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W 331	Continued From page 23 During interview with E3 on 4/13/06 at 12:30 P.M. , E3 stated that the usual ambulance service for adults of the facility was busy on the morning of 3 /27/06 and the facility was referred to another ambulance service. Per continuing interview with E3 on 4/18/06 at 1:40 P.M., E3 said that she first became aware that R1 had been taken to the wrong hospital when R1's father called E3. E3 stated that R1's father was upset that the facility had told him that his daughter had been taken to one hospital but was actually transported to a different one. E3 also stated that she was the only facility staff in R1's room when the ambulance crew were readying R1 for transport and she feels certain that she told them to take R1 to the hospital listed on the transfer forms. Per interview with E2 on 4/18/06 at 4:00 P.M., E2 stated that she had personally conducted the investigation into the death of R1 and had also written the report. E2 explained that it is Quality Assurance's protocol for unusual occurrences and confirmed that R1's death met this criteria.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.620a) 390.700a)1)2) 390.700b)c) 390.1020a)1) 390.1020b)1)3) 390.1040a) 390.1040i)1)2)5)6)8) 390.1040j)	W9999		

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390.1040k)1)2)3)
390.3240a)

Section 390.620 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 390.700 Serious Incidents and Accidents
a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.
1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number.
2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence.
b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved.

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c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents.

Section 390.1020 Medical Services
a) General Medical Services
1) The facility shall have a written program of medical services approved in writing by the medical advisory committee that reflects the philosophy of care provided, the policies relating to this, and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility.
b) Medical Emergencies
1) The medical advisory committee shall develop policies and procedures to be followed during medical emergencies including, but not limited to, foreign body aspiration, poisoning, acute trauma (fractures, burns, and lacerations), cardiac arrest, acute coronary, acute cardiac failure, asthmatic or allergic reactions, acute convulsion, shock, diabetic coma, insulin shock, and acute respiratory distress.
3) At least one staff person shall be on duty at all times who has been properly trained to handle medical emergencies.
(Source: Amended at 29 Ill. Reg. 12988, effective August 2, 2005)

Section 390.1040 Nursing Services
a) The facility shall have a written program of Nursing Services, providing for a planned medical program, encompassing nursing

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treatments, rehabilitation and habilitation nursing, skilled observations, and ongoing evaluation and coordination of the resident's individual habilitation plan.

i) The responsibilities of the director of nursing shall include, at a minimum, the following:

1) Assigning and directing the activities of nursing and auxiliary service personnel.

2) Planning an up-to-date resident care plan for each resident in cooperation with the interdisciplinary team based on individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Services such as nursing, developmental, activities, dietary, and such other modalities as are ordered by the physician, shall be reflected in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed every three months.

5) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing and auxiliary personnel.

6) Coordinating health services and nursing services with other resident care services such as medical, pharmaceutical, dietary activities, and any other restorative and habilitative services offered.

8) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 390.610

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j) Nursing care (including personal, habilitative and rehabilitative care measures) shall be practiced on a 24 hour, seven day a week basis in the care of residents. Those procedures requiring medical approval shall be ordered by the attending physician.

k) Nursing care shall include at a minimum the following:
1) All medications including oral, rectal, hypodermic, and intra-muscular shall be properly administered.
2) All treatment such as: enemas, irrigations, catherizations, applications of dressing or bandages, supervision of special diets, restorative and habilitative measures in Section 390.1620(a)(11) and other treatments involving a like level of skill, shall be properly administered.
3) All 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, nursing or psychosocial evaluation and treatment shall be provided.

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 are not met as evidenced by the following:

Based on interview and file review, nursing services failed to:

(1) thoroughly assess and monitor R1's changing health condition including vital signs when R1

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started running a temperature, had diarrhea, emesis, nosebleeds and shallow/rapid respiration;

(2) follow physician's orders;

(3) follow the facility's policy/procedures for oxygen administration, change of resident's condition, notifications of emergency transfers to the hospital for R1;

(4) develop a nursing care plan related to diagnosis of Hepatitis C with related nosebleeds, and

(5) thoroughly investigate why R1 was taken to the wrong hospital emergency room for evaluation on 3/27/06.

