herself. E2 confirmed that there was a period of time around December where the facility was not doing IDT team daily meetings.

On 3/2/06 at 2:15pm, E1 was asked why R1 died. E1 stated there was a complete breakdown in communications between the nurses, the Director of Nurses and the Doctors.

Review of the Preadmission Screening information provided by E2 on 2/17/06 at 9:22am identifies R1 as having been experiencing medical problems while at the mental institution. It also states in a progress note dated 11/15/05 by the social worker that R1's daughter had been informed of R1's electrolyte imbalance and a possible move to the hospital. Per interview with E2 at that time indicates this information is not placed on the chart but kept in a separate file. E 2 said it is not accessible to the nurses, the care plan coordinator and either physician which was confirmed in interview.

In interview with Z7, Physician, IDPH's Medical consultant, Z7 stated ordering Vistaril in place of the Zyprexa makes no sense as they are in two different classifications of drugs. Z7 stated R1, due to her history of Schizophrenia, needs medication to control her behaviors and the psychiatrist should have been informed by the nurses that R1 was receiving no medication for her Schizophrenia when the Vistaril was discontinued. Z7 also stated the nurses

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F9999	Continued From page 80 neglected to inform the extent of R1's deterioration/behaviors to both physicians or action would have been provided sooner. Z7 stated the nurses neglected to monitor R1's food and fluid intake when ordered by the physician and as a nursing measure when her refusals of both began. The facility neglected to assess R1's behaviors adequately upon admission and failed to identify behaviors. The facility staff failed to complete BEHAVIOR COUPONS identifying R1's behaviors and neglected to hold daily meetings to discuss her condition. The facility did not have any means of tracking behaviors to determine if they increased/decreased or changed as only one BEHAVIOR COUPON was provided therefore the discontinuation of the Zyprexa was not under close supervision. The facility nurses aware that R1's Zyprexa had been discontinued abruptly failed to assess her for adverse effects. (A)	F9999		