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W 444	Continued From page 81 evacuation. This policy does not however, address investigating and evaluating the effectiveness of drills or actual situations (such as the 5/9/06 fire) to determine the whether the plans and procedures were effective and what, if any, changes need to be implemented. In review of a facility policy entitled "Disaster preparedness" it states that the facility shall have policies and procedures covering disaster preparedness in the event of fire, explosion...". It further states that corrective action is taken when inefficiency or problems are identified during an evacuation drill. This policy however does not address however, evaluating the effectiveness of an actual emergency (5/906 fire). In an interview with E1 (DON) on 5/16/06 at the facility at 3:40 p.m., E1 confirmed that all of her interviews for the fire investigation were complete and 16 pages of E1's interviews with staff were presented. In review of these interviews, there are references to staff working as a team and working quickly. However there is no documented evaluation and summary of the fire to identify problems that occurred. E1 confirmed that this time that there was no evaluation summary of the 5/9/06 fire.	W 444		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.1040a) 390.1410a) 390.1420a) 390.1660b) 390.3240a)	W9999		

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W9999	Continued From page 82 Section 390.1040 Nursing Services a) The facility shall have a written program of Nursing Services, providing for a planned medical program, encompassing nursing treatments, rehabilitation and habilitation nursing, skilled observations, and ongoing evaluation and coordination of the resident's individual habilitation plan. Section 390.1410 Medication Policies and Procedures a) 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 the Act and this Part, shall be in compliance with all applicable federal, State and local laws, and shall be followed by the facility. Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. Section 390.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 390.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.)	W9999		

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W9999	Continued From page 83 These medications shall be administered as ordered by the licensed prescriber and at the designated time. Section 390.1660 Other Resident Record Requirements b) The resident's record shall include information regarding the physician's notification and response regarding any serious accident or injury, or significant change in condition, as required by Section 390.1030(j) of this Part Section 390.3240 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) These regulations were not met as evidenced by the following: Based on observation, interview and record review, the facility has failed to implement their system to prevent neglect for R11, when: 1) The facility neglected to investigate R11's Pica towel ingestion incident. 2) The facility neglected to notify the Department of R11's towel ingestion Pica incident. 3) The facility neglected to take sufficient steps to prevent recurrence of R11's harmful Pica. 4) The facility neglected to collect and analyze R 11's Pica data relative to trends and patterns and the possible need for program changes. 5) The facility neglected to adequately monitor	W9999		

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W9999	Continued From page 84 and intervene for R11's documented harmful Pica . 6) The facility neglected to implement their own policies and procedures to prevent neglect for R 11. A. 1) In review of a resident roster that validates level of functioning , R11 functions in the profound range of mental retardation. R11's 10/ 13/2005 IPP (Individual Program Plan) cover sheet documents further medical diagnoses of Hydrocephalus with Shunt, Chronic Constipation and Degenerative Scoliosis. R11's "Behavior Summary" within her IPP states that R11 exhibits Pica behavior by placing inedible objects into her mouth and that this behavior occurs one to five times a day. A "Behavior Support Consultation" from the consulting psychologist, dated 4/12/06, states that R11 has a long history of placing items in her mouth. This report also states that R 11 would rather place her clothing or a towel into mouth rather than suitable items available to her which are attached to her wheelchair. R11's Maximum Growth Potential Plan within her IPP documents that R11 is incontinent of bowel and bladder, is diapered every two hours or as needed, requires staff assistance with activities of daily living (eating all meals, bathing, brushing teeth and hair and dressing), is non-ambulatory, requires a wheelchair for mobility and requires every two hour repositioning. A 10/3/05 speech/ language evaluation documents that R11 is non-verbal and further states that R11 continues to exhibit, "severe PICA behaviors... and will ingest items when left unattended - shirts, socks,	W9999		

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W9999	Continued From page 85 sheets, shoe strings, etc." Per observations made at the facility on 5/10/06 at 3:30 p.m., R11 was observed to rely totally on staff for transfers and for incontinence care. In a phone interview with Z3 (guardian) on 5/19/06 at 9:00 a.m., Z3 stated that R11 has had this behavior all of her life, that R11 will ingest sheets, blankets and clothing. In an interview with E12 (QMRP for R11), on 5/12/06 at the facility at 9:30 a.m. (E13 {QMRP} and E2 {Administrator} present), E12 stated that R11 will also pull on staff 's clothing when exhibiting her Pica behaviors. On 3/21/06 nurse's notes (12:00 p.m.) state that R11 was noted to have a "lg" (large) emesis after eating lunch and was also noted to be crying (with) discomfort. The assessment documents that her abdomen was hard with hyperactive bowel sounds. An enema was given at this time. 3/21/06 nurse's notes (1:30 p.m.) document that R11 had, "Xlg results", and "shredded towel noted." 03/22/06 nurse's notes (0500), document that R 11 had another large emesis in the a.m. 3/22/06 nurse's notes at 7:30 a.m. document that an enema was given with large results and with some strings. In an interview with E3 (Licensed Practical Nurse - LPN), at the facility on 5/12/06 at 10:00 a.m. (with Director of Nursing - {DON} present - E1), E 3 confirmed that she had administered the	W9999		

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enema on 3/21/06 and confirmed that R11's 3/21/06 1:30 p.m. bowel contents contained towel material. E3 further noted that she could tell it was cloth material, but was brown in color as it was mixed in with the bowel contents. E3 also confirmed that on 3/22/06 at 7:30 a.m., she observed "strings" in R11's bowel contents. E3 stated that she couldn't tell any more, just that it was "stringy."

In an interview with E1 (DON), at the facility on 5/12/06, (with E2 {Administrator} and E4 "Director of Operations} present), E1 confirmed that R11's Pica incident (resulting in two separate bowel movements containing towel like material (3/21 & 3/22/06), had not been investigated by the facility .

