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F 490	Continued From page 65 fell again sustaining a fractured orbit below one eye, a hip injury, a subdural hematoma and a sub arachnoid bleed. The resident suffered a permanent change in her cognitive status as a result of the fall. The facility failed to determine the safety risk of R1's adapted wheel chair, and did not implement safety measures to prevent falls for other residents who are at risk for falls. These failures resulted in an Immediate Jeopardy This applies to 3 residents who are at risk for falls . (R1, R9, R10) G. The facility failed to ensure that a resident with a Peripherally Inserted Intravenous Catheter (PICC), line for administering intravenous antibiotics was monitored, flushed and removed by professional nurses with knowledge in the care of a PICC line and performed within the nurses scope of practice. These failures resulted in an Immediate Jeopardy This is for 1 resident with a Peripherally Inserted Central Catheter (R16). H. The facility failed to ensure that a Registered Nurse was designated as Director of Nursing to oversee nursing staff and resident care services from April 13, 2006 - April 19, 2006. During this time the facility was found have residents who were in Immediate Jeopardy.	F 490		

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1030a)1) 300.1030a)2) 300.1210b)2) 300.1210b)3) 300.3240a) 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury or significant change in a resident's condition that threatens the health safety or welfare of the resident. 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur form time to time in long term care facilities. These medical emergencies include, but are limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure or arrest.) 2) Cardiac emergencies (for example, ischemic pain, cardiac failure or cardiac arrest). 300.1210 General Requirements for Nursing and Personal Care b) General nursing shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) All treatments and procedures shall be	F9999		

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administered as ordered by the physician.
2) Objective observations of changes in a resident's condition shall be made by the nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident.

These regulations are not met, as evidenced by the following:

I. Based on interview and record review the facility failed to assess a resident's (R2) change in condition beginning on 3/10/06 which progressed to a full Cardiopulmonary Arrest on 3/11/06. The staff on duty failed to initiate Cardiopulmonary Resuscitation (CPR) when a resident was found unresponsive, pulseless, and no respirations.

This is for 1 of 1 residents who experienced Cardiopulmonary Arrest (R2)

The part of the violation includes the following example:

1. R2's nurse's notes dated 1/10/06 documented, "complains of shortness of breath." No other entries on the nurse's notes were documented for R2 until 3/11/06. R2's nurse's notes dated 3/11/06 at 2:25 PM showed the " patient complained of shortness of breath, pulse oximetry 76% on room air, heart rate 111, respiratory rate 32...oxygen placed, R2 gagging stating he has complaints of shortness of breath,

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anxious. 2:35 PM, heart rate 112, pulse oximetry 88-90% on 2 liters (oxygen) (per) nasal canula, head of bed up...2:40 PM Certified Nursing Assistant (CNA) called nurse E6 (Licensed Practical Nurse - LPN) to the bedside. R1 conscious and able to understand commands. Oxygen up to 2.5 liters per nasal canula, pulse oximetry 68% and pulse 106. 2:45 PM R1's eyes rolled back, diaphoretic, no respirations visible, no lung sounds, unable to palpate pulse...nurse initiated 911, administered rescue breaths per mask, airway blocked, finger sweep with no visible confirmation of blockage...Emergency Medical Technician (EMT) assumed care of patient. R1 continued to have agonal respirations, heart rate 27 per EMT monitor. EMT performed defibrillation X 1, continued with chest compressions...EMT left building with R1."

The facility summary sheet, dated 2/17/06, documents that R2 is a Full Code.

During an interview on 4/19/06 a 1:30 PM, E9 (LPN) stated that she did not notify R2's physician on 3/10/06 when he became short of breath. E9 stated that she and E6 (LPN) went to R2's room. E9 said that R2 had stated, "I can't breathe" and complained of shortness of breath. E9 stated, " We put the head of R2's bed up and put oxygen on. E6 stayed with R1 and I went to call the doctor. I went back to the room and R2 was not breathing but had a pulse. I checked it radially. I gave 1 rescue breath and his chest did not rise. I moved R2's head and gave another. R2 was on his back with head slightly elevated and his skin was wet. R2 had a pulse when he left here."

On 4/19/06 at 2:10 PM, E6 (LPN) stated, "R2

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complained about trouble breathing. We put the head of his bed up. R2 had no airway but had a pulse. We had a pulse oximeter on him (to check R2's pulse and oxygen saturation). When we gave rescue breaths his chest didn't rise. We gave 2-4 rescue breaths, actually probably 4 rescue breaths. E9 called 911 when we realized R2 did not have an airway. The ambulance arrived in 5-10 minutes." E6 denied that any vital signs such as heart rate, respiratory rate, blood pressure, or pulse oximetry were documented during this time. E6 stated R2's blood pressure was not taken. E6 said the EMT's came and gave R2 chest compressions and then shocked him. E6 stated the facility staff did not initiate CPR on R2. During the interviews with E6 and E 9 the only person who attempted rescue breathing was E9. The nurse's notes on 3/11/06 at 2:45 PM document "no respirations...unable to palpate pulse."

During the interview on 4/19/06 at 2:10 PM, E6 said she had only been a Licensed Practical Nurse (LPN) since October 2005. This is her first nursing job. When asked about the facility orientation she said she had shadowed 2 different nurses for 3 days. She was never educated on the facility's policy on what to do in an emergency situation.

