STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145909	A. BUILDING _____ B. WING _____	C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HILL HEALTHCARE	**SOUTH FOURTH STREET GREENVILLE, IL 62246**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #0740887 / IL27513 A partial extended survey was completed.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		3/29/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to immediately consult a resident's physician for 1 of 1 residents (R1) with a significant change in condition (including inability to chew, increased pain, crying, elevated temperature and refusal to attend dialysis). This failure resulted in R1 not receiving timely treatment. R1 expired within 14 hours of the first evidence of the decline. The findings include: According to the admission record and diagnosis record in the facility's medical records, R1 was a 72 year old resident with multiple diagnosis including: End Stage Renal Disease, Right Below the Knee Amputation (12/8/06), Coronary Artery Disease, Diabetes Mellitus, Congestive Heart Failure, Right Intertrochanteric Femur fracture (8/24/06), Peripheral vascular disease, and Decubitus ulcers. Nurses notes dated 2/19/07 11:10am indicate R1 was also on contact isolation for MRSA (Methicillin Resistant Staphylococcus Aureus). According to an incident report investigation of 2/18/07 R1 had a fall from the wheelchair resulting in a 3 to 5 centimeter laceration to R1's right eyebrow. A second incident report from 2/21/07 found R1 had a second fall on 2/20/07 that resulted in an Odontoid fracture and a 9.5 x 5 centimeter hematoma on the left forehead. Nurses notes dated 2/23/07 indicated R1 returned from a hospital stay related to the incident of 2/20/07 at 4:30pm. The notes state "res (resident) very sleepy" and give vital signs of 97.4T, 66P, 16R, 120/74BP. The nurses notes	F 157		

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F 157	Continued From page 2 continue with an entry at 6pm indicating the resident was having difficulty chewing when fed and the diet order was changed to pureed by the speech therapist. At 8:00 pm the nurses notes state "T101.0 Tylenol given for elevated fever. Res in a lot of pain. face is so swollen that she cannot open her eyes" .... will cont to monitor". A note at 9:20pm indicates the temperature is 98.8 axillary. The record shows no further entries until 3:00am when the note states "...administered Vicodin for preventive measures so med (medication) would have time to work before getting up for dialysis". At 3:45 the nurses notes continue with the staff attempting to get R1 up and ready to leave for dialysis. "when staff was using turn sheet to put (mechical lift device) pad underneath, res was grimacing et crying in pain" .. "she (resident) said she did not want to go. this nurse asked resident if she was refusing et she stated "yes". will monitor" At 4:00am nurses note continue and explain to transporter for R1 "that resident refusing and was in too much pain" When questioned on 3/5/07 at 11:25am, E2 (Director of Nursing) indicated that there are no further notes or documentation available that would indicate that R1 was further monitored for a change in condition or that R1's physician was made aware of R1's trouble chewing, fever, crying out in pain and refusal to attend dialysis. E2 confirmed that R1's physician was not phoned until 8:am when R1 was found expired at 7:45am.	F 157		
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		3/29/07

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F 309	Continued From page 3 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to adequately monitor; assess; and immediately consult with the resident's physician for 1 of 1 residents (R1), who had a change in condition (inability to chew, increased temperature, crying out in pain, and refusal to attend dialysis). This failure resulted in R1 not receiving timely treatment. R1 expired within 14 hours of the first evidence of decline. The facility further failed to follow policy; identify code status; and begin Cardiopulmonary Resuscitation for 1of 1 residents (R1) who was found without signs of life and had "full code" status. This failure resulted in the lack of resuscitation efforts according to R1's wishes and failure to follow facility policy and procedures. These failures resulted in an Immediate Jeopardy. While the the Immediate Jeopardy was removed on 3/5/07, the facility remains out of compliance at a severity level two while the facility continues staff education related to monitoring and assessing; identifying code status and evaluating staff understanding. The findings include: 1. According to the admission record and	F 309		

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F 309	Continued From page 4	F 309		

diagnosis record in the facility's medical records, R1 was a 72 year old resident with multiple diagnosis including: End Stage Renal Disease, Right Below the Knee Amputation (12/8/06), Coronary Artery Disease, Diabetes Mellitus, Congestive Heart Failure, Right Intertrochanteric Femur fracture (8/24/06), Peripheral vascular disease and Decubitus ulcers.