2. On 3/21/06 nurse's notes of 12:00 p.m. state that R11 (see diagnoses in example #1 above), was noted to have a "lg" (large) emesis after eating lunch and was also noted to be crying (with) discomfort. Assessment documents that her abdomen was hard with hyperactive bowel sounds. An enema was given at this time.

3/21/06 nurse's notes (1:30 p.m.), document that R11 had, "Xlg results" and "shredded towel noted ."

3/22/06 nurse's notes (0500), document that R11 had another large emesis in the a.m.

3/22/06 nurse's notes (7:30 a.m.), document that an enema was given with large results and with some strings.

In an interview with E1 (DON), at the facility on 5/

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W9999	Continued From page 87 12/06 at 11:45 a.m. (E2 {Administrator} and E4 {Director of operations} present), E1 confirmed that the Department had not been notified of R11 's Pica incident. 3. R11's (see diagnoses in example #1), record review documents that R11's most recent IPP was held on 10/13/05. R11's IPP identifies formal programming and services in the following areas: - increase opportunities for choice making skills. - increase independence with ADL (activities of daily living)/vocational skills through participation in feeding and work study. - increase opportunities for switch use for environmental control purposes. - increase opportunities for sensory stimulation-increase awareness in identifying edible and non-edible items. A 2/16/06 Human Rights/Behavior Management Committee meeting documents that R11 has informal behavior interventions for her Pica. In an interview conducted at the facility on 5/12/06 at 9:30 a.m. with E12 (QMRP), E13 (QMRP), with E2 (Administrator) present, E12 and E13 confirmed that the 3/28/06 document entitled " Behavior In-service" is R11's current informal behavior program. Per this program, staff are to constantly inspect R11's environment to ensure that harmful items are not within her reach; R11 should not wear soft and thin long sleeve shirts, bibs, gloves/mittens, towel, or any clothing items that she can grasp and put in her mouth; during bed time R11 is to wear long pants/P.J., and shirt - no pillow, soft/thin linen blanket, bib, socks or extra clothing and undergarments on her bed or	W9999		

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within her reach; be placed one meter away from other individuals to prevent reaching out for items; not to be positioned near drawers curtains and vocational/activity bins and staff are to always ensure at all time that R11 will not chew or put into her mouth any inedible items.

Nurse's notes of 3/21/06 at 12:00 p.m. document that R11 was noted to have a "lg" (large) emesis after eating lunch. R11 was also noted to be crying (with) discomfort. Nursing assessment documents a hard abdomen with hyperactive bowel sounds. An enema and pain reliever was given for her discomfort. At 1:30 p.m. on the above date, nurse's notes document that R1 had "Xlg" (extra large) results with shredded towel noted in the bowel contents.

Nurse's notes of 3/22/06 document that at 0500, R11 had another large emesis. On the same date at 7:30 a.m., an enema was given with large results and some strings observed in the bowel contents.

Review of facility inservice records presented by E13 (QMRP) document that staff training was presented on 2/24/06 and again on 3/28/06 (after the 3/21/06 pica incident).

In an interview with E13 (QMRP) at the facility at 9:25 a.m., E13 confirmed that E12 (QMRP) is R 11's QMRP.

In an interview with E12 and E13 on 5/12/06 at the facility at 9:30 a.m. (with E2 present - Administrator), E12 stated that R11's annual IPP was 10/13/05. E13 stated the only meeting that has occurred for R11 since the 11/13/05 IPP, is

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the Human Rights/Behavior management Committee meeting dated 2/16/06. In review of the minutes of this meeting it states, "(R11) was discussed. At this time she has informal behavior interventions for PICA, a behavior she has had her whole life. Informal data collection will continue as well as informal procedures."

Per review of R11's program and medical records, there is no reproducible documentation to validate that the facility has taken any further steps to prevent a similar recurrence of the 3/21/06 pica incident for R11, with the exception of the 3/28/06 in-service training. There is no reproducible documentation that the IDT team has re-convened to reassess R11's environment, the need for possible increased supervision, or the need for possible program changes.

4. Nurse's notes for R11 (dated 3/21 & 3/22/06), document that R11 (see diagnoses in example # 1), experienced emesis after her lunch, with discomfort, crying, hard abdomen and hyperactive bowel sounds. An enema was administered with extra large results, the bowel contents noted to contain "shredded towel". Another large emesis was noted the next a.m., enema administered, with large results and some strings noted in the bowel contents.

R11's record review documents that R11's most recent IPP was held on 10/13/05.

In an interview conducted at the facility on 5/12/06 at 9;30 a.m. with E12 (QMRP), E13 (QMRP), with E2 (Administrator) present, E12 and E13 confirmed that the 3/28/06 document entitled, " Behavior In-service" is R11's current informal

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behavior program. Review of R11's monthly summary data documents the number of Pica incidents for R11 as follows:

4/1-30/06 - at day training 0
at the facility - 0

3/1-31/06 - at day training - 12;
at the facility - 7

2/1-28/06 - at day training - 0;
at the facility - 32

In an interview with E12 (QMRP), at the facility on 5/12/06 at 9:30 a.m. (with E13 {QMRP} and E 2 {Administrator} present), E12 stated that regarding R11's pica data, staff complete data sheets. E12 explained that when staff see R11 attempt a Pica behavior, staff intervene. One incident means one attempt and intervention. Data collection is completed at the day training site and the facility. When asked, E12 stated that the data collected does not include what item was attempted by R11, whether staff were successful in retrieving the item or not and whether R11 was successful in swallowing the item or not, nor the particular environment R11 was in within the day training site and the facility.

5. R11 (see diagnoses in example #1) has a well documented and long history of Pica behavior. Her current IPP (10/13/05) further documents R 11's Pica preference for cloth type material, as does the phone interview with R11's guardian (Z3) on 5/19/06 at 9:00 a.m.

