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W 331	Continued From page 50 All staff will be instructed regarding the Visiting Resident Consent Form. The Administrator instructed the Directors and Supervisors of the Program, Social Services and Nursing Departments. The Administrator has put into effect a policy regarding Overnight Visits for Preadmission Evaluation, Policy 12.14. The Administrator instructed the Directors and Supervisors of the Program, Social Services and Nursing Departments regarding this policy. The Director of Training will instruct the direct care staff regarding this policy. The Health Services Supervisor will instruct the nursing staff regarding this policy. The Health Services Director will instruct the nursing staff on the assessment and documentation of body systems. The Director of Training will instruct the direct services personnel on the signs and symptoms of healthcare concerns to be reported to nursing for any resident of the facility. While the Immediate Jeopardy was removed on 2/4/11 at 12:25 PM, the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210	W9999		

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350.1220e)
350.1220i)
350.1220j)
350.1230b)3)6)7)
350.1230d)1)
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.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1220 Physician Services

e) All residents shall be seen by their physician as often as necessary to assure adequate health care.

i) Each resident admitted shall have a complete physical examination, within five days prior to admission, or within 72 hours after admission to the facility.

j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to,

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W9999	Continued From page 52	W9999		

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.

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:
The DON shall participate in:
3) Periodic reevaluation of the type, extent, and quality of services and programming.
6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

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 Regulations were not met as evidenced by:

Based on record review and interview nursing failed to provide adequate and prompt medical care for 1 of 1 individual (R27) who was temporarily staying at the facility to determine whether or not a permanent placement would be

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W9999	Continued From page 53 appropriate. R27 was admitted to a local hospital's Intensive Care Unit. R27 was then transferred to another medical facility in which she expired in the Emergency Room from respiratory distress. Nursing failed to: 1) Ensure the physician did a physical assessment for 1 of 1 individual (R27). 2) Obtain physician's orders for medications and Standing Medical Orders for 1 of 1 individual (R27). 3) Obtain vital signs as per the facility's established procedure for 1 of 1 individual (R27). 4) Notify the physician promptly of temperatures greater than 101 degree Fahrenheit for 1 of 1 individual (R27). 5) Thoroughly assess pulmonary status for 1 of 1 individual (R27) who had a SpO2 (Saturated Peripheral Oxygenation)of 80- 83%. 6) Provide a complete neurological assessment for 1 of 1 individual (R27) who had fallen out of bed. 7) Thoroughly assess for dehydration 1 of 1 individual (R27) who had elevated temperatures. 8) Follow facility's practice of sending an individual to the Emergency Room for elevated temperature greater than 101 degree Farenheit, for 1 of 1 individual (R27). 9) Ensure the facility has a policy in place that identifies how facility will meet the medical needs	W9999		

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W9999	Continued From page 54	W9999		

for 1 of 1 individual (R27) who was temporarily staying at the facility to determine whether or not a permanent placement would be appropriate.

Findings Include:

ICAP (Inventory of Client and Agency Planning) of 6/18/09, identifies R27 as a 24 year old female who functions at the Profound level of Mental Retardation with additional diagnosis of Cornelia de Lange Syndrome. The ICAP states that R27 functions at a broad independence score of 1 year 6 months. Under section titled, "Problem Behaviors," the ICAP states that R27 is never uncooperative. The ICAP further states that R27 has a guardian, walks, needs assistive devices, and utilizes communication board.

Genetics Home Reference (Internet site http://ghr.nlm.nih.gov/condition/Cornelia de Lange Syndrome) dated 1/25/11, states , "Cornelia de Lange syndrome is a developmental disorder that affects many parts of the body. The features of this disorder vary widely among affected individuals and range from relatively mild to severe. Cornelia de Lange syndrome is characterized by slow growth before and after birth, intellectual disability that is usually severe to profound, skeletal abnormalities involving the arms and hands and distinctive facial features."

Review of document (untitled /"R27's name"/ no date) states the following: "Visit: 1/5/11- 1/19/11." This document further states, "R27 can walk around but does have an awkward gait and may be at risk for falls, she also uses a wheelchair for long distances. R27 does feed herself and will be on a mechanical soft diet and will need to be