Nurses notes dated 2/19/07 11:10am indicate R1 was also on contact isolation for MRSA (methicillin resistant staphylococcus aureus). According to an incident report investigation of 2/18/07, R1 had a fall from the wheelchair resulting in a 3 to 5 centimeter laceration to R1's right eyebrow, a second incident report from 2/21/07 found R1 had a second fall on 2/20/07 that resulted in an Odontoid fracture and a 9.5 x 5 centimeter hematoma on the left forehead.

R1's transfer sheet from a hospital in Missouri dated 2/23/07 indicate R1 returned to the facility from the hospital after a stay related to the fall and fracture of 2/20/07. R1's medical record contain nurses notes dated 2/23/07, at 4:30pm, indicating R1 is readmitted to the facility. The notes state "res (resident) very sleepy no complaint of pain/disc (discomfort) voiced. (hard collar) in place V/S 97.4T, 66P, 16R, 120/74BP" . Further notes follow at 6:00pm "resident was having a hard time chewing. N/O (new order) received from speech therapy reg. (regular) diet to pureed diet ..." 8:00pm "T101.0 Tylenol give for increased fever. Res in a lot of pain. face is so swollen that she cannot open her eyes." 9:20pm "Tep (sic)(temperature) decreases 98.8 axillary. .... will cont (continue) to monitor". There are no further notes until 3:00am, "Vicodin for preventive measures so med (medication) would have time to work before getting up for dialysis will monitor. At 3:45am ...."when staff

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F 309	Continued From page 5 was using turn sheet to put (mechanical lift) pad underneath res. was grimacing et (and) crying in pain. ..... she (R1) said she did not want to go this nurse asked resident if she was refusing et she stated "yes" "Will monitor". 4 am nurses notes indicate the nurse explained to the transporter that the resident was refusing and "was in too much pain". 5:45am nurses notes indicate that during shift change the nurses stopped in R1's room and E3 talked with R1. R1 mumbled she was "ok" and the notes state "resp even even and nonlabored, will mt (monitor)". At 7:45am E3 is called to R1's room and R1 is found with no signs of life and no response to stimuli. Interview with E2 (Director of Nursing) on 3/5/07 at 11:25am found she had been called at 3:50am and instructed the nurse that it was R1's right to refuse dialysis and that Z1 (physician) should be called. A telephone interview with E6 (LPN) the nurse on the night of 2/23/07, found she had no further records of any assessments for R1. E6 indicated she did not assess R1's pain and assumed the pain was from R1's stump as it had been in the past. E6 further indicated she had been in and out of R1's room but did not have documentation of the visits and did not have any other vital signs or physical assessments for R1. R1's transfer sheet and readmission orders from the hospital on 2/23/07 indicate R1 had orders for a pain patch. There is no entry into R1's nurses notes indicating if the patch was in place. E6 was unable to say whether R1's pain patch was in place or not. E6 indicated during the phone interview that she did not expect R1 to expire. E6 stated she did not call the doctor about R1's changes (inability to chew, increased temperature, increase in pain, and refusal of dialysis) E6 indicated that the next shift was to call the doctor. E6 went on to state I was	F 309		

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F 309	Continued From page 6 "running behind. It was a hairy night". However, R1 expired before Z1 was contacted regarding R1's changing condition. Telephone interview with Z1 on 3/7/06 at 10:55am found that Z1 had not been notified regarding R1's condition prior to R1 expiring. Z1 indicated that when she was informed of R1's death she asked the facility if there were any indications that R1 was expected to die. Z1 stated the facility said "no". Z1 stated she had expected R1 to be stable upon release from the hospital. Z1 was read portions of R1's nurses notes from the evening of 2/23/07 to the morning of 2/24/07 including the inability to chew, increased pain, crying and refusal of dialysis. Z1 indicated that the facility failed to make her aware of these conditions and that "They should have let me know" and I "have to know what is going on with my patients". A review of the facility's "Change of Condition" policy and procedure found in part,"The facility shall promptly notify the resident, his/her attending physician, and representative of changes in the resident's medical / mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)". The procedure section indicated, in part: 1. Notifying Attending Physician of Changes in Resident's Medical/Mental Condition. The nurse will notify the resident's attending physician or on-call physician when there has been: d) A significant change in the resident's physical/emotional/mental condition; 2. Review of R1's nurses notes from the early morning of 2/24/07 found at 5:45 am the night	F 309		

