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	14E845	A. BUILDING _____ B. WING _____	C 06/20/2006

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F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.610a) 300.690a)2) 300.1210a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 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. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence.	F9999		

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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.

These REGULATIONS were not met as evidenced by:

Based on record review and staff interviews, the facility failed to assure that staff follow facility procedures for monitoring residents whereabouts on the night shift for 3 of 12 sampled residents (R 1, R2, & R3). When R1 was not seen in his bed at twelve midnight, staff did not follow facility policy to try and locate R1's whereabouts. Six hours later R1 was found in a bathtub without vital signs. The facility also failed to complete and send to the Department a narrative summary of the incident regarding R1.

Findings Include:

Incident report dated 05/23/06 states that at 6:10 a.m., R1 was found by his roommate (R4) in the tub. Staff checked R1, and code blue was called. Cardio-pulmonary resuscitation (CPR) attempted; vital signs were non-palpable.

Nurses note dated 05/23/06 at 6:10a.m. states

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code blue was called by 5th floor nurses aide (CNA). All staff responded. R1 was found in his room bathtub (508) in a supine position, water in tub was dripping, and no water was noted in tub. R1 did not respond to verbal or physical stimuli. Vital signs were checked and none noted. CPR initiated, and 911 was called. At 6:20a.m. fire department and paramedics arrived. R1 was assessed, and CPR was discontinued. Physician was notified. At 8:20a.m. R1 was transferred to the morgue.

R1 was admitted to facility on 04/18/06. Diagnosis was schizoaffective disorder, bipolar with psychosis. Assessment showed R1 to be alert and oriented and was independent in all activities of daily living. For the time R1 was at facility, he was medication-compliant and his condition was stable. R1 had no history of drug or alcohol abuse. During interview E21, Case Manager, stated R1 mostly kept to himself in his room, occupied his time with reading, and did not socialize much with other residents.

On 06/13/06 at 11:45a.m. E1 (Administrator until 06/14/06) and E2 (Director of Nurses) were interviewed. E2 stated it is facility policy for staff to make rounds every two hours and to actually see a resident. E2 stated R1 was last seen at 11 p.m. by CNA going off duty. At 12a.m. rounds R1 was not in bed. CNA (E12) on duty on the 5th floor reported this to the charge nurse (E11). E 11 apparently paged R1 with no response. E2 stated if a resident is not found in his room at night, staff should look in day rooms. E2 was asked by surveyor if staff should look in bathrooms, and E2 stated staff should check bathrooms. E2 was asked if R1's bathroom was

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checked when R1 was not found in bed. E2 stated the bathroom was not checked.

Facility policy for Routine Room checks states it is the policy of this facility to make routine resident checks to assure that the resident's safety and well-being are maintained. Procedures include a resident check will be made every two hours by nursing personnel. Routine resident check involves entering the resident's room to determine if the resident's needs are being met, if there has been any change in condition, and if resident has any complaints. Changes are to be reported to charge nurse at once.

Facility policy for Missing Residents states if a resident cannot be located in the facility, an overhead page is made. Alert all charge nurses and case-managers to look for the resident. Check the sign out book to determine if resident signed out. Interview roommates and staff to determine if anyone has knowledge of the resident's whereabouts. Notify Administrator and PRSD (Psychosocial Rehab Services Director). If missing for 24 hours notify police. Notify physician and family and document the resident's status.

E12, CNA, was on duty on the 5th floor on the night of the incident involving R1. During interview on 06/15/06 at 6:45a.m., E12 stated that evening and night staff are to check resident whereabouts every two hours and document on the 24 hour census sheet. E12 came on duty at 11p.m. At 12a.m. E12 checked R1's room and he was not in bed. E12 stated she had R1 paged and told the nurse. There was no response to

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page. E12 was asked if any other search was done, if she talked to any staff, or called front desk to check if R1 signed out, and E12 stated " no." E12 documented at 2a.m., 4a.m., and 6a.m. that R1 was not in his bed and stated to surveyor she did not search facility for resident. Surveyor asked E12 if she ever looked in R1's bathroom or shower room on 5th floor and E12 stated "no." In the morning E12 stated she was told by R4 (R 1's roommate) that R1 was in the tub. E12 stated she went to R1's bathroom and found R1 in the tub, and he appeared blue and stiff. Code Blue was called and all staff responded. 911 was also called.

E14, CNA, was on duty at first floor main desk on the night of the incident involving R1. During interview on 06/15/06 at 6:55a.m., E14 stated no staff ever called the front desk looking for R1 while she was on duty. E14 stated she also never heard an overhead page for R1 during the night. The only page she heard was the call for the Code Blue at approximately 6:10a.m. E14 stated she did receive instructions to call for 911 the morning of 05/23/06. E14 was asked what is expected of staff while making rounds at night. E 14 stated residents are to be checked every two hours; if not in bed, then bathrooms are to be checked.