On 5/11/06 R11 was observed at the facility beginning at 3:20 p.m. At 3:20 p.m., R11 was

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W9999	Continued From page 91 observed in her bed and appeared to be sleeping, her back facing the outer edge of her bed. A pillow with a pillow cover was observed at the foot end of R11's bed. At 3:30 p.m. E14 (CNA) was observed providing incontinence care to R11 while R11 was in her team room, in her bed. At 3:45 p.m., R11 was observed to be up in her wheelchair (still in her room). R11 was observed to be dressed in a matching outfit, which consisted of pink long pants and a long sleeved pink pull over top. This material was observed to be soft and thin as compared to a heavier typical sweat suit material. The sleeve on R11's right sleeve was pushed up to her elbow and the sleeve on R11's left arm was at her wrist. There were no staff in the room. At 4: 00 p.m., R11 was again observed. There were no staff in the room and R11's sleeves were as described at the 3:45 p.m. observation. R11 was observed again at 4:10 p.m., no staff were in the room and the sleeves remained the same as described at the 3:45 p.m. observation. At 4:25 p .m., R11 was observed again. There were no staff in the room and R11's left sleeve was pulled down over her knuckles. When surveyor touched R11's left sleeve at the area just above her knuckles, the material was damp. Additionally, R 11's shirt was pulled up and bunched above her wheelchair tray on the right side of R11's tray. At all other observations described above, R11's shirt was not pulled up and bunched above her wheelchair tray. In review of R11's 3/28/06 informal behavior management plan, it documents that R11 exhibits Pica behavior by placing inedible ("harmful") items in her mouth. Under Recommendations it states: staff should constantly inspect R11's	W9999		

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immediate environment to ensure that harmful items are not within her reach; R11 should not wear soft and thin long sleeve shirts, bibs, gloves /mittens, towel, or any clothing items that she can grasp and put in her mouth; during bed time, R11 will wear long pants/P.J., and shirt. She will not have pillow, soft/thin linen or blanket, towel, bib, socks or any extra clothes and undergarments on her bed or within her reach; she should be one meter away from other residents to prevent her from reaching out to any items; she should not stay near drawers, curtains and vocational activity bins where she can grab items and staff should always ensure at all times that R11 will not chew or put in her mouth any inedible (" harmful") items.

In an interview with E14 (CNA) on 5/11/06 at the facility after the above described observation, E 14 stated that she does not usually work in R11's team room. E14 confirmed that she completed R 11's incontinent care and dressed R11 in the long sleeved pink outfit. E14 stated that she was aware of R11's Pica behavior, and had pushed up R11's sleeves to her elbow.

6. In review of the facility's abuse/neglect policy it states the following, "(Facility) will not condone resident abuse or neglect by anyone, including staff members.....It is the policy of this facility that all incidents or suspected incidents of resident abuse or neglect,.....be reported immediately to the Administrator/designee. The Administrator/ designee shall report in a timely manner to the appropriate agency...."

Within this policy, neglect is defined as, "....any failure by the facility or an employee to carry out

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required and appropriate clinical services, habilitation, or treatment as ordered by a physician or other authorized personnel that is the proximate cause of psychological harm or physical injury to an individual. It also includes any act or omission by the facility or an employee that endangers an individual's health or safety or fails to respond to an obvious and immediate need of an individual, regardless or whether or not there is an injury."

Under the "Procedure" section of this policy it states, "All personnel, residents, and visitors are required to report incidents of resident abuse or neglect or suspected incidents of resident abuse or neglect.....Following the discovery of an incident or alleged abuse or neglect, serious injury...the facility representative shall report to .....THE DEPARTMENT OF PUBLIC HEALTH..... The report should include:...Any allegation of neglect that may be the result of any action or omission by the facility or any employee thereof... Any serious injury to an individual, however inflicted (including self-injury), that is not alleged to be the result of abuse or neglect.....The facility shall...Ensure the immediate health and safety of involved individuals.....Initiate the preliminary steps of the investigation including initial interviews and gathering of evidence and documents..."

In the facility policy entitled, "RESIDENTS RIGHTS AND FACILITY RESPONSIBILITIES", it states, "No resident shall be abused or neglected ".

Under a nursing policy entitled "Incident Report", it states: "POLICY": An incident is any

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W9999	Continued From page 94 happening that is not consistent with the routine operation of the facility or the routine care of a particular resident. It may be an accident or a situation that could result in an accident. It could be an error in care. Any unanticipated outcomes in relation to any of our residents require an incident report to be filled out...Supervisor will initiate investigation into cause of incident and methods of preventing similar incidents from happening." In review of the facility's ACTIVE TREATMENT POLICY, it states, "Each client must receive a continuous active treatment program, which include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services... that is directed toward (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status." In review of the facility's INDIVIDUAL SERVICES PLAN POLICY, it states, "At least monthly, the QMRP shall review the plan and document in the record that: 1) Services are being implemented; and 2) Services identified in the plan continue to meet the individual's needs or require modification or change to better meet the individual's needs." In an interview with E2 (Administrator) and E1 (Director of Nursing DON) on 5/11/06 at 5:48 p.m ., E1 and E2 stated that there have been no allegations of staff abuse or staff neglect that the facility has investigated since 3/3/06.	W9999		

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W9999	Continued From page 95 B. Based on observation, interview, and file review, the facility failed to provide nursing services in accordance to resident needs when they failed to : 1) Ensure reproducible documentation of facility nursing assessment prior to sending three residents to the emergency room and upon their return to the facility; ensure notification to the physician for recommended emergency room after-care follow-up, when R's 3, 7 & 8 were involved in a facility fire. 2) Ensure a current nursing care plan to provide for on-going assessment, monitoring, follow-up and communication with R1's physician regarding his history of Gastrointestinal Bleed/ Gastrointestinal Esophageal Reflux Disease, Chronic Constipation and G-tube feedings. 3) Ensure a current nursing care plan to provide for on-going consistent assessment, monitoring and follow-up for R6s on-going leg edema. 4) Ensure every two hour positioning for R6, related to her high risk status for skin breakdown. 5) Ensure a current nursing care plan to provide for consistent assessment, monitoring, follow-up and communication with R11's physician, regarding consistent bowel assessments and increased bowel movement monitoring after R11 's emesis and subsequent bowel movements containing Pica material.	W9999		