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W9999	Continued From page 55 monitored as she at times cheeks her food. R27 should also have a mat by her bed at all times." Program Progress Note of 1/5/11 (no time) states that R27 was admitted to (facility) for overnight visit. This note further states, "Lt (left) foot four, Rt (right) 5 toes bil (bilateral) crossed. Rt (right) arm 2 digits Lt (left) none." (typed as written) Review of R27's Program Progress Notes 1/5/11-1/10/11, E9/ Licensed Practical Nurse documented on 1/8/11 at 6:30 AM, R27 temperature of 102.8, pulse of 125, SpO2 (saturated peripheral oxygenation) of 80-83. Further review of Program Progress Notes, R27 continued to have abnormal temperatures 1/8/11-1/10/11. AACN Procedure manual for Critical Care, Fourth Edition (W.B.Saunders copyright 2001) states, "Normal oxygen saturation values are 97%- 99% in the healthy individual. An oxygen saturation value of 95% is clinically accepted in a patient with a normal hemoglobin level." Program Progress Note on 1/10/11 at 7:00 AM states, "T (temperature) 101.3 P (pulse) 120 Resp (respiration) 40 unable to obtain pulse ox (SpO2/ Saturated Peripheral Oxygenation) due to physical condition. 140/80 BP (blood pressure) by leg. Skin pale resp. (respiration) labored. 7:30 AM DON (Director of Nursing/ E8/ Health Services Supervisor) called et (and) talked to (Z2/ guardian). Res. (resident) sent to (local hospital) ER (emergency room) per ambulance." (typed as written) EMS (Emergency Medical Services) Preliminary	W9999		

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W9999	Continued From page 56 Report (dated 1/10/11) states that EMS arrived on scene at 7:49 AM. EMS documented the following vitals for R27: 8:02 AM BP 85/51, Pulse 150 Respirations 34 8:12 AM BP 110/56 Pulse 151 Respirations 40 The EMS Preliminary Report further states that R27's skin was pale and hot. Under Comments or Further Treatment, the EMS report states, "Pt (patient) w/(with) elevated temp (temperature), low BP, rapid breathing, dehydration. (Facility) staff report Pt new to facility w/ increased temp past 3 days. Staff report pt. sluggish per normal activity status. Unable to attain pulse ox due to Pt. Cornelia De Lange Syndrome. Pt extremities deformed. No cyanosis noted. Hot to touch." EMS Preliminary Report states they arrived at (local community hospital) at 8:12 AM. R27's ED (Emergency Department) Report (dictated per Z8/ Physician on 1/10/11 at 11:32 AM) states under Physical Examination: "VS (vital signs) Temperature 99.7, pulse 148, respirations 26, pressure 101/66, saturation 90% on 15 L (liters) NRB (non rebreathe). Severe pallor. Tachycardia. Breath sounds diminished both sides. Rhonchi and rales bilaterally." The ED Report further states, "The patient is markedly neutropenic, bilateral infiltrates in both lungs and urinary tract infection also." R27"s Progress Note per Z7/ Physician (of local hospital dictated on 1/10/11 at 5:14 PM) states under the section titled "Impression" the following: 1. Acute Respiratory failure secondary to	W9999		

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W9999	Continued From page 57 progressive pneumonia with acute respiratory distress syndrome. 2. Hypotension secondary to severe sepsis. 3. Iron deficiency anemia. Z7 further states on R27's progress note (dated 1/10/11) under section titled "Plan" the following: 1. The patient will be maintained on mechanical ventilatory support. 2. In view of the patient's persistent hypotension, the patient was started on Levophed with improvement of blood pressure in addition to intravenous fluid administration and blood transfusion for severe anemia. 3. I discussed the patient's poor condition and worsening condition with the patient's mother/Z2, and at this time, she (Z2) requested for transferred to (pediatric medical facility). Imaging Report of the Chest (dated 1/10/11) states, "Impression: Bilateral Pneumothoraces with extensive lung collapse and consolidation. the changes are more extensive on the left." Discharge Summary (dictated per Z1 on date of 1/18/11) of local community hospital, states, "Admitting Diagnosis: Sepsis and extensive bilateral pneumonic infiltrate." (Pediatric Medical Center) Face Sheet (Dated 1/10/11) states that R27 arrived in emergency department at 7:37 PM. Pediatric ICU (Intensive Care) Consult Note per Z9 (dated 1/10/11) states, "About five minutes before landing (R27 being transported from local hospital to pediatric medical center) she (R27)	W9999		

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W9999	Continued From page 58	W9999		

became bradycardic and CPR (cardiopulmonary resuscitation) was started and continued as she was brought to ER trauma room." The Pediatric ICU Consult Note further stated, "CPR was stopped when (Z2/guardian) arrived and Z2 asked to stop when I (Z9) explained her the situation. The time of death was (8:06 PM). I explained the mother the course of events and my suspicion that the most likely cause of (R27's) death was overwhelming sepsis and septic shock."

Report of Postmortem Examination (dated 1/21/11) states, "The death of this 24 year old, white female, (R27), is from bronchopneumonia. A significant factor in her death is Cornelia de Lange Syndrome."

