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F 309	Continued From page 9 These policies and procedures will be reviewed and monitored by the Quality assurance program for any patterns or trends that require additional investigation. Date of total completion for all the above corrections is 3/3/06.	F 309		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1030a)2) 300.1210b)3) 300.3240a) Section 300.1030 Medical Emergencies a)2) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long term care facilities. These medical emergencies include, but are not limited to, such things as: Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). Section 300.1210 General Requirements for Nursing and Personal Care b)3) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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 evaluation and treatment shall be made by	F9999		

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nursing staff and recorded in the resident's medical record.

Section 300.3240a) Abuse and Neglect

300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

Based on interviews and record reviews, the facility failed to assess, monitor and evaluate the emergency medical needs for one resident (R1) on 2/9/06. R1 was noted on 2/9/06 at 7:45 A.M. with a grand mal seizure. On 2/9/06 at 8:20 A.M. (35 minutes after the seizure episode), R1 was found lifeless. R1 had previous history of myocardial infarction , CVA(cerebral vascular accident) and seizure disorder. R1 was a full code.

The facility failed to implement the following:
1) monitor drug (Dilantin) therapeutic level closely as per physician order to address recent seizure episode (1/2/06) that had required further treatment for R1 at the hospital.
2) provide further assessment (cardiac and neurological) after R1 was observed by facility staff with a grand mal seizure (2/9/06).
3) ensure that a licensed staff monitor R1 after the grand mal seizure activity (2/9/06).
4) evaluate emergency medical needs and initiate/perform CPR (cardiopulmonary resuscitation) after R1 was found lifeless precipitated by the grand mal seizure episode.

Findings include:

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F9999	Continued From page 11 R1 was a 75 year old female with diagnoses of seizure disorder, CAD (coronary artery disease), depression and hypertension. R1 was originally admitted to the facility on 12/24/05. Review of R1 's hospital record dated 12/16/05 showed that R1 was status post myocardial infarction. R1's history and physical dated 12/28/06 showed that R1 had history of myocardial infarction and CVA. Review of "Interdisciplinary Discharge Summary" dated 2/9/06 showed that R1's reason for admission to facility was for PT/OT (physical and occupational therapy). Social service notes dated 12/26/05 and 12/31/05 indicated that code status was discussed, and that R1 wished to be a full code. R1 was scored 24/30 (normal to very minimal impairment) for MMSE (Mini-Mental Status Examination). Clinical record also showed that R1 was very anxious, yelled a lot, and was incontinent of bowel and bladder. Review of current MDS (minimum data set) dated 1/6/06 showed that R1 scored 4/4 (total incontinence) for bowel and bladder functions. Record indicated that on 1/2/06 (approximately a week after R1 was admitted to the facility), R1 had an episod of grand mal seizure. Due to this seizure activity episode, R1 was sent to the hospital immediately for further seizure assessment. R1 was sent back to the facility on the same day (1/2/06). Z1 (attending physician) gave an order on 1/2/06 to monitor Dilantin drug level weekly, due on Mondays. Further review of record showed that this order to monitor drug level (Dilantin) and to check for therapeutic levels was not implemented. Dilantin level test was only done once (1/9/06). The following Mondays (1/ 16/06,1/23/06,1/30/06 and 2/6/06) Dilantin drug	F9999		

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level tests were not done. R1 had another episode of grand mal seizure which precipitated her death on 2/9/06. Because facility was not aware of the current Dilantin level due to failure to follow through on laboratory test, they were not alerted to possible subtherapeutic levels which could precipitate seizure activity.

When interviewed on 3/1/06, E3 (Assistant Director of Nursing) stated that it was only Monday of 1/9/06 that the Dilantin drug level was done. E3 also stated that the remaining Dilantin drug level tests were not done and were missed because the physician order for these tests was not transcribed properly.

The following was documented in R1's chart:
2/9/06, 7:45 A.M., "Called to room per CNA-patient noted to have seizure activity-observed by 2 nurses and CNA-lasting approximately 2 minutes. Post seizure patient was verbally responsive and responded to painful stimuli. Blood pressure 110/70, pulse 70, respiration 20 - skin moist to touch-color pale."
2/9/06, 8:00 A.M., "writer (licensed practical nurse-E4) left the room to call MD to notify patient condition secondary to seizure activity. CNA in room completing A.M. care for patient. MD paged and responded. Order received to have STAT Dilantin level laboratory."
2/9/06, 8:05 A.M.-8:10 A.M., "CNA (E7) in room making beds for other resident."
2/9/06, 8:20 A.M., -"this writer (E4) entered patient room and patient had expired-unable to obtain blood pressure, pulse, respiration, pupils dilated and non reactive, absence of sphincter control-confirmed by 2 nurses."
2/9/06, 8:25 A.M., paged to MD to informed

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and responded."
2/9/06, 8:35 A.M., "ADON (assistant director of nursing) notified patient's son per phone that patient expired."
2/9/06, 11:15 A.M., "Body removed per funeral home."