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W9999	Continued From page 96 6) Ensure proper administration of R11's bowel control medication and follow-up to R11's thigh and abdomen abrasions, affecting 6 of 11 in the sample (R's 1, 4, 6, 7, 8 & 11). Findings include: 1. In review of a facility notification to the Department from E1 (DON), it states that on 5/9/06 at approximately 8:00 p.m., staff discovered and extinguished a small fire in a bedroom closet. A 5/9/06 report from the responding ambulance service documents that 3 individuals were taken by ambulance to the emergency room for further assessment. The residents are identified as R's 3, 7 & 8. In review of a resident roster that validates level of functioning, R3 functions in the profound range of mental retardation. Review of his current physician's orders of 5/1/06-5/31/06 document that R3 has additional diagnoses of Congestive Heart Failure, Hypertension and Down Syndrome and is 53 years of age. Standing orders for R3 state that if resident exhibits respiratory distress of any kind, check oxygen saturation immediately . If oxygen saturation is below 91% at room air, start oxygen at 2 liters and regulate to maintain oxygen saturation greater or equal to 91% unless otherwise ordered by physician. Wean off oxygen as indicated. Per observations made at the facility on 5/10/06 in the a.m. at the facility, R 3 was observed to be ambulatory. R3's current IPP (Individual Program Plan), documents that R 3 has a state appointed guardian, can verbalize and uses gestures to communicate.	W9999		

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W9999	Continued From page 97 In review of the ambulance service report for R3, dated 5/9/06 it states that this service was called to the scene for a fire stand-by. While there, ambulance staff were called for (R3) regarding difficult breathing. Vitals were: blood pressure - 100/70, pulse 63; respirations 16; oxygen 98% on 15 lpm (liters per minute). The report states that R3 was monitored per ambulance staff until arrival at the hospital emergency room. Per review of the hospital's Emergency Department After Care Instructions, R3 was released at 2258 with a provisional diagnosis of " Smoke Inhalation" and was to see his physician for follow-up within 48 hours. The radiology report dated 5/10/06, under "Impression", states, "Congestive Heart Failure or Pulmonary Edema." In review of nurse's notes for R3 there are nursing notes for 5/5/06. The next nursing notes are dated 5/9/06 at 10:05 p.m. and state that R3's guardian was called and a message left to return the call to the facility. In review of this note, there is no reproducible documentation that facility nursing assessed R3 prior to his ambulance transport to the hospital. The next nurse's note is 5/10/06 at 0530. This note states, informed (guardian) on (R3's) return to the facility. There is no nursing assessment of R3, since his return from the emergency room until 5/10/06 at 0545, at which time vitals and oxygen saturation was documented. There is another nurse's note for 5/10/06 at 8:30	W9999		

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a.m. that documents vital signs for R3 (temperature - 96.2; pulse - 82; respirations - 20; and oxygen saturation at 92%). This note also states that R3 consumed all of his breakfast, breathing was non-labored; lung sounds clear bilaterally; skin color within normal limits with no apparent respiratory distress noted.

There is no further assessment by facility nursing until 5/10/06 at 3:20 p.m. when notes state that R 3 was in bed sitting up and respirations were slightly labored. Vital signs as follows: temperature 95.2; pulse - 86; respirations - 22; and oxygen saturation - 70-82%. The facility physician was notified with orders to send R3 to the emergency room. A note on the same date at 7:45 p.m. documents that R3 was admitted to the hospital with a diagnosis of Congestive Heart Failure.

In an interview with E1 (DON), at the facility on 5/ 16/06 at 2:15 p.m. (E2 {Administrator}, surveyor and Southern Region Supervisor present), E1 stated that there was no documentation of any nursing assessment for R3 prior to his hospital transfer after the 5/9/06 fire. E1 stated that nursing did complete a triage of all residents. E1 also confirmed at this time that there should be a facility nursing assessment upon return from the hospital, unless the resident was back to normal.

In a phone interview with E16 (Facility Physician) on 5/23/06, when asked how smoke inhalation would affect R3, given his diagnoses of Congestive Heart Failure, E16 stated that anything that stresses the lungs can bring on an exacerbation of the Congestive Heart Failure. E

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W9999	Continued From page 99 16 cited examples of cold and smoke. When asked if E16 would expect increased nursing assessment after R3's return from the emergency room (given his "smoke inhalation" emergency room discharge diagnosis), E16 replied, "Yes, absolutely." (As above, R3 did not receive facility nursing assessment upon his return from the emergency room; with his first facility nursing assessment not occurring until 5/10/06 at 0545. Additionally, after R3's 5/10/06 8:30 a.m. nursing assessment, no further assessments were completed until 3:20 p. m., when R3 was sent to the emergency room). Additional examples for R's 7 and 8 regarding lack of assessment by facility nursing prior to transport to the emergency room and upon their return to the facility. In review of a resident roster that validates level of functioning, R's 7 and 8 function in the profound range of mental retardation. In review of R7's current physician's order sheet, R7 has additional diagnoses of Cerebral Palsy, Seizure Disorder, Hydrocephalic, Scoliosis, Hypothyroidism, Bilateral Hip Dislocation, Gastroesophageal Reflux Disease (GERD), Asthma, Chronic Constipation and is fed per G-tube. A facility document entitled "Health/Medical " documents that R7 requires full assist for all ADL's, as needed suction, nebulizer treatments and oxygen. A document that validates residents who require a wheelchair for mobility, confirms that R7 requires a wheelchair for mobility.	W9999		

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In review of nurse's notes of 5/9/06 for R7, there is no reproducible documentation that R7 was assessed by facility nursing prior to her transport to the emergency room.