The narrative for the ambulance dated 3/11/06 for R2 documents "Ambulance 1 and Ambulance 2 responded to a trouble breathing call. Upon arrival R1 was under the care of Ambulance 1's crew. We contacted Ambulance 1 after arrival and they informed us we had a code. Ambulance 1's crew started Cardiac Chest Compressions...R 1 had an agonal rhythm...was cool to touch and

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F9999	Continued From page 70 pulseless. We shocked the patient at 360 joules with no changes in the patient's condition..." The Emergency Department record for R2 dated 3/11/06 document "The patient was a 64 year old who was seen on 3/11/06 at 3:05 PM. The patient was brought by ambulance from a local nursing home in cardiopulmonary arrest. The patient...was undergoing rehabilitation at the nursing home. R2 was found unresponsive...in an agonal rhythm and cool to the touch. Physical Examination: R2...without visible signs of life. R 2 had no spontaneous respiratory effort. R2 had no palpable pulse or audible heart tones. R2's pupils were fixed and dilated. Extremities were cool and flaccid. R1 remained asystolic and was pronounced dead at approximately 3:25 PM." The facility's policy and procedure on Code Blue states "Determine responsiveness; cessation of heart rate, respirations. If "Full Code" status, initiate EMS by dialing 911 and announce loudly on the facility intercom system "Code Blue to room 262." Nurse to take charge in calling instructions out to other staff; one to initiate CPR, one to get the crash cart, one to call the physician and emergency contact or family member and copy chart papers. Once crash cart is present, connect oxygen to the Ambu-bag for breaths and continue manual chest compressions until paramedics arrive. Attempt IV (intravenous) insertion for accesses. When documenting, include multiple time frames of findings; "No BP (Blood Pressure), No RR (respiratory rate), No HR (heart rate), etc. And response to findings: CPR initiated and 911 called." Document the condition of resident as paramedics leave."	F9999		

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R2's Physician Order Sheet dated 3/1/06 documents his diagnoses including Coronary Artery Disease, Hypertension, Sleep Apnea, and Hyperlipidemia.

R2's Care Plan dated 2/17/06 lists as a problem Ineffective Airway Clearance related to the diagnosis of Sleep Apnea. The approaches are to monitor oxygen saturation, respiratory rate, distended neck veins, air hunger, cyanosis, confusion and/or lethargy. R2s Care Plan for risk for Impaired Gas exchange dated 2/17/06 lists the approaches as "monitor for signs and symptoms of respiratory distress."

II. The facility failed to monitor blood glucose levels and administer sliding scale insulin as ordered, calibrate blood glucometers, ensure that the nurses knew how to use the blood glucometers, notify the physician when residents' glucose levels were above or below identified parameters, and have a plan for responding to hypoglycemic reactions.
This applies to 10 of 20 residents with Diabetes. (R6, R16, R17, R4, R18, R21, R19, R20, R22, R 23)

The examples include:

1. R17 has diagnoses of End Stage Kidney Disease, Hypertension, Coronary Artery Disease, and Diabetes Mellitus per Physician's Order Sheet for April 2006. R17's assessment dated 3/ 31/06 documents that R17 has no short or long term memory deficits.

On 4/18/06 at 2:00 p.m. R17 said that she woke

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this morning soaking wet with sweat and very shaky. "I told staff that I was having an insulin reaction and needed orange juice. Staff told me that they did not have any orange juice. I do not get snacks at night like I should before I go to bed. If the aides are out smoking it is hard to get help." During an interview on 4/25/06 at 3:30 p.m. R17 stated, "Yesterday (4/24/06) I did not get my morning insulin at 7:00 a.m. before breakfast like I am supposed to. I got my insulin just before lunch. My blood sugar was high in the 290's."

R17's Physician's Orders for April 2006 document that R17 is to receive Novolin 70/30 20 units subcutaneously every morning at 7:00 a.m. R17's Diabetes Flow Sheet for April 2006 shows that on 4/24/06 her blood glucose was 296.

On 4/25/06 the Glucometer QA Log Sheets for the first floor and the New Beginnings Unit were reviewed. Both QA Log Sheets were blank for the month of April. The 2 South Glucometer QA Log Sheet showed that the glucometer was tested for accuracy on a 24 hour basis through April 19th. The facility was unable to provide any evidence that the glucometer was calibrated to ensure accurate testing beyond 4/19/06.

On 4/25/06 at 2:30 p.m. E10 (Administrator) said that the glucometers are to be calibrated every 24 hours on the night shift. The results of the calibration test are to be documented on the Glucometer QA Log Sheet.

2. R4 has diagnoses to include Diabetes Mellitus, Hypoglycemia and Diabetic Hyperosmolar per review of R4's Physician Order Sheet(POS) dated April, 2006. The POS notes that 'when

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blood sugar is less than 60 or greater than 300 call the doctor.'

Review of R4's nurses' notes show:'4/7/06- At 1925 CNA called nurse into dining room because R4 was "acting funny". The (blood glucose) read 45. Two sugar pills were given dissolved in water, along with glass of juice. R4 kept eating small bites of food. (Blood glucose) went to 48. Kept eating checked at 6:45 p.m. read 38. Another sugar pill dissolved in water followed. 1855 (blood glucose) 35. R4 received a Glucagon 1 mg injection. 1910 blood glucose 48. R4 drank more juice. 1925 blood glucose 57....