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F 309	Continued From page 7	F 309		

nurse and the day nurse were conducting a walk-through and stopped in R1's room. The note indicates "asked how res (resident) was doing, res mumbled "ok" resp (respirations) even and nonlabored, will mt.(monitor)" The next note at 7:45am states "called to res room, no resp, pupils fixed and dilated, no apical pulse verified by 2 nurses no response to stimuli, res trunk cool to touch with feet/hands cold, face pale lips dusky, no signs of life. 8:00am "DON notified MD office notified, (Z5) (family) notified, coroner notified. 11:25am "funeral home here to pick up body, body released to the funeral home..." There are no further notes in the residents records to indicated R1 was given any further care by the facility staff.

Located directly inside the front cover of R1's medical record was a neon yellow form labeled CODE STATUS . A large * is in place in the section FULL CODE The section states All measures of resuscitation including: CPR Calling 911 (AMBULANCE) EMERGENCY IV'S AND MEDICATION. The section labeled NO CODE is Xed out. The form is labeled with R1's name.

R1's current physician's orders prepared by facility staff upon re-admission on the afternoon of 2/23/07 indicate Code Status: "Full", and under the section labeled other orders: "Fall Precautions": 15 minute visual checks.

When E2 was questioned on 3/1/07 at 10:55am about the code status for R1 and if CPR was attempted E2 responded that CPR was not done because the resident was cold and dusky. Later when asked about the order for 15 minute checks for R1, E2 searched and could no find documentation to indicate the checks were ever started upon R1's return from the hospital on the afternoon of 2/23/07.

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F 309	Continued From page 8 A telephone interview on 3/1/07, at 11:15am, with E3 (LPN) the day nurse for R1 on 2/24/07, found that she only saw R1alive on the walk-through documented in the nurses notes. E3's actions on the morning of 2/24/07 were reviewed with E3. E3 indicated she was passing medications when she was called to R1's room and R1 was not breathing. E3 related she was unaware that R1 was a full code and did not initiate CPR . E3 indicated R1's pupils were set. E3 was questioned and responded that she has been employed at the facility for 6 years and is currently CPR certified. E3 indicated she has never had anyone to expire at the facility that was a full-code. A review of the facility's CPR policy on 3/5/07 and 3/6/07 found the following: "Cardiopulmonary resuscitation (CPR) is instituted in cases of recognized cardiac and /or pulmonary arrest to sustain or support a resident's cardiac and /or pulmonary function(s) until advanced life support systems are available." "CPR will be instituted on all residents in recognized cardiac and / or pulmonary arrest except those residents for whom a "no code" order has been written by the physician or for those whom the physician determines that CPR is not medically indicated." A review of the facility's CPR Procedure (in part) found: .... "* Determine if the resident has a "No Code" order". The Immediate Jeopardy was identified on	F 309		

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F 309	Continued From page 9 3/5/07. The Immediate Jeopardy was determined to have begun on 2/23/07 when the facility staff failed to monitor; provide 15 minute visual checks; assess R1's physical condition; and failed to notify R1's physician. Further, the Immediate Jeopardy continued when the facility failed to follow R1's code status. E1 was informed of the Immediate Jeopardy at 2:00pm on 3/5/07. The facility took the following steps to remove the Immediate Jeopardy: 1. Licensed nursing staff were inserviced on CPR and Code status on 2/26/07 and again on Full Code, DNR and CPR on 3/5/07 in house and via phone. 2. All resident charts were labeled with appropriate code status on 3/5/07. 3. Licensed nursing staff were inserviced on 3/5/07 at 4:30pm regarding: Change of Condition, Pain Assessment, Documentation, Admission Assessment and General Physical Assessment. 4. As of 3/5/07 all policies and procedures were reviewed for CPR, Code Status Identification and Resident Nursing Assessments. 5. The facility held a simulated cardiac arrest for a resident in Full Code status at 5:30pm on 3/5/07.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 10 300.1010h) 300.1030a)2) 300.1035a)4) 300.1210a) 300.1210b)3) 300.3240a) Section 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 a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 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 from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life sustaining treatment. Every facility shall establish a policy concerning the implementation	F9999		

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F9999	Continued From page 11 of such rights. Included within this policy shall be: 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) 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 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 abuse or neglect a resident. These Requirements are not met as evidenced by:	F9999		

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F9999	Continued From page 12	F9999		

Based on record review and interview the facility failed to adequately monitor; assess; and immediately consult with the resident's physician for 1 of 1 residents (R1), who had a change in condition (inability to chew, increased temperature, crying out in pain, and refusal to attend dialysis). This failure resulted in R1 not receiving timely treatment. R1 expired within 14 hours of the first evidence of decline.

