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F 324	Continued From page 16 clients on suicide precautions, updating care plans & services as appropriate, and report on progress in QA meetings.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.12120b)1) 300.1210b)3) 300.1210b)6) 300.3240a) 300.1650d)1) 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 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 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	F9999		

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further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1650 Control of Medications
d) Inventory Controls
1) For all Schedule II controlled substances, a controlled substances record shall be maintained that lists on separate sheets, for each type and strength of Schedule II controlled substance, the following information: date, time administered, name of resident, dose, licensed prescriber's name, signature of person administering dose, and number of doses remaining.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Based on record reviews,interviews and review of the facility policy and procedure regarding medication administration, the facility failed to ensure that a resident (R2) who has a history of polysubstance overdose (10/11/04) and a recent history of verbalizing an intention to ingest pills, does not have massive quantities of medications in his possession. The facility also failed to properly and accurately account and monitor R2 's controlled medications. This failure led to R2 ingesting large amounts of Morphine Sulfate on 5 /7/06 causing him to be hospitalized with

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admitting diagnosis of narcotic overdose. R2 expired at the hospital on 5/10/06 from renal failure and narcotic overdose.

Findings include:

R2 was a 48 years old male with multiple diagnosis to include relapse of lymphoma. R2 was originally admitted to the facility on 10/20/04 from the hospital after being admitted for polysubstance overdose and respiratory failure. Review of R2's nurses' notes dated 12/17/04 showed documentation of resident being on suicidal precaution. Review of R2's records showed that on 3/1/06, the facility started a petition to involuntarily admit the resident to the hospital due to verbalization of potentially harming himself. The involuntary admission form states, " Resident was recently told that he has 2 - 3 months to live d/t (due to) the severity of his cancer. Per resident's physician, the resident told her that he was going to ingest pills in order to eliminate any possible suffering. Res has a h/ o (history of) suicidal attempts. Resident may possibly harm himself." The resident was not involuntarily admitted to the hospital because the resident claimed that what the physician/ oncologist (Z6) told the facility about him ingesting pills to eliminate his suffering was not true. Review of the social service progress notes dated 3/1/06 showed that R2 stated to the social service director that, "he would like medications to stop his sufferings, once all medical options are obsolete. Resident denied any concrete suicidal ideations." Further review of the social service progress notes dated 3/1/06 showed documentation that Z6 "appeared to believe that the nsg (nursing) home is not familiar w/ (with)

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the resident's history."

Review of R2's incident report dated 5/7/06 (8:15 a.m.) showed, "Resident informed staff that he took a large amount of pills (200 pills)."

During interviews held on 6/20/06 at 3:10 p.m. E3 (nurse) stated that on 5/7/06 at approximately 8: 15 a.m., she was informed by R2's CNA that R2" does not look good." When E3 came in R2's room to check the resident, E3 noticed that R2 was in his wheelchair with his head backwards and his eyes closed. E3 stated that R2 would respond to his name but would mumble when talked to. E3 stated that R2 looked like he was " in distress." 911 was called for R2. Per E3, R2 was going in and out of consciousness and was very delusional. E3 stated that in between R2's episodes of going in and out of consciousness, the resident (R2) told the fire department personnel and the facility staff that he took 200 pills but he did not say what kind of medication. E3 stated that she asked the resident what kind of medication he ingested since E3 had not started her medication pass yet. R2 stated that " the pills were on the top level drawer inside his bedside table." The fire department personnel pulled out a black hygiene travel bag inside the drawer and took out its contents. Per E3, inside the bag were papers and bottles of medication with pills inside. When the fire department personnel took the blue and white labeled bottle out of the bag, R2 was asked if this was the medication he took, resident responded, "yes." E 3 stated that they did not know what kind of medication were inside the medication bottle, so E3 called the pharmacy and gave the description and the numbers inscribed in the tablets. E3

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stated that based on those descriptions the pharmacy informed her that those medications were Morphine Sulfate 30 mg. Per E3 there were 95 tablets of Morphine sulfate 30 mg inside the blue and white medication bottle. Per E3, after R 2 was taken by the 911 paramedics to the hospital, she and two other facility staff (a CNA and a housekeeper) checked R2's room and drawers. Inside R2's drawers, they found two bottles of Vodka (1 unopened, 1 was 3/4 full) and found several empty prescription bottles without labels and one prescription bottle with medications inside. E3 stated that she gathered all the above mentioned contrabands and placed it inside the medication room to be given to the Director of Nursing.