Findings include:

(1) Failure to Assess and Monitor Changing Health Condition

According to physician's orders, dated 3/1/06 - 3/31/06, R1 was a 28 year old female with diagnoses of Severe/Profound Mental Retardation, Hepatitis C - Remission, Seizures, Nose Bleeds, Osteoporosis, and History of Left Foot Fracture.

Per notification report dated 3/27/06 from E2, RN/Director of Nursing (DON), to the Illinois Department of Public Health, R1 was taken to the emergency room on 3/27/06 at 6:40 A.M. and expired at the hospital later that morning at 10:50 A.M.

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W9999	Continued From page 29 Per review of nurse's notes in R1's chart, the following documentation from 3/25/06 to 3/27/05 was noted: "3/25/06 - 7A Res. on bed crying @ this time. Flushed face and warm to touch. T-100.8, PRN Tylenol 1000mg given as ordered........No resp distress noted. Lung sound clear bilaterally. Clear nasal d/c noted. 9A - T-99 11A - R - 97.6 2P - 100.6, PRN Tylenol given as ordered. Cry @ times. 4P - T - 98.8 6P - T - 97.8 8P - T - 99.0 9:30P - latest T - 98.2, asleep on bed....No apparent problem noted. Resp easy and lung sound clear bilaterally. 3/26/06 - (Shift change - no time noted) Temp was 100.3. Tylenol administered....Tempt was 99 .6, 99.8 in the morning 0600am and pt had nose bleeding in am as well. 6A - Res. on bed. Asleep @ this time. T - 99...... No apparent discomfort noted. 8A - T - 99, nosebleeding noted. Bleeding controlled. No resp. distress noted. 10A - T - 98.9, resting comfortable 12N - T - 98, up on chair. Ate fairly 2P - T - 98.7 4P - T-99.3 6P - T - 98.9 8P - T - 99.1 9:30 P - T- 98.9. No further nose-bleeding noted. 11P - T - 98.9 Inct of 2 large loose stools but had	W9999		

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W9999	Continued From page 30 suppository & prune juice. No bleeding from nose - Appears to be sleeping curling up on (L) side trying to cover head (with) covers. 3/27/06 1:45 AM - T 101.2 - Tylenol given. Lung sounds clear - wakeful but no distress 3AM - T 100.2, had large green stool loose & med greenish emesis 4AM - T 99.1 Respiration shallow & rapid 26-28. Asking for "pop" & taking small sips (with no) emesis - Lung sounds remain clear 5:15AM - Checked by charge nurse - O2 order from standing orders - O2 given at 2 - 3 L/min per mask for O2 sat 85. Resident will not leave O2 on - when held on O2 sat up to 89-90. Resp remain rapid & shallow. 5:45AM - T -100.6 Tylenol ES 1000mg repeated & kept down - 1 small yellowish loose stool reported by direct care staff - Condition reported to day nurse & will continue to monitor. 3/27/06 - 5:45A - Received report from (night) nurse - Went into room - resp labored - nose & lips slightly cyanotic - T99.9 - R40 - O2 sat 80% - BP 90/64. O2 put on @ 4L via NC (nasal cannula) - O2 sat 88 - 90% - lungs clear - skin warm to touch - res restless & moaning. 6:05A - (Physician) called - New order received 6:06A - Father notified of above 6:15A - Executive Director notified 6:17A - DON notified 6:20A - Ambulance notified to transport (to hospital) for eval 6:25A - O2 sat 88% on 4L via nc - Resp continues to be labored - P - 180 - T100 - lips remain slightly blue	W9999		