1) On R27's Program Progress Notes dated 1/8/11 at 12:45 PM, E9/ Licensed Practical Nurse documented, "Z1/Physician here reported (typed as written) given on (arrow pointing up/ elevated) temp (temperature). His recommendation (arrow pointing up) temp goes back to 102. call mother et (and) recommend to send to ER (Emergency Room) for labs and evaluation." (typed as written)

Review of Program Progress Notes 1/5/11-1/10/11, there was no further written documentation that physician had assessed R27.

In an interview with E9/Licensed Practical Nurse on 1/18/11 at 4:31 PM, E9 stated that Z1/Physician was on the unit to see other individuals when she reported R27's elevated temperature and that the mother did not really want her to go to hospital. E9 confirmed that Z1

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W9999	Continued From page 59 gave parameters that if R27's temperature became greater than 102.0 to contact the mother and encourage R27 to be sent to Emergency Room for evaluation. E9 confirmed that Z1 did not assess R27 on 1/8/11 or during R27's visit to the facility. In an interview with E8/Health Services Supervisor (HSS) on 1/18/11 at 3:42 PM, E8 stated, "Visitors are assessed by nursing. No physical by physician until actually admitted. Not actually seen by physician until hospitalized." In an interview with Z1/Physician on 1/20/11 at 9:02 AM, Z1 stated "No" when asked if he had seen R27 while at facility. Z1 stated that he had seen R27 only after she was admitted to local hospital on 1/10/11. 2) In review of R27's Physician's Orders/ POS (no date) the area marked Physician's Signature is not signed. In the medication column, the POS lists Prevacid 30 mg dly (daily), Gabapentin 200 mg every AM and Gabapentin 400 mg every HS (hour of sleep). This POS does not list Motrin, Tylenol or to follow Standing Medical Orders. Standing Medical Orders (dated / Revised 8/10) provided to surveyor on 1/19/11 at 3:38 PM, has 4 pages. On page 4 there is an area for the Physician's signature. These Standing Medical Orders do not state Motrin as one of the medications to be given for an elevated temperature. The Standing Medical Orders (Revised 8/10) found in R27's record has only page 1 (with R27's name) and page 3. Surveyor could not find	W9999		

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W9999	Continued From page 60	W9999		

pages 2 or page 4 of Standing Medical Orders in R27's record. There was no evidence of the physician ordering the Standing Medical Orders to be followed for R27.

The PRN (as needed) Medication Information (no date) for R27 has documentation that R27 was given Tylenol for an elevated Temperature five times and Motrin for an elevated temperature three times between 1/8/11- 1/10/11.

The Medication Record (no date) has documentation that Prevacid 30 mg was administered daily in AM(morning) and Gabapentin 200 mg daily in AM to R27 from 1/6/11- 1/10/11. This Medication Record also has documentation that R27 was administered Gabapentin 400 mg daily at HS (Hour of Sleep) from 1/5/11-1/9/11.

In an interview with E1/Administrator on 1/20/11 at 12:01 PM, E1 stated, "We do not do physicals on visitors until admissions. We have a contract with (local hospital) for Z1 as our consultant. He's under their guidelines that he cannot do two physicals because of reimbursement. We've decided that we will pay for the first visit, so that we can consult with Z1." E1 confirmed that facility did not have physician's orders or Standing Medical Orders for R27. E1 confirmed that this change is made in response to this incident, so that facility will have physician's orders for individuals visiting the facility home medications and for the facility's physician's Standing Medical Orders.

In an interview with Z1/Physician on 1/20/11 at 9:02 AM, Z1 stated "I don't recall" when asked if

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W9999	Continued From page 61 he gave orders for R27's medications and Standing Medical Orders. 3) Review of Documentation for Overnight Guests (no date) under section Overnight Guests, states "Document each shift to include vital signs during entire stay." Review of Program Progress Notes written by facility nurses from 1/5/11- 1/10/11 the following are the Vital Signs obtained by facility: 1/5/11 (no time documented) no vitals documented 1/5/11 7:30 PM "Resident very uncooperative with vitals only assessed Temp (temperature) at 95.7" 1/6/11 6:00 AM- no vitals documented 1/6/11 8:30 PM- "Resident refused vitals, T 96.0" 1/7/11 6:50 PM- no vitals documented 1/7/11 8:30 PM- "Refused Vitals." 1/8/11 6:30 AM-"T (temperature) 102.8 R20 P (pulse)125 SpO2 (Saturated Peripheral Oxygenation) 80-83 approx" 1/8/11 9:00 AM- "T 100.3", no other vitals obtained 1/8/11 12:00 noon- T103.4, no other vitals obtained 1/8/11 12:45 PM- No vitals documented 1/9/11 6:00 AM- "T 101.4, 8:00 AM-T 100.7, 12:00 Noon- 99.2, 3:15 PM- T 101.1 , unable to obtain other vitals" 1/9/11 8:40 PM note- "100.0 at 4:00 PM, 100.8 T at 6:00 PM, Tylenol liquid two tsp (teaspoon) given at 8 PM for high temp" 1/10/11 1:05 AM- "T 97.6 Resp (respirations) 18, 5:05 AM temp 98.2 AM resp 18" no other vitals taken.	W9999		