After Care Instructions from the emergency room document R7's provisional diagnosis as "smoke inhalation", with discharge time as 2200. A 5/11/06 assessment data document from the hospital notes under chief complaint ; "Chemical Exposure."

In review of nurse's notes for R7, there is no reproducible documentation of assessment of lung sounds for R7 until 5/10/06 at 8:00 a.m.

In review of R8's current physician's order sheet, R8 has additional diagnoses of Cerebral Palsy, History of Asthma, History of Pneumonia, Allergie, Status/Post Scoliosis Surgery, Chronic Constipation and receives G-tube feedings. Per a "Health/Medical" facility document, R8 requires full assist for ADL's and receives as needed suctioning, nebulizer treatments and oxygen. A document that validates residents who requires a wheelchair for mobility confirms that requires a wheelchair for mobility.

In review of nurse's notes of 5/9/06 for R8, there is no reproducible documentation that R8 was assessed by facility nursing prior to her transport to the emergency room.

After Care Instructions from the emergency room document R8's provisional diagnosis as, "smoke inhalation," with discharge time as 2320.

In review of nurse's notes for R8, there is no

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W9999	Continued From page 101 reproducible documentation of assessment of R8 's vitals or lung sounds until 5/10/06 at 5:30 a.m. Additionally, per the After Care Instructions from the emergency room, R's 3 and 7 were to receive physician follow-up in 48 hours and R8 in 24 hours. In review of R's 3, 7 and 8's nurse's notes, there is no reproducible documentation that the physician was notified of these recommendations from the emergency room. In an interview with E1 (DON) at the facility at 2: 15 p.m. (E2 {Administrator}, surveyor and Southern Region Supervisor present), E1 confirmed that the facility physician has not seen R7 or R8 since the 5/9/06 fire. In a phone interview with E16 (facility physician) on 5/23/06 at 1:50 p.m., when asked if he would expect to be notified by facility nursing of the emergency room's after care instructions for R's 3, 7 and 8, he stated, "Yes, I would." 2. In review of a facility roster that validates level of functioning R1 functions in the profound range of mental retardation. Review of R1's current physician's orders document the following additional diagnoses: Seizure Disorder, Status/ Post Ischemic Encephalopathy, Cerebral Atrophy with Shunt, Gastroesophageal Reflux Disease (GERD), History of Upper GI (Gastrointestinal) Bleed, Hypoxia Secondary to Aspiration Pneumonia, Chronic Constipation and Organic Mental Syndrome, feeding per G-tube. A facility " Health/Medical" document validates palliative care for R1, full assist for ADL's, repositioning every two hours, and as needed suction, nebulizer treatments and oxygen.	W9999		

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W9999	Continued From page 102 A 3/9/06 lab report for R1 documents his Hemoglobin as 11.3 (Normal value is listed as 13.2-17.3). In review of nurse's notes for R1, there is a nursing note dated 3/5/06. The next nursing note is dated 3/20/06. There is no nursing documentation of the abnormal lab value and no reproducible documentation that nursing notified the physician of this lab outcome. In an interview with E1 (DON), at the facility on 5/16/06 (E2 {Administrator} and E3 {Director of Operations} present), E1 stated that she would expect nursing to notify the physician of R1's abnormal lab, given his history of GI bleed. Nurse's notes of 3/27/06 at 8:00 a..m. document that on the night shift, R1 had an emesis made up of brown liquid. R1 received Phenergan and an enema. Nurse's notes of 4/19/06 at 6:00 a.m., state that R1 was noted to have two large emesis' made up of brown liquid. R1 noted to be trying to have a bowel movement. Abdomen was noted to be hard and slightly distended, with hyperactive bowel sounds. An enema was given with extra large results at 8:00 a.m. On 4/25/06 at 9:00 a.m., nurse's notes document that R1 had a large coffee ground emesis with an, "X Xlg black tarry stool". In review of the nurse's notes, there is no reproducible documentation that the facility physician was notified of R1's brown liquid emesis, coffee ground emesis and black tarry stool.	W9999		

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W9999	Continued From page 103 In an interview with E1 (DON), at the facility on 5/16/06 in the p.m., (E2 {Administrator} and E4 {Director of Operations} present), E1 confirmed that she would expect physician notification of R1 's brown liquid emesis, coffee ground emesis and black tarry stool. When asked (same interview) what E1 would expect nursing staff to assess regarding R1's brown liquid emesis, E1 stated she would expect nursing to assess abdomen, bowel sounds and color and the same assessments for coffee ground emesis and black tarry stool. Nurse's notes of 3/27/06 at 8:00 a.m., that report the liquid brown emesis do not document any assessment of R1's abdomen or bowel sounds, but is noted to have good skin color. In a phone interview with E16 (facility physician), on 5/23/06 at 1:50 p.m., when asked if he would expect to be notified of R1's brown liquid emesis, coffee ground emesis and black tarry stool, E16 replied, "Sure, yes". In review of R1's current Nursing Care Plan (photo copied by surveyor on 5/16/06), his diagnoses includes Chronic Constipation, GERD, Seizures and Osteoporosis. In review of this plan there is no reproducible evidence that the plan addresses R1's Chronic Constipation or his History of GI Bleed. E1 was informed at the 5/16/06 interview (see above), that per the review of R1's Nursing Care Plan, the plan does not address R1's Chronic Constipation of his History of GI Bleed. There was no response or comment from E1.	W9999		

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3. In review of a resident roster that validates level of functioning, admit/discharge record and Comprehensive Nursing Summary of 3/3/06, R6 functions in the profound range of mental retardation. R6 is non-verbal and requires total assist for all ADL's. Her current physician's orders document that R6 has Dementia, Parkinson's Disease, Hypertension and has a current order for "TED HOSE - ON EVERY A.M., OFF AT BEDTIME". Physician's orders document that R6 receives Lasix 40 mg., tablet, one tablet by mouth every morning - first order date 10/28/05, (which was increase by another 40 mg. on 5/706 - per review of a physician's order dated 57/06). In a 5/12/06 interview at the facility at 11:45 a.m., E1 (DON), confirmed that R 6's Lasix and support stockings are used to reduce edema.