During the same interview with E3, she stated that she is not the regular nurse on R2's unit. E3 stated that she was not aware and was not informed that R2 had history of polysubstance overdose, nor was she aware that R2 had verbalized in the past, of wanting to ingest pills to end his life. E3 told the surveyor that if she was informed of R2's history of suicidal attempt and ideations, she would have checked the resident frequently and monitored closely, she would have made sure that he swallowed his medications, and would have been more conscious and observant of resident's environment and belongings to ensure that the resident did not have any harmful substances that the resident could use to harm himself, including any medications being kept inside drawers.

During interviews held on 6/21/06 at 1:03 p.m., E 4 (nurse) stated that, on 2/23/06, she received a call from Z6 (Cancer physician). Per E4 she was

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informed that R2 is very upset because he was diagnosed with recurring lymphoma. E4 stated that she was informed by Z6 of R2's history of suicidal ideations. Per E4 she called the facility psychiatrist to see the resident. Further interviews with E4 revealed that she does not know what kind of suicidal attempts R2 did in the past. E4 stated that R2's suicidal precaution is not always endorsed or written in the facility 24 hour report. E4 also stated that there was no instruction given to check resident's environment or belongings for any contrabands (such as alcohol and medications).

During interviews held on 6/21/06 at 12:00 noon, E2 (Assistant director of nursing) stated that the facility does room checks of the entire facility, including resident belongings. Resident's drawers are checked and medications and substances that should not be there are removed from the resident's room. E2 stated that the last time the facility did rooms check was last March 2006.

During interviews held on 6/22/06 at 10:30 a.m., E5 (Director of nursing) stated that she was not aware of R2's history of polysubstance overdose until the surveyor informed the facility during the daily status meeting on 6/21/06. During interviews made on 6/20/06 at 11:20 a.m., E5 showed the surveyor the articles that were found inside R2's bedside drawers. The following were as follows: 2 bottles of Vodka (1 unopened, 1 was open, 3/4 full), a medication bottle with blue and white label (non-aspirin extra strength) inside were 95 Morphine sulfate 30 mg, another prescription medication bottle with a label of, " Levaquin 500 mg," inside were 38 tablets of

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F9999	Continued From page 22 Klonopin 2 mg and 7 tablets of Klonopin 0.5 mg. Review of R2's POS (physician order sheet) showed orders for Morphine sulfate 30 mg, 1- 2 tablets every 4 hours as needed for breakthrough pain since 2/23/06. The Morphine sulfate 30 mg orders was increased to 60 mg - 90 mg every 3 to 4 hours as needed for pain on 4/16/06. This Morphine sulfate order was in effect until the resident was sent to the hospital on 4/26/06. Review of R2's POS dated 5/3/06 (readmission) showed an order for the resident to receive Morphine sulfate 60-90 mg every 2-3 hours as needed for pain. Further review of R2's POS showed that the resident's Klonopin was increased to 2 mg on 12/9/05 to be given at bed time. R2's POS also showed that he have an order for Klonopin .5 mg twice a day from 2/24/06 . Review of R2's controlled substance proof of use for Morphine sulfate 30 mg from 3/17/06 through 5/5/06 showed several times when the Morphine sulfate was not accounted. The following dates were as follows: 2 tablets not accounted for between 3/1/06 and 3/2/06, 3 tablets not accounted for between 4/20/06 and 4/21/06 and 1 tablet not accounted for 4/25/06. Review of R2 's controlled substance proof of use for Clonazepam 0.5 mg (Klonopin) showed that there were 2 tablets not accounted for between 3/ 19/06 and 3/20/06, Klonopin 2 mg, 1 tablet not accounted for between 3/18/06 and 3/19/06. The facility did not properly and accurately account and monitor R2's controlled medications. During interviews held on 6/22/06 at 12:30 p.m., surveyor showed both E5 and E2, R2's controlled	F9999		

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substance accounting form and informed them that the facility staff was not properly and accurately accounting the resident's controlled substances. Surveyor asked both E5 and E2 if they were informed about this controlled substance accounting discrepancies, both did not respond.