E13, CNA, was on duty on the fourth floor on 05/ 22/06 the night of the incident involving R1 and on the following night of 05/23/06. During interview on 06/15/06 at 7:10a.m. E13 stated if a resident is not in his/her bed at time of room check, day rooms are checked; and if resident is not seen then, they are marked 'O' as out of building. E13 stated staff are not to page anyone

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F9999	Continued From page 15 overhead at night. Fourth floor resident census check sheet for night of 5/22/06 shows that at 10:00p.m. nothing was documented as to R3 whereabouts. For rest of night R3 is marked as 'O' and his whereabouts are not listed. Fourth floor resident census check sheet for night of 5/23/06 shows that at 10:00p.m. R2 was noted to be in bed. For rest of night R3 is marked as 'O' and his whereabouts are not listed. E13 stated she did not page to find the resident and stated she did no search of building to find R2 or R3. During interview E13 stated that the morning of 05/23/06 R4 (R1's roommate) came to her and stated R1 had been in the bathroom all night and he needed to use bathroom to get ready for the day program. E13 and E12 then went to R1's bathroom and saw R1 in the tub. E13 stated R1 appeared dead. E13 stated R1's mouth and tip of nose was blue, there was a little water in the tub, and water from faucet was running. E17, CNA, was on duty on the third floor on 05/22/06 the night of the incident involving R1. During interview on 06/15/06 at 7:30a.m. E17 stated if a resident is not seen during rounds, then the bathroom should be checked. E17 stated she does not remember hearing any overhead page that anyone was looking for R1 the night of 05/22/06. E17 also stated no knowledge of anyone searching for R1 and doesn't recall if anyone came to third floor to look for R1. E17 did recall that Code Blue was called the morning of 05/23/06, and all staff responded	F9999		

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F9999	Continued From page 16 to the call. E11, Licensed Practical Nurse, was the nurse on duty 05/22/06 the night of the incident involving R 1. E11 stated she was told by a CNA after 12a.m . that R1 was not in his room. E11 told CNA to call other floors to see if anyone saw R1. E11 stated CNA should have checked R1's bathroom and to see if R1 had signed out at the front desk. E11 stated she was never told again that R1 was not seen by staff. E11 stated she did respond to the Code Blue called the morning of 05/22/06 by E12. E11 stated that she saw R1 in the bathtub and assessed R1. R1 had no vital signs and appeared stiff and blue. Resuscitation was attempted. After 911 arrived resuscitation attempts were discontinued. On 06/13/06 R4, R1's roommate, was interviewed. During interview R4 stated that R1 went to take a bath on 05/22/06 somewhere between 9:30p.m. and 10:30p.m. R4 stated he got up sometime during night to use bathroom and R1 was still in tub. R4 said he did not look around bathtub curtain, used bathroom, and went back to bed. About 6:10a.m. he said he found R 1 in tub and went to tell nurse. On 06/14/06 at 9:00a.m. surveyor interviewed Z1, Medical Records Supervisor for the Coroner's office, and Z1 stated listed cause of death for R1 is arteriosclerotic cardiovascular disease. On 06/14/06 at 1:57p.m. surveyor interviewed Z1, Coroner, who stated R1's cause of death is listed as arteriosclerotic cardiovascular disease. Z1 was asked if R1 had a heart attack. Z1 stated that it was possible; however, he could not say	F9999		

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for sure because no autopsy was conducted. Z1 also stated he could not estimate time of death.

On 06/14/06 at 2:45p.m. call lights in room 508 were tested in the presence of E5 and E19 (CNA's). Neither light was functioning at bed 1 or bed 2. Signal above door did not light, and there was no response from nursing staff. Bathroom call system was also tested. At first observation, the call light did have a long cord which was tied to a rail next to the toilet. Button was in the down position indicating call had been activated. Surveyor switched the call button in the up position and signal above outside door lit up and nursing staff responded by over head page for staff to respond to 508 bathroom call light. This bathroom call system was reversed and could not be activated by anyone pulling the call cord. If someone needed assistance in the bathroom, they would have to be able to stand up and push button in the up position to activate call.

A report dated 05/24/06 was sent to the Department which stated R1 was noted unresponsive in bath tub. No water noted in tub. Emergency procedures initiated. 911 called. Paramedics arrived and discontinued CPR (cardio-pulmonary resuscitation). Per Coroner, cause of death natural due to heart attack.

On 06/13/06 at 11:45a.m. surveyor requested investigation of above incident from E1, Administrator, and E2, Director of Nurses. At approximately 3:00p.m. surveyor again requested investigation of incident. At approximately 4:00p. m. E2 stated an investigation was conducted by E9, Corporate Staff, but only abuse investigations are kept on file. An investigation of this incident

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F9999	Continued From page 18 was never presented to surveyor. Incident investigation by surveyor revealed that R 1 was found as stated above. Further investigation revealed that R1 was last seen by staff at approximately 10p.m. on 05/22/06. Staff are to document resident whereabouts ever two hours on the nightshift and have procedures to follow if a resident in not seen. Documentation showed that R1 was not seen through the night shift of 05/22/06 (actually a.m. of 05/23/06). Interviews revealed that staff never looked in bathroom nor completed a search of building. During interview on 06/15/06 E10 (current Administrator) stated the incident of 05/23/06 regarding R1 was not considered a serious incident because Coroner's office listed death as natural causes due to heart attack. (A)	F9999		