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W9999	Continued From page 62 1/10/11 7:00 AM - "T 101.3, P 120, Resp (respirations) 40, unable to do pulse ox (Saturated Peripheral Oxygenation) due to physical condition, 140/80 BP (blood pressure) by leg. Skin pale resp. labored." (typed as written) In review of R27's Program Progress Notes (1/5/11 -1/10/11) there is no written evidence that nursing evaluated vital signs (inclusive of temperature, blood pressure, pulse and respiration) every shift. In interviews with E8/Health Services Supervisor on 1/18/11 at 3:42 PM and 1/19/11 at 3:38 PM, E8 stated, "Nurses would assess like any of our admits, once a shift except when they go to day training." E8 confirmed that nursing do all their documentation in Program Progress Notes. Surveyor had E8 review R27's Program Progress Notes dated 1/5/11 -1/10/1. E8 stated "They should have had more vitals taken/recorded. They (nurses) could have taken respirations, even when R27 was noncompliant." 4) Standing Medical Orders (Revised 8/10) states, "Notify physician of fever over 101." In review of R27's Program Progress Note 1/5/11-1/10/11, R27 had a temperature greater than 101 degree Farenheit as follows: 1/8/11 at 6:30 AM-T (temperature)102.8 "Talked with mom,states wanted her to have Tyl (Tylenol) et (and) push fluids, states she had a temperature a couple weeks ago." 1/8/11 at 12:00 noon-"T 103.4 Tyl (Tylenol) liquid given talked with mother, says she rather she	W9999		

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(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
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wasn't sent ER. Feels she's fighting off a bug."
1/8/11 at 12:45 PM- "Z1 here reported given on elevated temp. His recommendation (arrow pointing up) temp goes back to 102, call mother et recommend to send to ER (emergency room) for labs and evaluation." (typed as written)
1/9/11 at 6:00 AM- 101.1
1/10/11 at 7:00 AM-101.3

Further review of R27's Program Progress Notes, dated 1/5/11-1/10/11, nursing documented that Z1 was given a report on R27's elevated temperatures taken on 1/8/11 at 6:30 AM and 12:00 noon until 1/8/11 at 12:45 PM. There was no further evidence of written documentation that Z1 had been notified of R27's elevated temperatures taken on 1/9/11 or 1/10/11. There is no written evidence that Z1 was notified of R27's abnormal SpO2 (Saturated Peripheral Oxygenation), respiratory status, lung sounds, hydration or other vital signs per review of Program Progress Notes dated 1/5/11-1/10/11.

In interviews on 1/18/11 at 3:42 PM and 1/19/11 at 3:38 PM with E8/Health Services Supervisor, when surveyor requested policy on elevated temperature, E8 stated that nurses would follow PRN Protocol. E8 presented the surveyor with a copy of "Standing Medical Orders" (Revised 8/10) and stated this was their PRN protocol that nurses would follow. E8 confirmed that Standing Medical Orders state to notify the Physician of temperatures greater than 101.

5) Review of R27's Program Progress Notes, dated 1/5/11- 1/10/11, showed the following assessment of R27's pulmonary status were

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documented:
1/5/11 (no time) Admission Note states "Lungs Clear"
1/8/11 6:30 AM, states "T (temperature) 102.8 R (respirations) 20 P(pulse) 125 SpO2 (Saturated Peripheral Oxygenation) 80- 83 approx. (approximately). "
1/10/11 1:05 AM- " T 97.6 Resp (respirations) 18"
1/10/11 5:05 AM- "T 98.2 Resp 18"
1/10/11 7:00 AM- "T 101.3 P 120- Resp 40 unable to obtain pulse ox due to physical condition 140/80 BP by leg. Skin pale resp. labored."

Further review of Program Progress Notes, dated 1/5/11- 1/10/11, show no further written documentation of assessing R27's pulmonary status related to elevated temperature or the SpO2 reading of 80- 83 could be found.