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6:40A - Ambulance here to transport to (hospital)
6:20A - Report called to (hospital)
10:50A - Received call from (hospital) - Res had expired"

Per interview with E3 (LPN/Licensed Practical Nurse) on 4/6/06 at 12:45 P.M., E3 stated documentation of non-routine treatments, vital signs, O2 sats, etc. are recorded in the nurses' notes and are not kept on separate logs. E3 said that everything done for R1 during the night of 3/26/06 and the morning of 3/27/06 was documented in R1's chart in the nurses' notes. E 3 confirmed that all of her notations from 5:45 AM on to 10:50A were documented in chronological order with the exception of telephone report to the hospital at 6:20 A.M.

Telephone interview with Z3 from the ambulance service on 4/17/06 at 1:00 P.M. confirmed that the paramedics arrived at the facility at 6:34 A.M. on 3/27/06 and found R1 in distress. According to the service run report from the ambulance service, the call was received at 6:25 A.M. and the paramedics arrived at the facility at 6:34 A.M. The report states that R1 was "found in bed alert to verbal, had no response and stared off. Staff stated (R1) normally can communicate short sentences, found (R1) in this condition, unknown time of onset. (R1) had patent airway, very shallow and rapid respiration.... SPO2 initially 82 %. Placed (R1) on oxygen and SPO2 rose to 97 %.......assessed vitals and checked BS (blood sugar) 56. (R1) given 25G Dextrose" per I.V.P. After Dextrose, (R1) would yell and pull at NRB, still had fast, shallow respirations."

During telephone interview with Z1, Emergency

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Room Physician, on 4/10/06 at 4:20 P.M., Z1 said that R1 died due to "pneumonia which caused overwhelming sepsis." Z1 explained that R1 died of organ failure related to pneumonia. Z1 said that when R1 came into the emergency room, she was in respiratory distress, had diffuse pneumonia, her heart rate was very rapid (at 160 + beats per minute) and "was in an almost un-survivable situation." Z1 stated that he started R 1 on broad spectrum antibiotics immediately. Z1 confirmed that R1 died at 10:59 A.M. on 3/27/06.

According to the hospital's Admission/Discharge Summary of R1's condition when assessed at the hospital on 3/27/06, R1 "was found in facility to have decreased level of consciousness in addition to respiratory distress. On further evaluation in the emergency room, she was found to have possible superimposed pneumonia with severe agranulocytosis (an acute condition in which the white blood cells drop to extremely low levels and neutrophils are high) in addition to acute renal failure and being in shock......While in the emergency room, patient's respiratory condition became worse and she passed away."

Per review of R1's death certificate, R1 expired on 3/27/06 at 10:59 A.M. due to "Respiratory Arrest due to, or as a consequence of Septic Shock due to, or as a consequence of Agranulocytosis."

During interview with E2 on 4/18/06 at 4:00 P.M., E2 stated that she had personally conducted an investigation into the death of R1 and had also personally written the report. E2 explained that it is Quality Assurance's protocol for unusual occurrences and confirmed that R1's death met

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this criteria.

Review of the facility's investigative report dated 3/29/06 confirms that no assessment or vital signs (except temperatures) were documented from the time R1 began running a temperature on 3/25/06 at 7:00 A.M. until 5:45 A.M. on 3/27/06. The report indicates that at this time, R1's respirations were "labored, nose and lips slightly cyanotic. Temp 99.9, pulse 178, blood pressure 90/64, respirations 40 and O2 sat 80%. Skin warm to touch, res. restless and moaning. Oxygen increased to 4 liters of O2, sats now 88-90%". Physician and father were notified at 6:05 A.M. and ambulance "called to transport to the emergency room for evaluation at 6:20am. Her O 2 sats at this time were 88% on 4liters. Respirations remain labored. Pulse 180, temperature 100 and lips remain slightly blue."