There is no evidence that R4's physician was notified of this episode. This was verified on 4/27 /06 at 12 noon with E1(LPN).

Review of R4's Medication Administration Record (MAR) and the Diabetic Flow Sheet for April, 2006 shows R4 had three glucose monitoring checks ranging from lows of 49-57 and five glucose monitoring checks from 325-400 and there was no evidence the physician was notified of these highs and lows. On 4/27/06 this was verified by E1.

3. R19 has diagnoses of Insulin Dependent Diabetes Mellitus, Electrolyte Imbalance and Hypoglycemia per review of the April, 2006 POS. R19 has physician orders to receive insulin on a sliding scale and regular scheduled insulin.

Review of R4's MAR and Diabetic Flow Sheet shows that there is no evidence that R19 received the sliding scale insulin 11 times from 04/01/06 to 04/26/06. On 4/17/06 at 6 a.m. and 4

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p.m. and on 4/18/06 at 6 a.m. R19 should have received regularly scheduled insulin. There is no evidence the insulin was given. On 4/27/06 at 12 :15 p.m. R19's records were reviewed with E1. E 1 verified there was no evidence to show the insulins were given.

4. R21 has diagnoses to include Hypoglycemia and Diabetes Mellitus per review of the April, 2006 POS. The POS had orders for R21 receive sliding scale insulin and regularly scheduled insulin.

Review of R21's MAR and the Diabetic Flow Sheet shows there is no evidence that R21 received the sliding scale insulin on 15 occasions from 4/1/06-4/26/06. On 4/6/06 R21 received 8 units of Novolin 70/30 insulin and the order reads 6 units should have been given. On the same date R21 should have received 6 units of Novolin Regular insulin and there is no evidence that this was done. On 4/10/06 R21 should have received 6 units of sliding scale insulin and there is no evidence it was given.

On 4/27/06 at 12:25 p.m. E1 verified it cannot be determined if the insulin was given.

5. The following residents were identified by the facility as having Diabetes and receiving blood glucose monitoring. anti-glucose med and/or insulin. Review of the April, 2006 Diabetic Flow Sheet and the April, 2006 POS and MAR shows no evidence that :

R18 received her regularly scheduled insulin five times during the month of April, 2006..

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F9999	Continued From page 75 R16 received his sliding scale insulin once and that the blood glucose check was not done once. R20 received her regularly scheduled HS(at bedtime) once and no blood glucose monitoring done as ordered. R22 received her sliding scale insulin twice during the month of April, 2006. R16, R18, R20, 22 records were reviewed with E 1 and E1 verified there was no evidence that the insulin/blood glucose monitoring were done. 6. R23 was not to receive Glypizide if the blood glucose was below 100. On 4/24/06 R23's blood glucose was 97. It was documented that Glypizide was given. On 4/27/06 at 12:30 p.m. E 1 verified this. III. The facility failed to provide treatment as ordered for one resident with Chronic Venous Stasis Ulcers (R6) and obtain a treatment order for one resident with new surgical sites to the foot . This is for 2 of 30 residents in the sample (R 6 and R16). The examples include: 1. R6's April, 2006 Physician's Order Sheet documents that R6's diagnoses include Insulin Dependent Diabetes Mellitus. The same document shows a treatment order for Bacitracin Zinc ointment, and Telfa dressing to open areas on legs, cover with ace wraps, change daily. The order does not include a cleansing order for the open areas.	F9999		

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F9999	Continued From page 76 R6's assessment dated 3/24/06 assessed R6 as having 8 stage two pressure ulcers, and stasis ulcers. R6's Pressure Ulcer Risk dated 2/9/06 assessed R6 to have a score of 7. (High risk for skin break down is 10 or below.) R6's Care Plan for Open areas to Both Lower legs and feet dated through 6/24/06 does not identify R6's risk factors for skin breakdown other than the diagnoses of Bullous Pemphigoid. There is no documentation that R6 is refusing to wear ace wraps to his lower extremities on R6's skin condition plan of care. The care plan for R6 entitled Pain documents that R6 has frequent statis ulcers. There is no documentation concerning R6's lower extremity edema, or refusal to wear ace wraps. R6's Treatment Administration Record for April, 2006 documents on April 17, 2006 that R6 has Left Lower Extremity Edema to the foot and ankle . R6 was observed sitting in a wheel chair across from the second floor dining room on 4/18/06 at 12:00 AM. R6 had gauze wraps to both lower ankles/feet. E8 Licensed Practical Nurse(LPN) was interviewed at 12:05 AM on 4/18/06. E8 was asked about R6's ace wraps not being on. E8 said that R6 refused his treatment today. R6 was observed in his room on 4/18/06 at 1:15 PM. R6 had both feet wrapped tightly in gauze. R 6's ankles were swollen and the gauze wrap was wrinkled and tight from the ankle swelling. R6 said that he has not had any ace wraps to his	F9999		