In an interview with E11 (Assistant Trainer), on 5/ 11/06 in R6's team room, at 1:00 a.m., E11 stated that she has worked in this team room with R6 for over two years, and that ever since she has worked with R6, R6 has always had leg swelling.

Nurse's notes of 4/25/06 (at 9:00 a.m.) ,document that R6 has blisters on her left lower leg caused by "Ted Hose"- temperature of 96 - no other vitals recorded. The following is a summary of nurse's notes for R6:

4/25/06 (at 2130), - support stockings remain off with legs (arrow up) as much as possible

4/26/06 (6:10 a.m.) - temperature is 96 - no other vitals

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W9999	Continued From page 105 9:00 a.m. - blisters intact - temperature is 95.5 - no other vitals 2100 - blisters are now open and TAO (Triple Antibiotic Ointment) applied. Her "TREATMENT RECORD" of 04/06 documents Bacitracin treatment beginning on 4/27/06 to the left leg blisters, every shift until healed. 4/27/06 - 9:00 a.m. - blisters open and reddened - no bleeding temperature - 96 - no other vitals there is no other nursing documentation for this date 4/28/06 - 9:00 a.m. - blisters to left calf open with yellow drainage - temperature 96.9 - no other vitals 2115 - blisters appear very red and inflamed and tender to touch 4/29/06 - 9:00 a.m. - temperature - 96 - no other vitals 9:00 p.m. - no vitals 4/30/06 - 0300 - temperature 96.6 - no other vitals (9:00 a.m.) - document treatment to blisters and recorded temperature - no other vitals documented (5:30 p.m.) - "reported (arrow up) swelling", on left leg - physician saw R6 - labs ordered and new orders (Per the MAR for 4/06 - Cephalexin 500 mg QID for one week for Left Leg Cellulitis was initiated) 7:15 p.m. document left leg still swollen - no vitals documented	W9999		

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W9999	Continued From page 106 5/1/06 - 5:20 a.m. - extremities remain swollen, warm and dry to touch, adequate skin color, pedal pulses palpable - temperature 95 9:00 a.m. - lower legs continue to be swollen and warm to touch - pedal pulses palpable - no redness notes - blisters draining small amounts of dark yellow drainage - temperature 95.8 9:00 p.m. - left leg still swollen - no vitals 5/2/06 - 5:40 a.m. - +1 pitting edema, pedal pulses palpable, extremities warm to touch, adequate skin color - temperature 99 9:00 a.m. - lower extremities continue to be swollen - temperature 96.8 1700 - temperature 95 - bilateral (arrow down) extremities continue to be swollen 5/3/06 - 4:50 a.m. - +1 pitting edema noted in lower extremities, pedal pulses slightly palpable, skin warm and dry to touch, legs elevated - temperature 96 9:00 a.m. - swelling continues bilaterally - temperature 96 8:30 p.m. - lower extremities continue to be swollen - +1 pitting edema, pedal pulses slightly palpable, lower extremities warm and dry , adequate skin color , kept legs elevated 5/4/06 - 9:30 a.m. - no redness noted on leg swelling - vitals taken and R6 sent to emergency room with ear laceration - returned to facility same day with 9 stitches to ear (posterior right pinna) p.m. - extremities remain swollen, kept elevated, adequate skin color - temperature 95 5/5/06 - 5:10 a.m. - left extremities continue to be swollen -kept elevated - pedal pulses	W9999		

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W9999	Continued From page 107 palpable, skin warm and dry to touch - temperature 95 9:00 a.m. - left leg continues to be swollen, no redness or warmth noted, pedal pulses present - temperature 96 8:30 p.m. - left leg continues to be swollen - pulse present - temperature 96 5/6/06 - 5:00 a.m. - left leg continues to be swollen - temperature - 96 9:00 a.m. - documents that medication was given for left leg Cellulitis - with no adverse reaction to the medication - there is no assessment of leg edema - temperature 96 9:00 p.m. - leg leg still swollen, pedal pulse (+) - temperature 96 5/7/06 - 5:00 am. - temperature 96 - there is no assessment of leg edema 8:00 a.m. - left leg still noted to have a small amount of drainage - will notify physician - no assessment of edema documented 8:50 a.m. - received physician orders to continue antibiotic for another 3 days 11:30 a.m. - physician here and ordered lab work 9:00 p.m. - pulse + X 2 on both legs - no further assessment of edema for this note Per review of a "Doctor's Orders and Progress Notes," the physician documents left leg edema as 1-2+ pitting. 5/8/06 - (5:00 a.m.) temperature 97.6 - pedal pulses present on both lower extremities - no further assessment of edema 9:00 am. - left leg continues to be swollen - no redness or warmth - started Lasix 80 mg - temperature 96.8	W9999		