In an interview with E9/Licensed Practical Nurse on 1/19/11 at 10:14 AM, E9 stated, "SpO2 (Saturated Peripheral Oxygenation) was difficult to get due to R27 only having 2 nubby (short) fingers. Couldn't get it on ear or toe." E9 further stated, "Unsure if blood pressure was accurate, I had to get it on her leg, due to no antecubital."

In an interview with E8/Health Services Supervisor on 1/19/11 at 3:38 PM, E8 confirmed that all nursing documentation would be found in the Program Progress Notes. When asked about nursing documenting R27 refusing vitals, E8 stated "They (nursing) could have taken respirations when R27 was noncompliant." When asked if she would expect further assessment of R27's respiratory status such as

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auscultating lungs sounds, E8 stated, "Normally they do. I would expect respirations to be assessed." E8 confirmed she could not present further evidence that nursing assessed R27's pulmonary status.

6) Program Progress Note of 1/10/11 states, "1:05 AM fell beside room mate bed on (L) (left) side of body apparently struck (L) side of head. No apparent S/S (signs or symptoms) injury. T97.6 Resp 18 Neuro (Neurological) sheet started. 5:05 AM Temp 98.2 resp Alert to physical stimuli- good eye control."

Neuro Check Floor Sheet (Form #P-75 Adopted 07/00) has a column for Vital Signs of Temperature, Pulse, Respirations and Blood Pressure to be documented. The documentation for R27 for 1/10/11 at 1:05 AM and 5:05 AM are temperature and respiration, no evidence of pulse or blood pressure documented. The Neuro Check Floor Sheet also has a column for Pupil Reaction (Brisk,quick,Sluggish or None). There is no written documentation in the Pupil reaction column for R27.

On the bottom of the Neuro Check Floor Sheet, under Vital Signs, it states, "Immediately report to physician or transfer to emergency services if the resident has: a) a rise in blood pressure, b)bradycardia, c)altered respiratory rate or rhythm, d) severe headache. These are the signs of impending intracranial crisis and Immediate emergency treatment is required."

In review of the Neuro Check Floor Sheet (dated 1/10/11) and the Program Progress Notes (dated 1/10/11) there is no written evidence that

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nursing assessed R27's blood pressure, pulse, pupils or full level of consciousness (oriented to person and place) on 1/10/11 at the 1:05 AM or 5:05 AM neuro checks.

In an interview with E8/Health Services supervisor on 1/18/11 at 3:42 PM, when asked about the Neuro Check Floor Sheet for R27, E8 stated "Those areas should have been filled out." E8 could not provide any additional evidence that nursing fully assessed neurological status.

7) In review of R27's Program Progress Notes, dated 1/5/11-1/10/11, R27 developed an elevated temperature of 102.8 on 1/8/11 at 6:30 AM. R27 had 8 more incidents of elevated temperatures documented running between 100 degree to 101.3 degree from 1/8/11 - 1/10/11 per Program Progress Notes.

In review of the fluid intake documented on Program Progress Notes, R27 drank the following:
1/8/11 6:30 AM- 3 glasses water (no measurement)
1/8/11 8:45 PM - 1/2 glass water
1/9/11 AM-120 cc chocolate milk, noon glass of water
1/9/11 8:40 PM- 1/2 glass fluid
1/10/11 (no time) 1 can ensure

In interviews with E9/Licensed Practical Nurse on 1/18/11 at 4:31 PM and 1/19/11 at 10:14 AM, E9 stated, "I was concerned about intake." When asked whether she assessed skin turgor for signs of dehydration, E9 stated, "No." When asked how facility monitored R27's intake, E9 stated "They (direct care staff/Team Lead) would inform nurse

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if they're (residents) not eating, drinking or having stools." When asked how these things are documented, E9 stated, "They (direct care staff/Team Lead) would document in Program Book. I'm not sure how they do it for the visitors. Team Lead has told us what they eat and drink."

In an interview with E8 on 1/19/11 at 3:38 PM, E8 confirmed that documentation of resident's status would be in Program Progress Notes. E8 further stated, "I hadn't thought of an I&O (intake and output). E8 was unable to provide any further evidence of documentation that nursing assessed R27 for signs of dehydration related to elevated temperatures and minimal fluid intake.

Program Progress notes state that R27 was refusing vitals outside of temperatures. There was no written evidence that nursing were assessing for signs of dehydration. (Examples-apical pulse, skin turgor, color of skin, skin temperature to touch, specific monitoring of fluid intake/ output).