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F9999	Continued From page 77 feet. R6 stood up to open the window and his gray jogging pants fell to below his knees. R6 had on no undergarments and said "Oh these damn pants" and quickly struggled to pull the pants back up. R6 was asked if ace wraps are applied to his lower extremities, R6 responded "what you see is what they do." 2. R16's April, 2006 Physician's Order Sheet documents the R16's diagnoses includes Diabetes Mellitus, and Cellulitis. The hospital report entitled History and Physical dated 3/29/06 documents that R16 had an Osteomyelitis of the Right foot with first and second toe amputations. R16's assessment dated 4/3/06 assessed R16 as having surgical wounds and skin desensitized to pain or pressure. Nursing Notes dated 3/31/06 at 3:30 PM document that R16 was admitted to the facility with a Peripheral Inserted Central Catheter (PICC) for antibiotic therapy to treat an infection of the Right foot. R16 had missing large and second toe to the Right foot due to surgical amputation with approximately 11 stitches. Review of R16's care plan for Antibiotic Therapy, dated 3/31/06 documents that R16 receives antibiotic therapy for Osteomyelitis of the Right Foot. The approaches include dressing changes as ordered, and monitor for signs and symptoms of infections to foot. Podiatry Consult Note for R16 dated 4/5/06	F9999		

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F9999	Continued From page 78 documents that R16's Right foot incision had no dressing covering it upon arrival to the office from the facility. The Treatment Administration Record for April, 2006 documents that the dressing to R16's foot began on 4/5/06. (A) ---------- 300.1210b)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 our, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable A resident having pressure sores shall receive treatment and services to promote healing, prevent infection and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on interview, record review, and observation the facility failed to have a system in	F9999		

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place to assure residents at risk for developing pressure sores do not worsen or develop new pressure sores. Residents were found on the first 3 days of the survey with new areas of breakdown. Ordered treatments were not in place nor were treatments obtained for residents with newly discovered open areas.

This is applies to 5 of 5 residents with new pressure areas. (R3, R8, R4, R5, R7)

The examples include:

1. On 4/18/06 at 12:40 PM R3 was observed in bed, laying on his back. E11 (Certified Nursing Assistant - CNA) turned the resident on his left side. A Pressure Ulcer was observed to R3's Coccyx. The dressing was not covering the wound, it was curled up and located on R3's upper middle back area. The resident was laying in a wet bed with a strong smell of urine.

R3's Treatment Documentation Sheet dated 4/1/06 lists the treatment to be a Tegasorb dressing to the coccyx to be changed every 3rd day and as needed.

R3's assessment dated 1/5/06 documents the resident as not having any Decubitus Ulcers. The MDS dated 4/12/06 documents R3 as having a Stage 2 Decubitus Ulcer.

R3's Care Plan dated 4/12/06 documents the resident to be "at risk for pressure sores related to frequent incontinent of bowel and bladder." The approaches are to do "quarterly skin assessment; toilet resident upon rising, before and after meals, at bedtime, and as needed

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during the night; provide peri care after each incontinent episode, adult briefs during waking hours, skin check weekly with shower notify nurse of any reddened areas; reposition every 2 hours and as needed; apply Baza cream for skin protection...treatment as ordered and indicated."

On 4/20/06 at 7:05 AM R3 was observed laying in bed, saturated with urine. E1 (LPN) turned the resident to his left side. There was no dressing to the Decubitus Ulcer on the coccyx. Open areas were also observed to the scrotum. There was no documentation that the staff were aware of R3's open areas on the scrotum, and there was no treatment order for these new open areas .

On 4/20/06 at 3:35 PM R3 was observed laying on his back with the head of the bed elevated. The resident was slid down in bed with both of his feet against the foot board. E13 (Director of Nursing - DON) turned the resident on his right side. The resident was saturated with urine. He had a transparent dressing on his coccyx and there was no treatment to R3's scrotum. R3's socks were removed by E13 (DON). The residents feet were dry, cracked, and flaking a large amount of dry skin.

2. On 2/18/06 at 4:30 PM R4 was observed laying in bed in room 218. The room smelled of a strong urine odor. E1(LPN/Nursing Supervisor) removed R4's covers and turned her onto the left side. The resident was laying in a wet bed. The under sheet had a large wet ring up to R4's upper back. The pad directly under R 4's buttocks had a large dark yellow ring which according to E1 was "damp". Observed to R4's

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F9999	Continued From page 81 left buttock was a dime sized open area that had no treatment on it. E1 said she was not aware that R4 had any open areas. On 2/18/06 at 3:25 PM E13 (Director of Nursing) removed R4's covers and turned her onto the left side. A dollop (thick lump like application of cream, not spread out over the wound bed) of a white substance was observed on the wound. There was no dressing covering the wound to protect it from being contaminated with urine or stool. R4 is identified by the facility to be at risk for skin break down. The 4/1/06 through 4/30/06 Treatment Flow Sheet shows the resident to have an order for Dermagran to the right Buttock twice daily until healed. The order was changed on 4/20/06 to Allevyn 2 X 2 dressing , that is to be changed daily. The assessment dated 3/2/06 shows R4 to be on a scheduled toileting plan. The MDS under skin condition lists 0's signifying there are no staged skin ulcers. 3. On 4/20/06 at 7:30 AM E1 (LPN - Nursing Supervisor) conducted a skin check on R7's lower extremities. The resident stated it itched very much. E1 rolled R7 onto her left side. The bed was very wet with urine. Noted to R7's posterior upper left leg was a large, denuded (loss of top layer of skin) area with no treatment observed to the area. The assessment dated 2/24/06 documents R7 to be frequently incontinent of urine and on a scheduled toileting plan. The skin condition	F9999		

