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W 382	Continued From page 16 tells me to watch it." E1, Assistant Administrator, was interviewed on 12/26/06 at 9:10am. E1 stated the TC is not responsible for watching the medication cart during medication administration. R1 on 12/14/06 during the 7:00am medication pass obtained R2's medication from the medication cart when E3, Nurse, failed to ensure it was locked when out of her sight.	W 382		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION Section 350.620a) Section 350.620b)6) Section 350.1410a) Section 350.1440a)2) Section 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, resident records, dental services, and diagnostic service (including laboratory and	W9999		

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W9999	Continued From page 17 x-ray). Section 350.1410 Medication Policies and Procedures a) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. Section 350.1440 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at or near the nurses' station in a locked cabinet, in a locked medication room, or in one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.) 2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requriements were not met as evidenced by the following:	W9999		

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W9999	Continued From page 18 Based on record review, observation and interview, the facility failed to develop and implement their policies and procedures to prevent neglect when they failed to: 1) ensure the medication cart was under continual observation during the AM medication pass on 12/14/06. 2) ensure a procedure was developed for investigation of missing medications. As a result of the facility's failure, on 12/16/06, R1 ingested R2's medications resulting in hospitalization for multiple drug overdose. Findings include: 1) R1, according to the Individual Habilitation Plan of 3/8/06, is a 28 year old male whose diagnosis includes Moderate Mental Retardation, Mild Cerebral Palsy, Right Spastic Hemiplegia, Seizure Disorder, Dehydration, Undesired Weight Loss, Severe Dysphagia and Meningoencephalitis. R1 is ambulatory and lives on the 3rd floor. Diet, per the Individual Habilitation Plan (IPP) of 3/8/06, is "Pureed (to mashed potato consistency)...." R1, per an Incident Report Investigation dated 12/16/06, has a history of stealing. R1, per the Physician's Orders Sheet (POS) dated 12/06, currently receives the following total dose of medications (meds) throughout the day: 1) Multi-vitamin 2) Nasal Spray 3) Calcium 500 with D 4) Ascorbic Acid 1000mg 5) Tegretol 1200mg	W9999		

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W9999	Continued From page 19 R2, per the POS of 12/06, is a 63 year old male whose diagnosis includes Severe Mental Retardation, Fragile X Syndrome, Benign Prostate Hypertrophy, Duodenal Ulcer, Anemia and Renal failure. R2's, per the POS of 12/06, total dose of medications throughout the day include: 1) Tegretol 900mg 2) Clonidine 0.3mg 3) Proscar 5mg 4) Ativan 1mg 3 times weekly 5) Renal Caps Softgel 6) Uroxatral 10mg 7) Minoxidil 5mg 8) Phoslo Gelcap 667mg 1 capsule 3 times daily with meals 9) Renagel 3200mg 10) Coumadin 1mg 11) Zyprexa 15mg 12) Toprol 100mg Per the Facility's Guidelines for Medication Administration, "During routine administration of medication, the medication cart is kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by." Per the Investigation Report dated 12/16/06, R1 had removed R2's medications from the med cart while the nurse, E3, had her back turned away from the cart. R2's meds for the week of 12/14/06 thru 12/20/06 were in the med cart during the	W9999		

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W9999	Continued From page 20 7:00am med pass on 12/14/06. This was verified by both Nurses E2 and E3 as E3 was on duty that day on the 3rd floor where both R1 and R2 reside. E3 recalls R2's meds were not in the med cart when she, at 11:30am, went to administer R2's meds. The investigation notes E3, Nurse, admitted to having left the med cart unlocked and not within her direct eyesight during the 7:00am morning medication pass on 12/14/06. On 12/26/06 at 11:29am E3, Nurse, was interviewed. E3 stated she did the 7:00am medication pass on 12/14/06. At 11:30am when she went back to the 3rd floor to get 2 other residents' medications she discovered R2's medications were missing. E3 was asked if she left the med cart unlocked during the morning medication pass. E3 said the former Director of Nursing had told her the TC, Training Counselor, is to stay with the med cart when she is away from it so there were times she did and the TC was there. Per the Investigative Report, E4, TC, was asked if the med cart was locked and said everything is locked when she goes into a room. When E4 was asked how often did you see the med cart unlocked and unobserved by the nurse, he was unable to remember. Asked during the med pass, was there ever a time the med cart was out of both your eyesight and the nurses eyesight, the report notes, "If she goes away from it, she tells me to watch it." Interview with E3, Nurse, on 12/26/06 at 11:29am states she did not ask E4, Training Counselor, to watch the med cart during the medication pass on 12/14/06.	W9999		

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W9999	Continued From page 21 Incident Report Investigation involving R1 and R2 notes on 12/16/06 at approximately 11:45am, R1 was observed with pallor and cyanosis. His blood pressure was 60/40 and his lips were cyanotic. 911 was called and the paramedics noted a white substance in his mouth which they removed. Approximately an hour later the hospital called and informed the facility they had found in R1's pockets a cell phone,a picture and multiple medications belonging to R2. Per the 12/16/06 Emergency Room notes upon arrival to the ER, R1's blood pressure was 60/0 and temperature was 95.3. Paramedics found a soap like substance caked in back of R1's mouth. This was removed prior to intubation. He was given Versed for intubation, and needed Versed while on a ventilator. Z5, Doctor, noted, "The patient underwent EGD which showed a caustic esophagitis in the mid-upper third with white material suggesting soap or detergent of some kind." He received charcoal thru a fiberoptic scope. He was admitted to the Medical Intensive Care Unit and a progress note dated 12/19/06 states he was transferred to the Critical Care Unit. Per the Endoscopy Report from the Hospital dated 12/16/06, "Plaques were found in the upper esophagus, Denuded epithelium in the upper esophagus from the UES to 30cms. Large amount of crystalline material in the esophagus causing an esophageal obstruction, An N-G tube could not be placed despite a few attempts because of the denuded mucosa. Retained food was found in the fundus. Large amount of pills and food in the stomach." Under Impressions from the Endoscopy Report:	W9999		