According to the investigative report, E4 (RN) was R1's nurse and also the charge nurse for the weekend. The report states that E4 did not think R1 was that sick, that she had not done a complete head to toe assessment and that she had not done complete vitals for R1.

Per surveyor interview with E4 on 4/20/06 at 8:45 A.M., E4 confirmed that she was R1's nurse and also the charge nurse on the weekend shift on 3/25 and 3/26/06 from 6:00 A.M. to 10:00 P.M. both days. E4 stated that she had not seen a cause for concern with R1, "nothing that raised a flag," noting only that R1 had been running a temperature that weekend. E4 said that she concentrated on R1's temperature and felt it was controlled with Tylenol.

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The facility's report states that E5 (CNA) had told E2 that R1 was "sick all weekend. She noticed that she (R1) was very, very weak and could not participate in her care like she did at other times. She also stated that (R1) cried at times and always felt hot when she touched her." Per report, E5 said she had reported these things to R1's nurse (E4).

Per interview with E5 on 4/20/06 at 10:00 A.M., E 5 confirmed that she had worked the weekend of 3/2506 and 3/26/06 and was the CNA for R1. E5 explained that when she "got there, her supervisor and her noticed (R1) was hot, running a high temperature." E5 said she reported this to the nurse (E4) who instructed E5 to give R1 a bath to help get her temperature down. E5 stated that R1 seemed fine the rest of day and also on 3 /26 as well. E5 said that R1 had diarrhea right before her shift ended on 4/26 but that was all. During this interview, E5 emphatically told the surveyor that R1 was not acting sick, was only warm that one time on Saturday morning, but was o.k. after her bath. E5 stated that she "knows how to recognize when someone is ill and would have told the charge nurse right away."

The facility's investigative report also states that E11 (charge CNA) was also interviewed and E11 had said that "she could tell (R1) was not feeling well because of her cry. She stated that it was different from other times. It sounded like she was in pain." E11 confirmed that she had informed the nurse (E4).

The investigative report states that E10 (CNA) was interviewed and had told E2 that R1 "would not eat but would drink. She also stated that she

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had reported this to the charge nurse" and that R 1 "is always a good eater."

Per interview with E10 on 4/24/06 at 11:20 A.M., E10 told surveyor that she worked on 3/26/06 from 6:00 A.M. until 10:00 P.M. E10 confirmed that she was the one who assisted R1 with her meals on 3/26/06 and that R1 didn't eat well at breakfast, didn't eat any of her lunch or dinner, only drinking a little of her milk. E10 also confirmed that R1 usually has a good appetite and this was unusual for R1 not to eat her meals. E10 stated that she had informed the nurse of R1 's poor appetite.

According to the facility's investigative report, E8 (RN/night shift) was also interviewed and had said that she didn't realize that R1 was that sick. Per report, E8 said that "she thought she (R1) had the same bug that some of the other residents had. At 3:00 A.M. when (R1) started vomiting and her temperature was still elevated, she told the charge nurse (E7/LPN). She said she did not call the doctor or the family because the charge nurse didn't tell her to." E2 also wrote in the report that E8 had stated that she might have done a complete assessment but hadn't charted it. E8 said that the charge nurse came into R1's room and took her temperature, then came back into R1's room at 5:15 A.M. Per report, E7 instructed E8 to start R1 on oxygen because R1's "respirations were still shallow and rapid." E8 said that she thinks she took R1's pulse and it was 90-120 but that she forgot to chart it.

E2's investigative report confirmed that R1 "does not have a history of any respiratory distress," but

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at 5:15 A.M. she now has "rapid shallow respirations and placed on oxygen. She is an adult with a pulse rate of 90-120. She has been having vomiting, diarrhea and a temperature as high as 101.2." E2 questioned E8 "why wouldn't you call the doctor and the father? She told me that she kept asking the charge nurse shouldn't we do something and she didn't say anything."