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F9999	Continued From page 82 section has 0's signifying there were no staged Pressure Ulcers. 4. On 4/20/06 at 7:20 AM R8 was observed laying in bed. E1(LPN - Nursing Supervisor) removed the covers and did a skin check. R8's bed was extremely wet and smelled of urine. E1 turned R8 onto her left side. An open area was observed on her coccyx approximately a 1/2 Centimeter in size. R8 has been noted by the facility to be at risk for skin break down. E1 was not aware of the wound. The skin risk assessment for R8 places her at a high risk for skin break down. There were no Care Plan or treatment orders for this problem. 5. R5's April, 2006 Physician's Order Sheet documents that R5's diagnoses include Diabetes Mellitus. R5's assessment dated 2/6/06 assessed R5 as having a stasis ulcer, and a resolved pressure sore. R5's latest Pressure Ulcer Scale dated 2/6/06 assessed R5 as a score of 14. (A score of 11- 15 is moderate risk) The April, 2006 Physician's Order Sheet documents an order to "Check Right third toe on Mon., Wed., and Friday for signs of changes, and infection. The order is crossed through with a line, and an undated entry next to the order to discontinue. The April, 2006 Treatment Administration Record for R5 documents ongoing initials for checking R 5's right foot. There is no documentation regarding the observations of R5's foot other than initials. Weekly documentation on R5's Treatment Administration Record documents that on 4/17/06 R5's Right 5th toe remains discolored, no fluid	F9999		

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F9999	Continued From page 83 filled blister remains. R5 was observed on 4/18/06 at 1:10 PM. R5 was laying in his bed, R5's sock was removed by E11 Certified Nursing Assistant (CNA). R5's Right foot had two open areas on the second toe, one on the top surface, and one on the under surface, the fifth toe was also observed to have an open area. The record had no current treatment orders for these areas. (A) --- 300.1210b)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care All necessary precautions shall be taken to assure that the residents' environment remains as free from accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on observation, record review, and interview the facility failed to reassess and change approaches after a resident fell out of her	F9999		

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F9999	Continued From page 84 wheel chair on 4/5/06. Later that same day the resident fell again sustaining a fractured orbit below one eye, a hip injury, a subdural hematoma and a sub arachnoid bleed. The resident suffered a permanent change in her cognitive status as a result of the fall. The facility failed to determine the safety risk of R1's adapted wheel chair, and did not implement safety measures to prevent falls for other residents who are at risk for falls. This applies to 3 of 3 residents observed, who are at risk for falls. (R1, R9, R10) The examples include: 1. R1's Physician's Order Sheet for April, 2006 documents that R1 was admitted to the facility on 4/4/06 with diagnoses that include Peripheral Vascular Disease, and New Left Below Knee Amputation. R1's assessment of 4/14/06 assessed R1 as having a long term memory impairment, moderately impaired cognitive skills for daily decision making, easily distracted, periods of altered perception, periods of restlessness, mental function varies over the course of the day, not able to test for standing balance, and partial physical support required for sitting balance, range of motion limitations with partial loss of voluntary movement of leg/foot on one side, lifted manually for transfer, frequent incontinence of bowel and bladder, and a fall in the last 30 days. An undated Safety Assessment for R1 showed R 1 as having a score of 14. (A score of under 14 indicates a resident is no longer at risk for falls.)	F9999		

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F9999	Continued From page 85 R1's Nursing Notes dated 4/5/06 at 5:30 PM document that R1 was found on the floor in front of her wheel chair. R1 was placed back in her wheel chair. The entry for 7:50 PM on the same day documents that a loud noise was heard from R1's room. R1 was discovered laying on the floor face down. R1 was crying "help me". R1 had a laceration to her left eye brow and bruising of her left eye. The hospital Emergency Room Record dated 4/5/06 documents that R1 had a Traumatic Sub-Arachnoid Hemorrhage and Left Orbital Fracture. R1 received X-rays to rule out a Fractured Right Hip. The Emergency Department Treatment Record dated 4/5/06 documents R1's pain level as "pretty bad." The hospital Physician's Progress Note dated 4/8/06 documents that R1 had edema of the soft tissue related to pelvic trauma. The hospital record entitled Computerized Tomography (CT) of Brain Without Contrast (radiological diagnostic scan of R1's brain) report dated 4/5/06 shows that R1 had an apparent Blow Out Fracture of the Left Orbit. (shattering of the bones below the eye) The same report shows that R1 had Posttraumatic extraaxial hemorrhages. (bleeding within the brain) The hospital report entitled Neurosurgery Consultation dated 4/5/06 documents that R1 suffered a closed head injury with traumatic subarachnoid hemorrhage. R1's prognosis is documented as poor based on her medical problems, her age, and current condition.	F9999		

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The emergency room Physician (Z6) who treated R1 was interviewed on 4/18/06 at 1:15 PM. Z6 said that it was possible for R1 to have sustained a Blow Out Orbital Fracture from a fall but, not too many are related to just a fall, usually occurs from hitting something. Z6 said " A Blowout Fracture takes plenty of force."