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W9999	Continued From page 22 1) Plaques in the upper esophagus 2) Food, retained in the fundus 3) Alkali damage in the upper esophagus. Damage was on one wall. On 12/27/06 Z2, Nurse, and Z3, Social Worker, were interviewed at 10:05am. Z2 stated R1 was brought to the hospital due to ingesting medications and suspected of ingestion of laundry detergent. Z3 stated he will be NPO (nothing by mouth) for 1 - 3 months. He injured his esophagus and stomach. He needs to be on IV for his meds and is fed thru IV. She said, "He may not be able to eat; whatever he swallowed injured his stomach. The GI doctor felt it too high a risk to insert a tube since it may injure his stomach." Per Doctor's Progress Note dated 12/27/06, R1 may require a G or J tube in the future. On 12/29/06 at 12:31pm E5, Nurse, was interviewed. E5 stated she was called upstairs on 12/16/06 by the 3rd floor nurse. She stated, "R1 was sitting in the hallway, groggy, yellowish and cold. I asked for blood pressure and it was 60/40 on the left arm and 58/30 on the right arm. I called 911. I asked the Team Coordinator to get a wheelchair and I couldn't get a pulse. I took it at the heart and it was 80 something. I put O2 on full blast 15 liters and O2 sat was 93-94. The paramedics arrived and asked what this was in his mouth. It was all in his mouth from the left to the right of his jaw all the the way to his teeth. The paramedics took an object and started to dig it out. We took it, smelled it, white chemically, it looked like the little white packets of laundry detergent. Paged E6, Supervisor, and she didn't	W9999		

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W9999	Continued From page 23 think it smelled like laundry detergent to her. It was powdery, compact and you couldn't see the back of his throat." Initial investigation by surveyor determined R1 had potentially ingested laundry detergent. However, E1and E10 presented a sample of the ingested material to surveyor on 1/4/07. Upon observation of this material, it was a mixture including small white and various colors of small pieces mixed with fully crushed powdery substance. Some of the pills R1 was thought to have ingested include Phoslo, Renegel and the Renal Caps which are phosphorous in nature and replicate the appearance of laundry detergent when crushed and mixed with saliva. E1 was asked are there any individuals in the facility who exhibit pica behaviors. E1 provided a list including 4 individuals R3, R4, R5, R6 and 1 other, R7, who is being baselined. Upon request by surveyor on 1/3/06, E1, Assistant Administrator, faxed a facility document entitled "Abuse and Neglect, Recognition, Reporting and Prevention." On page 13 of the document, neglect is defined in part as, "The failure to carry out services, habilitation or treatment that did or could result in harm or injury to the individual." R1 on 12/14/06 during the 7:00am medication pass obtained R2's medication from the medication cart. R1 sustained damage to his esophagus requiring medical care. 2) Per an Employee Statement dated 12/17/06 by E9, Nurse, regarding R2's meds, "Noted meds	W9999		

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W9999	Continued From page 24	W9999		

out of stock Thursday 4:00pm. But I thought pharmacy still had resident status as discharged as the last weeks was. Awaiting delivery. Meds still out of stock Friday 12-15-06 called pharmacy spoke to Z6 states, 'Will check with his supervisor regarding re-sending and contact us later or in the am.' Had enough meds from last weeks delivery to medicate through 9:00am, 12-15-06."

Per an Employee Statement dated 12/16/06 by E5, Nurse, "On 12/15/06 Friday on 3rd R2's 7:00am and 12 noon medication was given from single individual pack and when or before going to dialysis R2 was given his 5pm medication to take to dialysis. No routine pre pack medication was available or seen in medication cart."

Per part of the Nursing Progress note dated 12/16/06, "Noted this am meds missing for week - called pharmacy - pharmacy stated meds sent on 12/12/06 noted meds in on 12/14/06 in am (3am)."

On 12/26/06 with E1, Assistant Administrator, the 3rd floor med room was observed. On top of Emergency box were 6 cards of medications. Surveyor asked E1 what the procedure is when there are extra medications. E1 stated the nurse sets them aside in the medication room and eventually destroyed. On 12/27/06 at 12:00pm E1 said the nurses haven't been clear on how long meds should be there adding she would write a policy to address this issue.

On 12/26/06 at 9:10am E1, Assistant Administrator, was interviewed. E1 stated E3, Nurse, came to her and told her around noon on 12/14/06 R2's meds were missing. E1 said they had no idea what happened to R2's meds. E1

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W9999	Continued From page 25 stated sometimes the meds slide behind the drawers (in the med cart) and we thought that's what happened. At 11:50am on 12/27/06 E1 was asked what is the procedure if medication is missing. E1 stated we look for it. We look at the med cart and if not found we call the pharmacy to make sure it was sent or re-order. She stated the facility does not have a policy addressing missing meds. (A)	W9999		