Per surveyor interview with E8 on 4/24/06 at 2:10 P.M., E8 stated that in her professional judgement R1 was not that sick. E8 stated that the flu had been going around and a lot of residents and staff had been ill. E8 said that R1 did have diarrhea but she had been given laxatives, an enema and prune juice per physician's orders. E8 stated that when the O2 mask was put on R1, she wouldn't leave it on. E8 confirmed that R1's O2 sat remained at 90 as long as she and the charge nurse (E7) held the mask on R1.

E8 told surveyor that she had 32 residents to take care of that night and had to leave R1's room but checked back frequently and R1 seemed stable. E8 also said that when the day nurse (E3) came on duty around 5:45 A.M., she and E8 checked on R1 and that E3 also tried giving oxygen per mask but R1 would not leave it on. Per E8, E3 said that she would call R1's doctor.

According to the facility's investigative report, E2 also interviewed E7 who was the charge nurse for the night shift of 3/26/06. Per report, E7 confirmed that she did not know that R1 had been sick all weekend but thought that R1 was in pain when she saw her at 5:15 A.M. E7 said that

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W9999	Continued From page 37 she thought as R1's nurse, E8 would have done full assessments and notified the physician if needed. Per report, E7 stated that they put R1 on oxygen because her "nose was cyanotic." Per confidential interview, R1's O2 levels remained at 90% when the oxygen mask was held on R1. This interview confirmed that the nurses did not stay in R1's room, however, because they had other tasks to complete. (2) Physician's Orders Not Followed According to the physician's standing orders, "if resident exhibits respiratory distress of any kind, check O2 sat's immediately. If SaO2 sat's are below 91% at room air start O2 @ 2L. Regulate to maintain O2 sat's greater or equal to 91% unless otherwise ordered by physician." However, per nurse's notes of 3/27/06 at 5:15 A. M., R1's O2 saturation level was at 85% and oxygen was given per mask at 2 - 3 liters per minute, with respirations rapid and shallow, but R 1's physician was not contacted. Nursing entry at 5:45 A.M. indicates that R1's temperature was 100.6 degrees, Tylenol was administered and R1 had small yellowish loose stool. At change of shift, the oncoming nurse (E3) documented at 5:45 A.M. that R1's respiration was labored, her nose & lips slightly cyanotic, her temperature was 99.9 degrees, respirations at 40 , pulse was 178 and her O2 saturation rate was at 80%. However, according to the nursing documentation, R1's physician was not contacted	W9999		

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until 6:05 A.M. During interview with E3 on 4/13/06 at 12:30 P.M., E3 stated that she personally called R1's physician at 6:05 A.M. and received new orders to transport R1 to the hospital. E3 explained that if R1 "would've gotten bad we would've called (R1's physician) sooner. I didn't think she was really, really bad."

Per discussion during the daily status meeting and exit conference meeting on 4/26/06 at approximately 11:50 A.M., E2 stated that if R1 had been that bad they would have called 911.

Additionally, per facility policy #6 (not dated), entitled Physician Notification, the physician is to be notified immediately when a resident is in respiratory distress defined as having an oxygen saturation rate below 90 and oxygen having been started.

During interview with E3 on 4/13/06 at 12:30 P.M., E3 stated that the physician's standing orders are routine orders that apply to all residents in the facility and would, therefore, be applicable for R1.

(3) Nursing Policies Not Followed

A) Oxygen Administration Policy

Per review of facility policy #27, Oxygen Administration, updated 3/4/00, "Oxygen may be administered to assist a resident in relieving or overcoming symptoms of respiratory distress." The policy states that if emergency oxygen administration becomes necessary, staff are to follow the PRN oxygen administration procedures which included obtaining a pulse oximetry reading (SaO2), set oxygen flow meter gauge to

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2 liters per minute, and obtain O2 sats after 5 minutes. If below 90%, "increase oxygen to 3 liters/minute".....and if O2 "remains below 90%, notify physician for further orders."