The Ambulance Radio Report dated 4/5/06 documents that upon arrival to the facility R1 was found laying on the floor in room 250. R1 had a laceration to the Left eye, and bruising to the Right eye. Staff reported R1 had an unwitnessed fall from her wheelchair.

Nursing Notes dated 4/8/06 show that R1 was readmitted to the facility from the hospital. Nursing Notes for 4/9/06 and 4/10/06 do not show any documentation related to assessing R1 's neurological status after R1's significant head injury.

E8 Licensed Practical Nurse (LPN) was interviewed on 4/19/06 at 10:00 AM. E8 said that after R1 fell the first time on 4/5/06 she was placed back in her chair. E8 said shortly after R1 's daughter left the facility, she heard a commotion in R1's room, and R1 was laying face down with her wheelchair in an upright position. " We noticed she was bleeding and had a black eye."

On 4/20/06 at 3:50 PM, R1's wheelchair was observed next to R1's bed. The wheelchair had an elevated left foot rest with a piece of plywood and a bath blanket duct taped to the distal portion of the board near the foot rest. A piece of

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F9999	Continued From page 87 foam was partially covering he plywood near the seat cushion. The wood extended from the foot rest to the underneath the gel seat cushion. There was nothing anchoring the wood under the gel cushion to prevent the wheel chair from tipping forward if R1 were to shift her body weight forward. R1 could be forcefully propelled forward from the unanchored end of the board. E11 (CNA) was interviewed at 4:00 PM on 4/20/06. E11 said that R1 has had this same wheelchair since admission. Review of Addendum A-4 Positioning and Moving Resident presented as facility Fall Prevention Program shows under Environmental Risk Factors, wheelchairs will have a safety check. R1's Care Plan for Fall Risk dated through 7/8/06 shows that R1 was observed on the floor on 4/5/06 twice. The Care Plan does not show which specific risk factors contributed to R1's fall occurrence. The Care Plan does not address the specific injuries R1 sustained with the second fall occurrence. (Closed Head Injury) Review of the Accident and Incident Logs for the past three months show: February, 2006 there were 40 occurrences of resident falls. March, 2006 shows there were 26 fall occurrences, and April, 2006 shows 17 fall occurrences as of April 18, 2006. E1 Licensed Practical Nurse (LPN) was interviewed on 4/19/06 at 3:10 PM. E1 said that they were trying to determine what specific care givers were responsible for falls. I have gotten rid of a lot of my second shift Certified Nursing	F9999		

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Assistants (CNA) because they were not monitoring their residents. What happened to R1 was just an isolated occurrence.

E1 Licensed Practical Nurse (LPN)/Nursing Supervisor, was interviewed on 4/19/06 at 2:35 PM. E1 said that after R1's first fall on 4/5/06 R1 was placed back in her wheelchair, "I can't see any documentation of interventions that were put in place at that time After R1's second fall the nurses should have done neurological checks every 15 minutes after the fall." E1 was unable to show that R1's neurological signs had been assessed every fifteen minutes after falling a second time on 4/5/06 and striking her head.

The facility document entitled Assessing Falls and Their Causes under section 1) After a Fall item a) if a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. The same document under item 2.) Defining Details of Falls: under item a) shows: After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred.

A confidential interview was conducted on 4/18/06 at 2:00 PM. Z1 said "half the time there is no nurse to be found, the nursing assistants are seen outside smoking, we can't find help."

2. On 2/18/06 at 4:30 PM R9 was found by surveyors on the floor of her room. There were 5 staff members at the nurse's station talking very loudly. The surveyor had difficulty getting the

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F9999	Continued From page 89 staff's attention to come and assist the resident. E 15 (Licensed Practical Nurse) was made aware that R9 was on the floor. Upon entering the resident's room she said this was her 3rd day of work and she does not know the residents. R9 has had a total of 13 falls in the past 3 months. R9's Care Plan dated 2/9/06 documents the resident is at risk for falls. One of the approaches listed is to check on the resident frequently. The resident is also to have an alarm on. There was no alarm attached to the resident at the time of the fall. Review of facility document entitled Falls and Fall Risk Managing under item number 4 shows: If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant 3. On 4/19/06 at 12:00 PM R 10 was observed in the bathroom trying to transfer herself from the wheel chair to the toilet. The resident has been noted by the facility to be at risk for falls. R10's assessment dated 3/28/06 under Physical Functioning and Structural Problems documents the resident requires extensive assistance to transfer from one surface to another. (A) ---------- 300.1210a)	F9999		

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F9999	Continued From page 90 Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-bring of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care ans personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. This regulation is not met, as evidenced by the following: Based on interview and record review the facility failed to ensure that a resident with a Peripherally Inserted Intravenous Catheter (PICC), line for administering intravenous antibiotics was monitored, flushed and removed by professional nurses with knowledge in the care of a PICC line and performed within the nurses scope of practice. This is for 1 of 1 residents with a Peripherally Inserted Central Catheter (R16). The examples include: 1. R16's April, 2006 Physician's Order Sheet documents the R16's diagnoses include Diabetes Mellitus, and Cellulitis. The hospital report entitled History and Physical dated 3/29/06 documents that R16 had Osteomyelitis of the Right foot with first and second toe amputations.	F9999		