8) R27's Program Progress Note of 1/8/11 at 6:30 AM state, "T (temperature) 102.8 R (respirations) 20 P (pulse) 125 SpO2 (Saturated Peripheral Oxygenation) 80 - 83 approx. (approximately) Tyl (Tylenol) given 3 glasses of H2O (water) given, abd (abdomen)soft. Sleeping in recliner through noc (night). Talked with mom, states wanted her to have Tyl (Tylenol) et (and) push fluids, states she had temp a couple weeks ago."

R27's Program Progress Note of 1/8/11 at 9:00 AM states, "T 103.4 Tyl liquid given talked with

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mother , says she'd rather she wasn't sent to ER (emergency room). Feels she's fighting off a bug. Will continue to push fluids." (typed as written)

R27's Program Progress Note of 1/8/11 at 12:45 PM states, "Z1/ Physician here reported given on (arrow pointing up/elevated temp). His recommendation (arrow pointing up) temp goes back to 102. call mother et recommend to send to ER for labs and evaluation." (typed as written)

In an interview with E9/ Licensed Practical Nurse on 1/18/11 at 4:31 PM, E 9 stated, The first elevated temperature, I called Physician who said to send to ER. I talked with mother and explained the facility's protocol. Z2 said that R27 felt warm over the holiday and that she gave her Tylenol. She (Z2/guardian) felt it was a flu bug, told me to give Tylenol and that she (Z2) would rather not send to ER." E9 further stated, "I talked with Z1 and reported the second elevated temperature, at which time Z1 told me that if temperature goes to 102 to call mom and send to ER."

In an interview with E10/ Social Service Director on 1/18/11 at 4:42 PM, E10 stated, "E9/Licensed Practical Nurse called and talked with me. She (E9) didn't know what to do, since she (R27) wasn't admitted. I explained to mother that our policy would be that R27 would be sent to Emergency Room to be evaluated. I said to Z2/ guardian she has a temperature of 102.8. Z2 said, then the body is doing what it's suppose too, it's fighting the infection." When asked if R27 had been a resident rather than visiting would things had been different, E10 responded, "She would have gone to the hospital."

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In an interview with E9 on 1/19/11 at 10:14 AM, E9 stated "When I gave Tylenol and the temperature went up instead of down, that really concerned me. Z1 asked on Sunday (1/9/11) how R27 was doing. I told him that the temperature broke on Saturday night (1/8/11). He (Z1) stressed again that the fever from the day before-He (Z1) basically said I really need to push mom to send out if fever persists."

In an interview with Z1/Physician on 1/20/11 at 9:02 AM, Z1 stated, "Yes the nurse told me about her (R27's) status. I strongly recommended that they send her out to ER. The nurse said that the mother did not want to send her out." Z1 further stated, "I gave nurse parameters and told her to contact mother and encourage to send out." When asked about policy/practice to send out if temperature greater than 101, Z1 stated, "Not always, if family doesn't want aggressive measures due to multiple deformities and has Health Care Power Of Attorney and they want treatment at the square (facility), then we would honor their wishes. For all we knew they had Power of Attorney." Z1 stated that R27 was admitted to local hospital for Pneumonia and died after extensive respiratory failure.

In an interview with E8/Health Services Supervisor on 1/19/11 at 3:38 PM, surveyor asked E8 if there was a policy that states individuals are sent to Emergency Room for temperatures over 101.0 degrees. E8 stated, "There's no policy. In training they (nurses) are taught to follow the Standing Orders. To call MD (Medical Doctor/ Z1. He (Z1) always sends to ER (emergency room) for temperature greater

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than 101."

Standing Medical Orders (Revised 8/10) states, "Notify physician of fever over 101."

9) Reviewed Policy # 3.09 Admission Process and Orientation of New Residents (Revised 5/07) which states the following:

Under section titled Policy; 7. "The facility will only admit individuals whose needs can be met by the facility."

Under Section titled Procedure the policy states:

A. Referral and Admission Process

Referral: Applications for admission are to be made with the Social Services Director in the facility. The Social Services Director shall assure that all needed information is obtained. Required information shall include at least a current comprehensive physical and a social/psychological evaluation. This information shall be reviewed by the Interdisciplinary Team for consideration for establishing an overnight visit for the purpose of further evaluation.

B. Overnight Visit

The Social Services Director sets up a date for the resident to make an overnight visit to the facility and the community workshop.

The Resident Services Director, Social Services Director, the Department heads and the community workshop are informed by the Social Services Director of the names and dates for

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visits.

A checklist form is filled out by the Team Leader observing visitor and given to the Program Director.

Reviewed Policy # 3.20 New Residents/ Visiting Residents Introduction (Revised 10/91) which states how staff will orientate the new resident/visitor to the facility.