The facility further failed to follow policy; identify code status; and begin Cardiopulmonary Resuscitation for 1of 1 residents (R1) who was found without signs of life and had "full code" status. This failure resulted in the lack of resuscitation efforts according to R1's wishes and failure to follow facility policy and procedures.

The findings include:

1. According to the admission record and diagnosis record in the facility's medical records, R1 was a 72 year old resident with multiple diagnosis including: End Stage Renal Disease, Right Below the Knee Amputation (12/8/06), Coronary Artery Disease, Diabetes Mellitus, Congestive Heart Failure, Right Intertrochanteric Femur fracture (8/24/06), Peripheral vascular disease and Decubitus ulcers. Nurses notes dated 2/19/07 11:10am indicate R1 was also on contact isolation for MRSA (methicillin resistant staphylococcus aureus).

According to an incident report investigation of 2/18/07, R1 had a fall from the wheelchair resulting in a 3 to 5 centimeter laceration to R1's right eyebrow, a second incident report from

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	145909	A. BUILDING _____ B. WING _____	C 03/08/2007

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CARDINAL HILL HEALTHCARE	**SOUTH FOURTH STREET GREENVILLE, IL 62246**

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F9999	Continued From page 13 2/21/07 found R1 had a second fall on 2/20/07 that resulted in an Odontoid fracture and a 9.5 x 5 centimeter hematoma on the left forehead. R1's transfer sheet from a hospital in Missouri dated 2/23/07 indicates R1 returned to the facility from the hospital after a stay related to the fall and fracture of 2/20/07. R1's medical record contains nurses notes dated 2/23/07, at 4:30pm, indicating R1 was readmitted to the facility. The notes state "res (resident) very sleepy no complaint of pain/disc (discomfort) voiced. (hard collar) in place V/S 97.4T, 66P, 16R, 120/74BP." Further notes follow at 6:00pm "resident was having a hard time chewing. N/O (new order) received from speech therapy reg. (regular) diet to pureed diet ..." 8:00pm "T101.0 Tylenol give for increased fever. Res in a lot of pain. face is so swollen that she cannot open her eyes." 9:20pm "Tep (sic)(temperature) decreases 98.8 axillary. .... will cont (continue) to monitor". There are no further notes until 3:00am, "Vicodin for preventive measures so med (medication) would have time to work before getting up for dialysis will monitor. At 3:45am ...."when staff was using turn sheet to put (mechanical lift) pad underneath res. was grimacing et (and) crying in pain. .... she (R1) said she did not want to go this nurse asked resident if she was refusing et she stated 'yes' "Will monitor". 4:00 am nurses notes indicate the nurse explained to the transporter that the resident was refusing and "was in too much pain." 5:45am nurses notes indicate that during shift change the nurses stopped in R1's room and E3 talked with R1. R1 mumbled she was "ok" and the notes state "resp even even and nonlabored, will mt (monitor)." At 7:45am E3 was called to R1's room and R1 is found with no signs of life and no response to	F9999		

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F9999	Continued From page 14 stimuli. Interview with E2 (Director of Nursing) on 3/5/07 at 11:25am found she had been called at 3:50am and instructed the nurse that it was R1's right to refuse dialysis and that Z1 (physician) should be called. A telephone interview with E6 (LPN) the nurse on the night of 2/23/07, found she had no further records of any assessments for R1. E6 indicated she did not assess R1's pain and assumed the pain was from R1's stump as it had been in the past. E6 further indicated she had been in and out of R1's room but did not have documentation of the visits and did not have any other vital signs or physical assessments for R1. R1's transfer sheet and readmission orders from the hospital on 2/23/07 indicate R1 had orders for a pain patch. There is no entry in R1's nurses notes indicating if the patch was in place. E6 was unable to say whether R1's pain patch was in place or not. E6 indicated during the phone interview that she did not expect R1 to expire. E6 stated she did not call the doctor about R1's changes (inability to chew, increased temperature, increase in pain, and refusal of dialysis). E6 indicated that the next shift was to call the doctor. E6 went on to state I was "running behind. It was a hairy night." However, R1 expired before Z1 was contacted regarding R1's changing condition. Telephone interview with Z1 on 3/7/06 at 10:55am found that Z1 had not been notified regarding R1's condition prior to R1 expiring. Z1 indicated that when she was informed of R1's death she asked the facility if there were any indications that R1 was expected to die. Z1 stated the facility said "no." Z1 stated she had expected R1 to be stable upon release from the	F9999		