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F9999	Continued From page 91 Nursing Notes dated 3/31/06 at 3:30 PM document that R16 was admitted to the facility with a Peripheral Inserted Central Catheter (PICC) for antibiotic therapy to treat an infection of the Right foot. R16 had missing large and second toe to the Right foot due to surgical amputation with approximately 11 stitches. R16's April , 2006 Physician's Order Sheet documents an order for: Cleocin Phosphate 150 milligrams per Milliliter vial 600 milligrams Intravenous two times a day for two weeks. The order began on 3/31/06. The same document shows an order dated 3/31/06 for: PICC line dressing to be changed every 5 days and as needed, flush with normal saline before and after medications in the PICC line, Heparin flush to PICC line after use. Review of the facility PICC policy related to PICC Catheter Removal documents under Policy: the nurse should know the length of the catheter prior to removal, the PICC line should be removed after the completion of therapy, if resistance is met during removal attempt, the catheter should be redressed and the infusion nurse should be notified. Catheters with suspected or documented thrombus formation will not be removed in the long term care setting. Under item VI. it shows that documentation should include the procedure, length of catheter removed, whether catheter was removed intact, intervention for any complication site assessment, patient response to procedure and or medication, and patient teaching. Review of PICC Flushing policy shows under Policy item 3) only 0.9% Sterile Saline for	F9999		

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F9999	Continued From page 92 Injection and/or Heparin, will be used for flushing a PICC catheter unless otherwise ordered. PICC Dressing Change Policy documents under item 6) Assessment of the catheter sites are performed at the following times: during dressing changes, every 2 hours during continuous therapy, before and after administration of intermittent intravenous medications or at least once every 8 hours between intermittent doses. The PICC Catheter Needleless Access Device Change Policy shows under item III, 1a, PICC Catheter needleless access devices are changed at the following times: at least every 7 days. Review of R16's Medication Administration Record of April, 2006 does not show documentation that R16's needleless access device had been changed per facility policy. The same document shows orders for: PICC flushes per order 5 cubic centimeters (ccs) of Normal Saline before and after usage/ the remainder of the order is crossed through with discontinue written, there is no date. The crossed out information on the order reads: Heparin chase after usage. Below this order is another order that reads: flush with 5 ccs Heparin after use, this order is dated 4/5/06. Both orders are signed out since 4/1/06. Review of manufacturers product information on R16's Catheter Maintenance documents to: Flush the catheter with heparinized saline every 12 hours or after each use. R16's Nursing Notes dated 4/11/06 at 8:00 AM	F9999		

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document that R16 was discharged to another facility. There is no documentation regarding status of R16's PICC line upon discharge. There is no documentation identifying the length of R16 's catheter. There is no specific documentation regarding checking/observing R16's catheter insertion site as specified in the facility policy.

E9 Licensed Practical Nurse (LPN) was interviewed on 4/20/06 at 6:30 pm. E9 said she was unsure if R16's PICC line had been discontinued prior to discharge. " I would have hoped they would have documented it. It has to be discontinued by an RN and an LPN did the discharge."

E1 (LPN)/ Nursing Supervisor was interviewed regarding the care and treatment of R16's PICC line on 4/19/06 at 2:35 PM. E1 was questioned regarding the flushing of R16's PICC line when the facility had no Registered Nurse in the building. E1 said that the LPNs who had special training were able to provide care for R16's PICC line." E8 LPN had advanced training so she is able to flush with Heparin because the Heparin is only going into the catheter tubing."

On 4/18/06 Z1 (Infusion Nurse) was interviewed per telephone. Z1 said that she provides training to Licensed Practical Nurses (LPN) on PICC line care. Z1 said that the nurses are trained to function under the supervision of a Registered Nurse (RN). "They are taught that they may not administer Heparin flush, that must be done by an RN."

Review of the facility nursing schedule for March, 2006 shows that the facility has only one RN on

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F9999	Continued From page 94 staff. A confidential interview was conducted on 4/18/ 06 at 10:45 AM. It was learned that LPN's have been told to care for PICC lines and did not feel that they were adequately trained or qualified under their scope of practice to do so. The Handbook of Geriatric Nursing Care; page 152, under complications of central venous catheters describes: Complications can occur at any time during the infusion therapy. Traumatic complications, such as pneumothorax, typically happen as the catheter is inserted but may not be noticed until after the procedure is completed. Systemic complications, such as sepsis, typically occur later during infusion therapy. Other possible complications include phlebitis and thrombus formation. According to journal article in Nursing Made Incredibly Easy, September/ October, 2005; article entitled, The line for central venous access starts here: the following areas should be monitored to avoid potential complications related to a central venous catheter: 1. Palpate catheter sites at least daily for warmth, tenderness, or drainage, which are signs of potential infection. 2. Compare the patients's left and right arms and chest sides, observing for jugular vein and chest wall vein distention, discoloration, or edema distal to the catheter insertion site: these may be signs and symptoms of of deep vein thrombosis. 3. After you've removed the dressing and before	F9999		