Reviewed Documentation for Overnight Visitor (no date) provided to surveyor by E8/ Health Services Supervisor on 1/20/11 at 8:15 AM, states the following :

Overnight Guests:
Physical assessment upon Arrival
Entry on nurses note sheets with reiteration of information obtained during assessment, placement, medications, diet and complete diagnosis.
Document each shift to include vital signs during entire stay.
Be sure to include any behaviors to nursing care and /or medication acceptance

In an interview with E1/Administrator on 1/20/11 at 12:01 PM, E1 confirmed there were no other policies regarding individuals visiting the facility. E1 further stated, "Our policy does not give specific guidelines on our visitors."

In review of R27's Program Progress Notes dated 1/5/11-1/10/11, R27 developed an elevated temperature of 102.8 on 1/8/11 at 6:30 AM with a SpO2(Specific Peripheral Oxygenation) of 80- 83. The Program Progress

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W9999	Continued From page 72 Notes dated 1/5/11- 1/10/11 documents nursing notified Z1/physician of R27's elevated temperature after the initial elevated temperatures on 1/8/11. In an interview with Z1 on 1/20/11 at 9:02 AM, Z1 had encouraged facility to send R27 to Emergency Room on 1/8/11 for evaluation, but due to Z2's/guardian request (not to send R27 to Emergency Room) facility did not send R27 for evaluation. R27 had 8 more incidents of elevated temperatures documented running between 100 degree to 101.3 degree from 1/8/11 - 1/10/11 per Program Progress Notes. There is no written evidence that nursing notified physician of R27's abnormal SpO2, lung sounds, hydration status or further elevated temperatures after the initial elevated temperature. Per Program Progress Note of 1/10/11 at 7:30 AM, R27 was sent to local hospital per ambulance for respirations of 40 and labored, temperature 101.3 , pulse 120, and pale skin. R27 arrived at the local hospital emergency Room at 8:12 AM on 1/10/11 and was admitted to Intensive Care Unit for Acute Respiratory Failure secondary to Pneumonia. Z2/guardian requested that R27 be transferred to pediatric medical facility. R27 was airlifted and arrived at the pediatric medical facility at 7:37 PM. During airlift transport from local hospital to pediatric medical facility R27 became bradycardic and CPR (cardiopulmonary resuscitation) was started. R27 expired in the Emergency Room at the pediatric medical facility on 1/10/11 at 8:06 PM from respiratory failure secondary to bronchopneumonia. These failures resulted in a delay in medical treatment for R27. (A)	W9999		

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350.620a)
350.1230b)3)5)7)
350.1230d)2)

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:
The DON shall participate in:
3) Periodic reevaluation of the type, extent, and quality of services and programming.
5) Training in habits in personal hygiene and activities of daily living.
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

d) Direct care personnel shall be trained in, but are not limited to, the following:
2) Basic skills required to meet the health needs and problems of the residents.

These Regulations were not met as evidenced by:

Based on observation, interview and record review the facility did not provide nursing services in accordance with their needs for 7 of 9 in the sample (R1- R7) and 19 outside the sample (R10 - R26, R28 and R29) when the facility failed to ensure:

a) clients are trained in the personal habit of handwashing prior to eating for R3 and R4, and R10--R26; and did not encourage or enable R4 to wash his hands after using the restroom.

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b) documentation of bowel movement monitoring is completed for R1-R7 who receive medication for elimination, have diagnoses of constipation and/or bowel disorder;

c) R4, who is confined to a wheelchair, has his repositioning need met.

d) evidence of documenting wound care assessment and monitoring or documenting the specific treatment given is completed for R28 and R29.

Findings include:

1. During 1/18/11 3:20 PM--5:35 PM observation, individuals R3, R4, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25 and R26, who ate their evening meal in the facility's second floor dining room, did not wash their hands prior to eating, nor were they encouraged to do so by the direct care staff.

The Residential Service Director (RSD) E2, during 1/18/11 5:35 PM interview, stated that she did not know which clients washed their hands prior to eating, that it is not part of their routine to do so and that it was definitely something she would have to look into.

R4, according to 8/25/10 Individual Service Plan, has an IQ (Intelligence Quotient) of 60. He "is verbal and easily able to make his needs and/or wants understood." R4 "utilized complex sentences to communicate within his environment."

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R4, during 8:24 AM 1/19/11 observation, was taken to the bathroom adjacent to his bedroom by Team Leader, E3. E3 used a sit to stand lift to remove R4 from his wheelchair to the toilet stool where R4 had a bowel movement. E3 then transferred R4 back to his wheelchair and dressed him. No handwashing occurred. E3 stated, at 8:32 AM on 1/19/11, when asked by the surveyor why R4's hands were not washed after using the restroom, that R4 cannot reach the sink based on the size of the room. R4, per 1/19/11 8:01 AM interview, stated that he uses a urinal and would be able to wash his own hands if the sinks were in reach.