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hospital. Z1 was read portions of R1's nurses notes from the evening of 2/23/07 to the morning of 2/24/07 including the inability to chew, increased pain, crying and refusal of dialysis. Z1 indicated that the facility failed to make her aware of these conditions and that "They should have let me know" and I "have to know what is going on with my patients."

A review of the facility's "Change of Condition" policy and procedure found, in part, "The facility shall promptly notify the resident, his/her attending physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)."

The procedure section indicated, in part:

1. Notifying Attending Physician of Changes in Resident's Medical/MentalCondition. The nurse will notify the resident's attending physician or on-call physician when there has been:

d) A significant change in the resident's physical/emotional/mental condition;

2. Review of R1's nurses notes from the early morning of 2/24/07 found at 5:45am the night nurse and the day nurse were conducting a walk-through and stopped in R1's room. The note indicates "asked how res (resident) was doing, res mumbled 'ok' resp (respirations) even and nonlabored, will mt.(monitor)." The next note at 7:45am states "called to res room, no resp, pupils fixed and dilated, no apical pulse verified by 2 nurses no response to stimuli, res trunk cool to touch with feet/hands cold, face pale lips dusky, no signs of life. 8:00am "DON notified

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F9999	Continued From page 16 MD office notified, (Z5) (family) notified, coroner notified. 11:25am "funeral home here to pick up body, body released to the funeral home..." There are no further notes in the resident's records to indicated R1 was given any further care by the facility staff. Located directly inside the front cover of R1's medical record was a neon yellow form labeled CODE STATUS. A large * is in place in the section FULL CODE. The section states All measures of resuscitation including: CPR Calling 911 (AMBULANCE) EMERGENCY IV'S AND MEDICATION. The section labeled NO CODE is Xed out. The form is labeled with R1's name. R1's current physician's orders prepared by facility staff upon re-admission on the afternoon of 2/23/07 indicate Code Status: "Full," and under the section labeled other orders: "Fall Precautions": 15 minute visual checks. When E2 was questioned on 3/1/07 at 10:55am about the code status for R1 and if CPR was attempted E2 responded that CPR was not done because the resident was cold and dusky. Later when asked about the order for 15 minute checks for R1, E2 searched and could no find documentation to indicate the checks were ever started upon R1's return from the hospital on the afternoon of 2/23/07. A telephone interview on 3/1/07, at 11:15am, with E3 (LPN) the day nurse for R1 on 2/24/07, found that she only saw R1 alive on the walk-through documented in the nurses notes. E3's actions on the morning of 2/24/07 were reviewed with E3. E3 indicated she was passing medications when	F9999		

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F9999	Continued From page 17 she was called to R1's room and R1 was not breathing. E3 related she was unaware that R1 was a full code and did not initiate CPR. E3 indicated R1's pupils were set. E3 was questioned and responded that she has been employed at the facility for 6 years and is currently CPR certified. E3 indicated she has never had anyone expire at the facility that was a full-code. A review of the facility's CPR policy on 3/5/07 and 3/6/07 found the following: "Cardiopulmonary resuscitation (CPR) is instituted in cases of recognized cardiac and/or pulmonary arrest to sustain or support a resident's cardiac and /or pulmonary function(s) until advanced life support systems are available." "CPR will be instituted on all residents in recognized cardiac and/or pulmonary arrest except those residents for whom a "no code" order has been written by the physician or for those whom the physician determines that CPR is not medically indicated." A review of the facility's CPR Procedure (in part) found: .... "* Determine if the resident has a "No Code" order." (A)	F9999		