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F9999	Continued From page 95 you've started site care, look for any evidence that he catheter has shifted. The polyester cuffs surrounding tunneled catheters shouldn't be visible externally. 4. Check for dampness or bloody drainage on the dressing, which might indicate a break in the central venous catheter tubing. 5. You should feel minimal resistance when flushing a central venous catheter or obtaining blood samples from one. A change in the amount of pressure required to flush the central venous catheter, or difficulty in aspirating blood from it, may indicate a full or parital occlusion, usually related to fibrin or clot buildup around the catheter. 6. Monitor the patient during the infusion for any sign of spiking fevers or reports of rigors while administering intermittent medications and solutions. 7. Common signs and symptoms of infection may not develop in a patient with diabetes. Instead watch for a sudden elevation in blood glucose in patient whose previous blood glucose reading had been stable. The facility failing to ensure that a resident with a Peripherally Inserted Intravenous Catheter (PICC), line for administering intravenous antibiotics was monitored, flushed and removed by professional nurses with knowledge in the care of a PICC line and practice within their scope of duties. (A)	F9999		

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F9999	Continued From page 96 --- 300.510a) 300.510e) 300.1220a) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Re. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. e) The licensee and administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.1220 Supervision of Nursing Services Each facility shall have a director of nursing services (DON) who shall be a registered nurse. These regulations are not met, as evidenced by the following: Based on observation and interview the facility failed to be administered in a manner that ensured designated staff were in charge of the facility operations in the absence of an administrator to assure resident care needs were met, and facility operations were maintained. On 4/18/09 there was no designated Administrator or Director of Nursing to oversee care and services were provided to the residents.	F9999		

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Facility staff failed to:
Initiate Cardiopulmonary Resuscitation on a resident who was found unresponsive, pulseless and not breathing and to ensure that all nursing staff were trained in resident care emergencies;
Ensure that nursing staff were knowledgeable in current practice related to Diabetes management, to perform blood glucose monitoring, to administer sliding scale insulin as ordered, and to respond to Hypoglycemic reactions;
Ensure that staff were aware of current status of residents skin conditions, implemented prevention measures to avoid further skin breakdown, and provided needed treatment of pressure ulcers to aid in healing;
Evaluate the safety risks of a modified wheel chair to prevent a resident from falling and sustaining serious injury; and
Prevent a resident from being verbally and physically abused.

This failure has the potential to affect all 75 residents in the facility

The examples include:

1. On 4/18/06 at 10:15 AM it was learned that the Administrator was out of the state on a holiday. E 1 Licensed Practical Nurse (LPN) was interviewed and said that the Director of Nursing had left last Thursday, and that E10 Acting Administrator was in Florida this week on vacation. E1 LPN said that there was no Director of Nursing and that she (E1) had been in charge since last Friday.

On 4/18/06 at 12:00 noon E14 Administrator was

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interviewed on the telephone. E14 said it was a holiday for him, and that E10 made her vacation without clearing it with him.

2. The following are examples of resident care needs not being met:

A. The facility failed to assess a resident's (R2) change in condition beginning on 3/10/06 and failed to notify the physician of the resident's shortness of breath. This failure resulted in R2's condition deteriorating over the next 24 hours and progressing to a full Cardiopulmonary Arrest on 3/11/06. The staff on duty failed to initiate Cardiopulmonary Resuscitation (CPR) when R2 was found unresponsive, pulseless, and no respirations.

B. The facility failed to ensure R6 was free from being slapped by a visitor in the facility on 4/22/06. This failure resulted in R6 becoming agitated and being removed from an activity he was enjoying.

C. The facility failed to monitor blood glucose levels and administer sliding scale insulin as ordered, calibrate blood glucometers, ensure that the nurses knew how to use the blood glucometers, notify the physician when residents glucose levels were above or below identified parameters, and have a plan for responding to hypoglycemic reactions. This applies to 10 of 20 residents with Diabetes. (R6, R16, R17, R4, R18, R21, R19, R20, R22, R23)

D. The facility failed to provide treatment as ordered for one resident with Chronic Venous Stasis Ulcers,(R6) and obtain a treatment order

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F9999	Continued From page 99 for one resident with new surgical sites to the foot . This is for 2 residents (R6 and R16). E. The facility failed to assist residents with eating on 4/18/06 and 4/19/06. These included residents who cannot feed themselves, were on mechanically altered diets, and who had weight loss. This applies to 7 residents (R9, R1, R11, R 12, R13, R14, R15). F. The facility failed to have a system in place to assure residents at risk for developing pressure sores do not worsen or develop new pressure sores. Residents were found on the first 3 days of the survey with new areas of breakdown. Ordered treatments were not in place nor were treatments obtained for residents with newly discovered open areas. This is applies to 5 residents with new pressure areas. (R3, R8, R4, R5, R7) G. The facility failed to reassess and change approaches after a resident (R1) fell out of her wheel chair on 4/5/06. Later that same day the resident fell again sustaining a fractured orbit below one eye, a hip injury, a subdural hematoma and a sub arachnoid bleed. The resident suffered a permanent change in her cognitive status as a result of the fall. The facility failed to determine the safety risk of R1's adapted wheel chair, and did not implement safety measures to prevent falls for other residents who are at risk for falls. This applies to 3 residents who are at risk for falls. (R1, R9, R10) 3. The facility failed to ensure that a resident with a Peripherally Inserted Intravenous Catheter (PICC), line for administering intravenous	F9999		