However, per review of the nursing notes for R1 on 3/27/06, the night nurse documented the following:

4AM - T 99.1 Respiration shallow & rapid 26-28. Asking for "pop" & taking small sips (with no) emesis - Lung sounds remain clear
5:15AM - Checked by charge nurse - O2 order from standing orders - O2 given at 2 - 3 L/min per mask for O2 sat 85. Resident will not leave O2 on - when held on O2 sat up to 89-90. Resp remain rapid & shallow.
5:45AM - T -100.6 Tylenol ES 1000mg repeated & kept down - 1 small yellowish loose stool reported by direct care staff - Condition reported to day nurse & will continue to monitor.

Telephone interview with E8 (RN) on 4/24/06 at 2 :10 P.M. confirmed that R1 had diarrhea during the night which E8 attributed to the laxatives previously administered per physician order. E8 also stated that she and the charge nurse had administered oxygen via facial mask but R1 would not leave the mask on. E8 said that when they were able to get the oxygen level back up to 90 by holding the mask on, she and the charge nurse left R1's room. E8 confirmed that R1 did not have the oxygen mask on at the time the nurses left the room but they felt she was stable.

Additionally, per nurse's notes, E3 charted the following:

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3/27/06 - 5:45A - Received report from (night) nurse - Went into room - resp labored - nose & lips slightly cynontic - T99.9 - R40 - O2 sat 80% - BP 90/64. O2 put on @ 4L via NC (nasal cannula) - O2 sat 88 - 90% - lungs clear - skin warm to touch - res restless & moaning.

6:05A - (Physician) called - New order received
6:06A - Father notified of above
6:15A - Executive Director notified
6:17A - DON notified
6:20A - Ambulance notified to transport (to hospital) for eval
6:25A - O2 sat 88% on 4L via nc - Resp continues to be labored - P - 180 - T100 - lips remain slightly blue
6:40A - Ambulance here to transport to (hospital)

However, no documentation was noted to indicate that pulse oximeter readings were taken after 5 minutes per facility policy. Nurse's notes document that R1 received the initial flow of oxygen (2 - 3 liters per minute) at 5:15 A.M., and resident would not leave the O2 on. The next nursing entry documents an O2 reading of 80% at 5:45 A.M. and that "O2 put on @ 4L via" nasal cannula.

The Oxygen Administration policy continues with further instructions after going through the above PRN orders, to set oxygen flow meter gauge at 4 liters/minute, obtain initial pulse oximetry reading and to maintain continuous readings and to notify physician.

Per interview with E3 on 4/6/06 at 12:45 P.M., E3 stated that as per her nursing notes, E3 did not call the physician until 6:05 A.M. on 3/27/06. At

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W9999	Continued From page 41 this time, per E3, the physician directed her to send R1 to the hospital. The Oxygen Administration policy also instructs facility staff to transport to hospital if resident " needs oxygen at 3 liters/minute (or more) for more than 15 minutes." However, per nursing documentation and interview with E3, the ambulance was not called to transport R1 to the hospital until 6:20 A.M. During telephone interview with Z2 (RN from physician's office) on 4/12/06 at 2:30 P.M., Z2 stated that Z5 (R1's physician) told her to relay to surveyor that the facility's nurses "probably should have called him sooner," when R1's O2 sats dropped during the early morning hours of 3/27/06. B) Change in Resident Condition Policy According to the undated facility policy, titled Change in Resident Condition, "A full set of vital signs is to be done and documented any time there is a change in a resident's condition. A full set of vitals must include temperature, pulse, respirations, and blood pressure. The full set of vital signs must be documented in the medical chart." Per review of R1's chart, nursing notes of 3/25/06 indicate that R1 had a temperature of 100.8 and was crying at 7:00 A.M. Documentation also indicates that R1 had a temperature of 100.6 at 2:00 P.M. and was noted to cry at times. Tylenol was given at both times. On 3/26/06 (no time recorded) R1's temperature was recorded at 100.1 degrees, that Tylenol was given and that R1's	W9999		

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nose had been bleeding as well. Nurse's notes indicate that R1's nose was bleeding again at 8:00 A.M. on 3/26/06.