When interviewed on 2/15/06 at 3:00 P.M., E4 (licensed practical nurse) stated that she was called by E6 (certified nurse assistant) to check R 1 on 2/9/06 at 7:45 A.M. E4 also stated that she immediately checked R1 and saw R1 having seizure activity. E4 described the seizure activity as R1's "eyes were rolled back, with all extremities and whole body with all jerking involuntarily." E4 further stated that R1's seizure activity lasted for approximately 2 minutes. E4 added that she checked x1 for R1's blood pressure, pulse and respiratory rate immediately after the 2 minute grand mal seizure. As E4 added, R1 had responded verbally when her name was called, had "responded to painful stimuli however was a little weak and tired after the 2 minute seizure activity." There were no further assessments to include cardiac and neurological status (i.e.: whether apical/radial beats, whether these beats were irregular, oxygen saturation level, any pain, reflexes including grasp reflexes, pupils sizes and reactions whether sluggish or are there any eye twitches to determine if R1 was still seizing). E4 also added that she left R1 lying in bed in room at 8:00 A.M. (2/9/06). E4 stated that E7 (CNA) was in R1's room making beds for another resident. E4 also added that she had instructed E7 to leave R1 in bed because of weakness. Per E4, R1 was last seen alive by E7 (CNA-certified nurse assistant) on 2/9/06 at 8:10 A.M.

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F9999	Continued From page 14 E4 continued to state that she walked to R1's room together with E3 (assistant director of nursing) just to check on R1 on 2/9/06 at 8:20 A. M. R1 was without monitoring by a skilled/ licensed staff after the grand mal seizure for at least 20 minutes. The CNA (E7) left in room was not given specific instruction to monitor the R1 and indeed was performing bedmaking tasks. E4 added that at this time, she found R1 was unresponsive, was unable to obtain blood pressure, pulse, respiration, pupils were dilated and non-reactive, no sphincter muscle control. As E4 stated, both she and E3 confirmed that R1 had expired. Per E4, both she and E3 did not attempt to perform CPR (cardio-pulmonary resuscitation). As E4 continued to state, "no reason for it because she had no vital signs." E4 also continued to state that E3 told her that "it's probably useless for CPR at this point." As E4 added, both she and E3 left R1's room. E4 proceeded to call Z1 (attending physician) as E3 proceeded to call Z4 (family member). E4 stated that she informed Z1 that R1's death was " unusual, it happened so fast." It was further stated by E4 that Z1's response after the notification was "probably had stroke of myocardial infarction from the seizure." This further indicates that with R1's medical history that included past MI (myocardial infarction) and seizures activity, that ongoing professional monitoring was needed. When interviewed on 2/15/06 at 1:50 P.M., E3 (Assistant Director of Nursing) stated that she walked with E4 to check R1 on 2/9/06 at 8:20 A. M. E3 added that both she and E4 found R1	F9999		

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F9999	Continued From page 15 lying in bed lifeless. E3 stated that R1 had no blood pressure, pulse, respiration, no reflexes, skin pale, not warm to touch but starting to cool and was starting to mottle on feet. E3 denied that R1 had rigor mortis. E3 added she has not seen R1 prior to the seizure activity at 7:45 A.M, or after the seizure and that she only saw R1 when she walked with E4 to check R1 at 8:20 A. M. E3 stated that it was a matter of 10 minutes when R1 was seen alive (8:10 A.M.) by (E7). As E3 stated, CPR was not performed when R1 was first seen lifeless because of the facility's " presumed death policy." Review of the facility's "Presumed Death Policy" revealed the following: "CPR will not be performed after an unwitnessed cardiac arrest if ALL of the following conditions are present: A. Pupils fixed and dilated. B. Mottled discoloration of the body. C. Absence of reflexes. D. Bowel and bladder sphincter control gone. E. Absence of vital signs (pulse and blood pressure) with the presence of the other symptoms listed above." When interviewed on 2/16/06 at 11:00 A.M., E6 (certified nurse assistant) stated that when she was giving care to R1 at around 7:45 A.M., R1 was observed to have her eyes rolling back and that upper and lower extremities were noted with strong involuntary jerking movements. E6 added that she immediately ran and called E4 and E5. Per E6 both E4 and E5 came to R1's room and saw the seizure activity. E6 left R1's room with E 4 and E5. E6 returned when R1 had expired	F9999		

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F9999	Continued From page 16 provided post mortem care. When interviewed on 2/16/06 at 3:30 P.M., E5 (licensed practical nurse) stated she came with E4 to check R1 after seizure activity. E5 described the seizure as resident having eyes rolled back, with whole body/extremities noted with involuntary jerking movements. E5 also indicated that E4 had checked R1 for vital signs (blood pressure,pulse and respiration) after the seizure activity. E5 also added that R1 look tired when both E4 and E5 left. E5 said that E7 was in same room making beds. When interviewed on 2/16/06 at 9:40 A.M., E7(CNA) stated that he was in the room when R1 was having the seizure. E7 described R1's seizure with eyes rolled back jerking involuntary movements all over the body. Per E7, after E4 took vital signs, both E4 and E5 left R1 in the room and there was no other assessment done. E7 stated that he stayed in the room to finish making a bed for another resident in the same room. E7 added that before he left R1's room at 8:10 A.M.(2/9/06), E7 asked R1 "are you okay?" E7 said that R1 replied "Okay." The above interviews indicated that R1 was without monitoring from licensed staff for 20 minutes between the onset of the seizure and the cardiac arrest. This also further indicates that there was only a 10 minute interval between the time that R1 was seen alive and the time that she was found dead and staff decided not to do CPR. When interviewed on 2/16/06 at 11:20 A.M., Z1 (attending physician) stated that E4 informed him that R1 had expired. Z1 asked E4 if CPR was	F9999		

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F9999	Continued From page 17 performed, and he was informed that CPR was not performed because R1 had met the criteria for the facility's presumed death policy. Z1 continued to state, "I went along with that." Per Z1, "my estimation for cause of death was myocardial infarction." Review of death certificate indicated that R1's cause of death was myocardial infarction. (A)	F9999		