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W9999	Continued From page 108 6:00 p.m. - left lower extremity still swollen - temperature 96.9 There is a 5/8/06 physician's order to hold R6's support stocking until the blisters heal. 5/9/06 - 0600 - left leg still swollen - temperature 96 9:00 a.m. - leg continues to be swollen - no redness or warmth noted - 10:00 (a.m./p.m. not documented) - lower extremities swollen 3+ edema - both legs elevated - afebrile 5/10/06 - temperature 96.6 - no assessment of leg/edema 2:00 p.m. - legs continue to be swollen bilaterally, no redness or warmth, pulses present - temperature 96.6 5/11/06 - 4:30 a.m. - vital signs and temperature (96) - no documentation of edema assessment 8:00 a.m. - temperature 96 - no documentation of edema assessment 2145 - temperature - 96 - no assessment of edema documented 5/12/06 - (no time documented) - temperature 97 - no assessment of edema documented 2100 - temperature 96 - no assessment of edema documented There are no nurse's notes for 5/13 and 5/14 - and therefore no assessment of R6's edema or vitals 5/15/06 (11:45) - no assessment of edema or vitals documented	W9999		

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W9999	Continued From page 109 5/16/06 - 7:00 a.m. - no assessment of edema documented - no vitals documented In review of the nurse's notes between 4/25/06 and 5/10/06, there is no consistent assessment or intervention by nursing of R6's edema. Assessments are varied between staff and shifts and from day to day - ie some assess visually only; some assess via pitting (+1, +2, etc); some assess pedal pulses, some do not; some assess by touch and color and others do not. Additionally, as a nursing care intervention, nursing on some shifts document elevating legs, and others do not. In review of R6's current Nursing Care Plan, the last review date is documented as April/2005. Confirmed in an interview with E1 (DON) on 5/12/06 at the facility at 1:00 p.m. (E2 {Administrator} and E4 {Director of operations} present). Per review of the Nursing Care Plan, there is no reproducible documentation that R6's leg edema is addressed in this plan. When asked about nursing interventions for R6' edema, E1 stated that R6 received Lasix and that the Maxzide that R6 receives for her Hypertension would also help with fluid retention. She further stated that the support stockings would also assist in reducing edema. When asked if elevation of the legs would help, E1 stated that what position she is in doesn't seem to affect her edema and that the diagnoses of Hypertension and Hypothyroidism is an issue influencing the edema.	W9999		

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W9999	Continued From page 110 Regarding nursing assessment, E1 stated that in evaluating the edema, it would depend on the cause of the edema, but skin color, nail beds and mottled legs would be part of the assessment. When asked if nursing would expect consistent pedal pulses or documentation of pitting edema , E1 stated no; further stating that R6 is weighed one time a month, so changes in weight would signal increased assessment need. E4 stated that she would expect a visual assessment at every shift and also cited cold skin, blanching and mottled skin assessments, that concerns in these areas would indicate the need for further nursing assessment. On 5/16/06 in an interview with the E1 (DON), at 11:45 a.m. at the facility, E1 stated that with the removal of R6's support stockings (as much as possible by nursing staff - 4/25/06 and by physician order on 5/8/06), she would not recommend any extra assessment of R6's leg edema. She further stated that no extra nursing interventions (such as elevating legs), would be taken unless there was a change in R6's edema. When surveyor presented nursing documentation of 5/2/06 for +1 edema, 5/7/06 for +2 edema and 5/9/06 for +3 edema, E1 stated that she would not consider this a change in condition. In a phone interview E16 (Facility Physician), on 5/23/06 at 1:50 p.m., when asked if R6's leg wounds caused by the support hose could have been avoided had the hose been properly applied, E16 replied, "Presumably so, yes". When asked if he would expect increased monitoring and assessment by nursing when R6	W9999		

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W9999	Continued From page 111 's support hose were discontinued (while wounds heal), E16 replied, "I would expect each shift to monitor for edema and if changes let me know." When asked if he would expect nursing to assess and monitor R6's leg edema in a consistent assessment manner, he replied, "Yes". that he would, "expect a consistent form of monitoring in order to actually assess if changes were occurring." 4. In review of R6's (see diagnoses in example # 4) current physician's orders it states that R6 is to be repositioned every two hours. Her Nursing Care Plan documents that R6 is incontinent of bowel and bladder and further documents a potential for skin breakdown due to immobility. On 5/11/06, R6 was observed at the facility in her team room. At 12:20 p.m. R6 was observed in her bed, the front part of her body facing the entry door to her room. R6 appeared to be sleeping. R6 was observed in the same position at each observation made after the initial observation (1:15 p.m., 2:20 p.m., 3:20 p.m., 3:30 p.m., 4:00 p.m. and 4:25 p.m.). R6 was not repositioned as per physician's orders. In review of R6's 3/6/06 Skin And Contracture Assessment Tool, R6 is at High Risk for skin breakdown (score more than 13 indicates High Rish - R6's score =15). Nurse's notes of 2/10/06 document protective skin covering to R6's buttocks. 2/11/06 notes document that the protective skin covering is intact, with no bleeding of drainage. Later notes on this same date document that the protective covering fell off of the "open area". Notes of 2/13	W9999		

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W9999	Continued From page 112 /06 document that the area is healed. Nurse's notes of 4/2/06 document that R6's buttocks are reddened, but skin is intact. Treatment was initiated and area is noted to be healed on 4/8/06. 5. In review of a resident roster that validates level of functioning, R11 functions in the profound range of mental retardation. R11's 10/13/2005 IPP (Individual Program Plan), current physician's orders, "Behavior Summary" within her IPP, Behavior Support Consultation of 4/12/06, Maximum Growth Potential Plan and her speech language evaluation, it documents that R 11 has further medical diagnoses of Hydrocephalus with Shunt, Chronic Constipation and Degenerative Scoliosis. R11 exhibits Pica behavior by placing inedible objects into her mouth and this behavior occurs one to five times a day. R11 has a long history of placing items in her mouth and would rather place her clothing or a towel into her mouth rather than suitable items available. R11 is incontinent of bowel and bladder, is diapered every two hours or as needed, requires staff assistance with activities of daily living (eating all meals, bathing, brushing teeth and hair and dressing), is non-ambulatory, requires a wheelchair for mobility and requires every two hour repositioning. R11 is non-verbal and per her current speech/language report, continues to exhibit, "severe PICA behaviors... and will ingest items when left unattended - shirts socks, sheets, shoe strings, etc." Per observations made at the facility on 5/10/06, at 3:30 p.m., R11 was observed to rely totally on staff for transfers and for incontinence care.	W9999		