Nursing entries on 3/27/06 beginning at 1:45 A.M. note that R1 was running a temperature of 101.2 degrees and that Tylenol was given. At 3:00 A.M., R1's temperature was 100.2 degrees and she "had large green stool loose & med greenish emesis." At 4:00 A.M., R1 had a temperature of 99.1 with shallow & rapid (26-28) respirations. At 5:15 A.M., R1's O2 sat was recorded at 85% and oxygen was administered and respirations " remain rapid & shallow." At 5:45 A.M., the night nurse documented that R1's temperature was 100.6 degrees and that R1's "condition reported to day nurse & will continue to monitor."

There is no evidence in nurse's notes for R1 that full vitals were taken from the time R1 started running a temperature of 100.8 on 3/25/06 at 7:00 A.M. until 5:45 A.M. on 3/27/06 when R1's vital signs were documented by the oncoming day nurse (E3) as R1 having a temperature of 99 degrees, pulse at 178 beats per minute, respirations at 40 breaths per minute, B/P of 90/64 and an O2 saturation of 80%.

Per interview with E3 on 4/13/06 at 12:30 P.M., E3 stated that she felt R1 was stable from the time she first assessed R1 at 5:45 A.M. up to the time of the arrival of the ambulance crew at 6:40 A.M. According to E3's nursing entries, at 6:25 A.M. R1's "O2 sat 88% on 4L via nc - Resp continues to be labored - P- 180 - T-100 by temporal - lips remain slightly blue." During this interview, E3 confirmed that no further lung sounds had been taken since 5:45 A.M.

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Per telephone interview with E10, CNA (Certified Nursing Assistant) on 4/24/06 at 11:20 A.M., E10 confirmed that she had worked from 6:00 A.M. to 10:00 P.M. on Sunday, 3/26/06. E10 stated that she fed R1 both lunch and dinner on 3/26. E10 said that R1 didn't eat her lunch or dinner and only drank a little of her milk. E10 stated that R1 usually has a good appetite and this was unusual for her not to eat her meals. E10 said that she informed the nurse after each meal that R1 had not eaten.

Per telephone interview with E4 (RN) on 4/20/06 at 8:45 A.M., E4 said that she was the charge nurse for the weekend of 3/25 and 3/26/06, working from 6:00 A.M. to 10:00 P.M. both days. E4 stated that there wasn't anything unusual about R1 during these 2 days other than R1 had run a temperature, but nothing that would "raise a flag" and that E4 concentrated on keeping R1's temperature controlled.

Interviews with both E2 and E3 on 4/18/06 at 1:40 P.M. confirmed that R1 had had no prior incidents or history of respiratory problems and that this was definitely an unusual occurrence for R1.

However, per review of R1's History and Physical dated 12/1/05, R1 was admitted to the facility on 11/28/05 with a diagnosis of History of Pneumonia.

C) Emergency Transfer Notifications Policy

According to the facility's undated Emergency Transfer Notifications policy, "in situations

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involving an emergency transfer to the hospital, the licensed nurse shall notify the physician, the ambulance company, the family, the Director of Nursing, and the Administrator. For an emergency transfer, it is critical that there be no delay in notification of the physician or ambulance."

However, review of the nurse's notes for R1 on 3/27/06 shows that the physician was called first at 6:05 A.M. , then the father at 6:06 A.M. the Administrator/Executive Director at 6:15 A.M., the Director of Nurses at 6:17 A.M. and the ambulance was called last at 6:20 A.M.