Review of the facility policy and procedure regarding medication administration states, that when a class II medication (controlled substance) are administered, the medication is accounted for on the resident's individual controlled substance record form by a licensed nurse. Inventory count must occur whenever the key for controlled medication changes hands, and at least at change of shifts. Inventory count must be recorded on the narcotic accounting sheet. Any discrepancy must be reported immediately to the Director of nursing or his/her designee.

Review of the facility internal investigation (5/8-5/13) made by E1 (assistant Administrator) showed that since R2's original admission on 10/20/04, R 2 had always been alert, oriented, able to communicate, and ambulatory until he returned from the hospital on 5/3/06. R2 was diagnosed with cancer in August 2005 and began chemotherapy in September 2005. R2 would go to his chemo treatments 2x a week for the last three months. He would leave the facility about 7 :30 a.m. and return to facility around noon. He would go without an escort. Further review of the facility internal investigation form showed that Z6 "wrote 2 prescriptions for Morphine on 4/11 and 4 /13 and gave them to the resident. Copies of prescription are in the chart but resident kept originals. If filled those 2 prescriptions could

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have gotten him 720 10 mg morphine pills." The facility investigation did not address how R2 could have gotten the two bottles of Vodka and the massive accumulation of Klonopin tablets. During a status meeting held with the facility on 6 /21/06 at approximately 2:00 p.m., E8 (Administrator) stated that the facility investigation regarding R2 having the original prescription and the facility having the copied prescription for Morphine sulfate was inaccurate and acknowledged that the facility did not do a thorough investigation to find out where the resident acquired those substances.

During interviews held on 6/21/06 at 11:45 a.m., Z6 stated that when R2 was diagnosed with lymphoma, R2 stated to her that he will never let himself suffer and he will take care of it. Per Z6, R2 would periodically verbalize that he would take his own life. Z6 stated that R2 was very depressed, emotionally distress significantly and that the resident did not believe that he have hope to live his life. Z6 stated that because of this behavior, R2 saw a psychiatrist in the hospital periodically, after he received his cancer treatments. Z6 told the surveyor that he has called the facility several times to inform them of the R2's history of suicidal attempts, including the resident's verbalization of ending his life. Z6 added that R2's primary physician (Z5) was also informed and made aware of the resident's history and suicidal ideations. Z6 further stated that R2 did not have any access to any medications in the cancer clinic.

During interview held on 6/21/06 at 12:30 p.m., Z 5 stated that R2 was terminally ill. Z5 stated that he was aware of R2's history of polysubstance

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overdose. Z5 also stated that he was aware of R 2's suicidal ideations. Z5 stated that the facility was also aware of this information and believes that the facility does check residents' belongings. Z5 stated that in R2's case the facility often times performed checks of resident's belongings daily, even going through their drawers to check for any substances or materials that they may use to harm themselves.

Review of R2's care plan showed no specific intervention in place to address potential medication overdose since the resident had this history. The facility also did not have a measure in place to monitor R2 and his environment for any contrabands or substances that he may bring with him inside the facility, since R2 went out of the facility for appointments unescorted.

During the daily meeting with the facility on 6/21/06 at 3:58 p.m., E8 agreed that the facility could have done better with regards to monitoring and checking R2 for any substances.

The facility failed to properly and accurately account and monitor R2's controlled substances per facility policy and procedure. The facility did not monitor R2 and his belongings to ensure that the resident did not have contrabands and substances with him that he could ingest to end his life, even though the resident had polysubstance overdose history and history of verbalizing wanting to end his life.

(A)