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W9999	Continued From page 113 In review of nurse's notes for R11, notes of 3/21/06 at 12:00 p.m. document that R11 was noted to have a large emesis after eating lunch. R11 was also noted to be crying and in discomfort. Her abdomen was hard with hyperactive bowel sounds. An enema was given and a pain reliever for discomfort. Nurse's notes of 3/21/06 at 1:30 p.m. document that R11 was noted to have extra large results with shredded towel observed in the bowel contents. In review of the 3/21/06 nurse's notes for 3/21/06, there is no reproducible documentation for any vitals assessment for R3. R3's treatment sheets do not document vitals for this day either. Nurse's notes of 3/22/06 at 7:30 a.m. document that another enema was given with large results and some strings. Temperature was 99.3 with abdomen soft and bowel sounds present. 3/22/06 nurse's notes for 12:00 p.m. document no further emesis - lungs clear - abdomen soft. 3/23/06 nurse's notes for 0500 a.m. document no further emesis noted this shift. In review of nurse's notes from 3/23/06 through 5/10/06, there is no reproducible documentation that R11's bowels were assessed. In review of R 11's "Treatment Records" from 3/1/06 through 5/24/06, R11's bowel movements are documented, but there is no reproducible documentation that they are further monitored for possible ingestion of nonedible substances.	W9999		

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W9999	Continued From page 114	W9999		

In a phone interview with E16 (Facility Physician), on 5/23/06 at 1:50 p.m., when asked if E16 would expect nursing to provide bowel assessments of a regular basis, and increase bowel movement monitoring after R11's towel ingestion Pica incident, E16 replied, "Yes, I would".

In review of R11's "NURSING CARE PLAN", the last review date is 04/06. Review of this plan does not provide for increased nursing assessment of R11's bowel's or increased monitoring of R11's bowel contents.

6. Per review of R11's (see diagnoses in example #6 above) 04/01/06-04/30/06 " TREATMENT RECORD" it documents that on 4/ 10/06, R11 had a "lg" (large) bowel movement on the 6-2 shift. The next documented bowel movement for R11 is on 04/14/06 on the 10-6 shift, documented again as "lg."

In review of R11's 4/1/06-4/30/06 physician's orders, they state that R11 is to receive Bisacodyl 10 mg. suppository, insert l suppository rectally as needed for Constipation. There is also an order for Fleet Enema, use rectally every 3rd day prn, repeat once if poor results - for bowel management. In review of nurse's notes, there is no reproducible documentation that R11's bowels were assessed from 4/10/06-4/14/06. In review of R11's 4/06 MAR, there is no reproducible documentation that R11 received Bisacodyl or a Fleets Enema between the 4/10/06 6-2 shift and the 4/14/06 10-6 shift.

In an interview with E1 (DON), at the facility on 5/ 11/06 at 3:50 p.m., E1 stated that giving as

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W9999	Continued From page 115 needed (prn) bowel control medications would depend on the individual resident, that it could be different for each. In an interview with E1 (DON), at the facility on 5/11/06 at 4:15 p.m., E1 stated that R11 should have received a Fleets Enema after 3 days without a bowel movement. E1 further confirmed that the facility does not have a policy regarding bowel movements/when to administer bowel control medications. In an interview with E1 (DON) at the facility on 5/12/06 at 11:45 a.m., E1 stated (regarding R11's lack of bowel movement in three days), that she would not expect an assessment of R11's bowels after three days. E4 (Director of Operations), also present at this interview, stated that the facility does not need a policy for bowel movements, but that she sees that the physician's orders could be clarified for R11. Additional example for R11, who per nurse's notes of 4/29/06 document an abrasion to R11 left thigh, approximately 1.5 centimeters, reddish in color; and another abrasion on the right side of her abdomen, approximately l centimeter. Treatment orders were noted in this nurse's note also. From 4/29/06 through 5/3/06, treatment on the thigh and abdomen is documented. The 5/3/06 note documents that the dressing is intact and states that nursing will continue to monitor every shift. In review of nurse's notes after 5/3/06 and through 5/10/06 there is no reproducible documentation for assessment , monitoring and follow-up to R11's abrasions. In review of the facility's abuse/neglect policy, it	W9999		

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W9999	Continued From page 116 states the following: "(Facility) will not condone resident abuse or neglect by anyone, including staff members...It is the policy of this facility that all incidents or suspected incidents of resident abuse or neglect...be reported immediately to the Administrator/designee. The Administrator/ designee shall report in a timely manner to the appropriate agency...." Within this policy, neglect is defined as, "...any failure by the facility or an employee to carry out required and appropriate clinical services, habilitation, or treatment as ordered by a physician or other authorized personnel that is the proximate cause of psychological harm or physical injury to an individual. It also includes any act or omission by the facility or an employee that endangers an individuals health of safety or fails to respond to an obvious and immediate need of an individual, regardless of whether or not there is an injury." In review of a nursing policy entitled, "Change in Resident Condition", it states, "A full set of vital signs is to be dome and documented any time there is a change in a resident's condition". A full set of vital signs (per this policy) includes temperature, pulse, respirations and blood pressure. The full set of vitals must be documented in the medical chart. In review of a Nursing policy entitled "Nursing Care Program", it states: "(Facility)" provides a planned medical program, encompassing nursing treatments, rehabilitation and habilitation nursing, skilled observations, and ongoing evaluation and coordination of each resident's individual habilitation plan...Each child shall have a written	W9999		

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W9999	Continued From page 117 habilitation care plan....This care plan will be reviewed every three months." (A)	W9999		