Per interview with E3 on 4/6/06 at 12:45 P.M., E3 said that everything done for R1 during the night of 3/26/06 and the morning of 3/27/06 was documented in R1's chart in the nurses' notes. E 3 confirmed that all of her notations from 5:45 AM on to 10:50A were documented in chronological order with the exception of telephone report to the hospital at 6:20 A.M. that R1 was originally supposed to go to.

(4) Failure to Develop Nursing Care Plan

According to current physician's orders, R1 was admitted on 11/28/05 to the facility with diagnoses of Mental Retardation, Hepatitis C - Remission, Chronic Gingivitis, Seizures, Nose Bleeds, Osteoporosis, and History of Left Foot Fracture.

Per review of the nurse's notes for R1, R1 had 2 nosebleeds on 3/26/06 which were documented at 6:00 A.M. and 8:00 A.M. The notes do not contain documentation as to what treatment, if

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any, was given to R1 to control the nosebleeds.

Review of the facility's nursing care plan for R1 confirmed that R1 did not have a specific plan to address her diagnosis of Hepatitis C and/or Nose Bleeds.

Per interview with E3 on 4/18/06 at 1:40 P.M., R1 's nosebleeds were related to Hepatitis C. E3 confirmed that the facility had not implemented a nursing care plan for either the Hepatitis C or nosebleeds.

(5) Failure to Conduct Thorough Investigation

According to nurse's notes dated 3/27/06 and R1 's transfer sheet, R1 was taken to be taken to a local hospital's emergency room for evaluation per physician's orders. E3's nurse's notes state that a report concerning R1 was called to this particular hospital. However, per review of the ambulance service run report, R1 was actually taken to another area hospital.

Telephone interview with Z4 on 4/5/06 at 2:15 P. M. confirmed that he had been notified that R1 was being taken to one of the area hospitals and when he got to the emergency room, he was told his daughter hadn't arrived yet. Z4 explained that he waited at this hospital for awhile, then realized he had forgotten to take his cell phone with him, so he drove home to get it. When he arrived home, Z4 said he had a telephone message from the facility that R1 had been taken to a different hospital. Z4 stated that he arrived at the receiving hospital at 9:00 A.M. where he found his daughter in pain and non responsive. Z4 said that his daughter died at 10:59 A.M.

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Per interview with Z1, emergency room physician, on 4/10/06 at 4:20 P.M., Z1 said that hospital personnel had gotten very little medical information about R1 when she came to the emergency room. Z1 confirmed that the ambulance service brought R1 to this particular hospital, but R1 was actually supposed to go to another area hospital.

Interview with Z3 from the ambulance service on 4/17/06 at 1:00 P.M. confirmed that Z3 had spoken with the paramedics who responded to the emergency call for R1 on 3/27/06 and they stated that they were verbally directed to take R1 to the receiving hospital.

According to the facility's investigative report dated 3/29/06, R1 was "transferred to the emergency room" at 6:40 A.M. and the facility " received a report from the hospital at 10:50am stating that (R1) had expired." However, the report does not indicate which hospital R1 was taken to or that she was actually taken to the wrong hospital.

During interview with E3 on 4/13/06 at 12:30 P.M. , E3 stated that the usual ambulance service for adults of the facility was busy on the morning of 3 /27/06 and the facility was referred to another ambulance service. Per continuing interview with E3 on 4/18/06 at 1:40 P.M., E3 said that she first became aware that R1 had been taken to the wrong hospital when R1's father called E3. E3 stated that R1's father was upset that the facility had told him that his daughter had been taken to one hospital but was actually transported to a different one.

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W9999	Continued From page 47 E3 also stated that she was the only facility staff in R1's room when the ambulance crew were readying R1 for transport and she feels certain that she told them to take R1 to the hospital listed on the transfer forms. Per interview with E2 on 4/18/06 at 4:00 P.M., E2 stated that she had personally conducted the investigation into the death of R1 and had also written the report. E2 explained that it is Quality Assurance's protocol for unusual occurrences and confirmed that R1's death met this criteria. (A)	W9999		