Per 1/19/11 8:15 AM observation, R4 was observed to grab the wheelchair bars and soiled wheelchair tires to propel his wheelchair without appropriate handwashing.

2. By record review and interview, there is no evidence of nursing staff assessing/monitoring bowel functioning, for individuals who receive medications such as stool softeners, laxatives or have history of bowel disorders.

A) The 8/25/10 Individual Service Plan (ISP) identifies R4 as a 56 year old verbal male who uses a wheelchair for mobility. This ISP further identifies that R4 has diagnoses that include in part, Spastic Quadriplegic, Cerebral Palsy, Functional Bowel Disease, and Gastritis. According to the 12/1/10 Physician Order Sheet (POS) R4 takes a daily capsule of Metamucil (bulk forming laxative) for elimination and Milk of Magnesia Suspension (laxative) 30cc's by mouth at bedtime if no BM (bowel movement) that day.

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ST MARY'S SQUARE LIVING CENTER	239 SOUTH CHERRY GALESBURG, IL 61401

(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
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B) R3, per 9/1/10 ISP, is a 63 year old ambulatory, nonverbal male who has "frequent bouts of diarrhea and has developed sores on his backside." This ISP further states R4 has a diagnoses, in part, of Gastritis, surgical /procedure (S/P) of Small Bowel Restriction (resection) for Release of Adhesions, History of Upper Gastrointestinal (GI) bleeding and Chronic Diarrhea. According ISP, he is on a general diet with prune juice and bran cereal.

C) The 8/24/10 six month review ISP states that R6 has the diagnoses, in part of Gastritis, Constipation, and has a Gastrostomy Tube in place. This plan further identifies that R6 takes the stool softener Docusate 150mg BID, receives Fibersource Liquid TID and a Fleets Enema every 3 days as needed (PRN).

D) Based on R1's Physician's Order Sheet (POS) dated 12/1/10, R1 is a 69 year old individual who functions at a mild level of mental retardation. Based on R1's POS, R1 has additional diagnoses of history of GI (gastrointestinal) Bleed and Constipation. R1 receives the following medications for promotion of bowel movements: Polyethylene Glycol 3350 PO one powd (powder) by mouth every morning and Metamucil Capsule take 1 capsule by mouth daily.

E) Based on R2's Physician's Order Sheet (POS), dated 11/1/10, R2 is a 79 year old individual who functions at a moderate level of mental retardation. Based on R2's POS, R2 has additional diagnosis of Constipation. R1 receives the following medications for promotion of bowel movements: Miralax OTC (over the counter)

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take 17 grams by mouth once daily with 8 oz (ounces) H2O (water) and Metamucil Capsule take 1 capsule by mouth twice daily.

F) Based on R5's Physician's Order Sheet (POS), dated 12/1/10, R5 is a 70 year old individual who functions at a profound level of mental retardation with additional diagnoses of Constipation and Hemorrhoids. R5 receives the following medication for promotion of bowel movements: Polyethylene Glycol 3350 PO Take 17 gram(s) per G-tube (Gastric) twice daily.

G) Based on R7's Physician's Order Sheet (POS) , dated 12/1/10, R7 is a 70 year old individual who functions at a profound level of mental retardation with an additional diagnosis of Constipation. R7 receives the following medication for promotion of bowel movement: Polyethylene Glycol 3350 PO Take 17 gram(s) by mouth once daily w/ H2O (with water).

License Practical Nurse (LPN), E13, stated during 1/19/11 3:18 PM interview that the Team Leaders (direct care staff) keep tract of individuals' bowel movements every shift. E13 stated it is reported to Program Directors (supervisors) and then they report it to the next shift.

The Program Director, E14, during 1/19/11 3:25 PM interview, stated that "they do not actually keep any bowel movement documentation." E14 explained that the Team Leader (direct care staff) reports the bowel movement to their supervisor at the end of the shift. That supervisor leaves a report for the oncoming supervisor who then reports this to their team leaders and so forth.

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W9999	Continued From page 78 After the 3rd shift (midnights) is completed, the documentation is tossed. E14 stated that there is no actual BM documentation kept in the individuals' files. E14 confirmed that unless you were working the day before, you would not know which individuals had bowel movements. Per interview on 1/19/11 at 3:05 PM with E7/ Program Director, surveyor asked, "Do you have any documentation for BM's (bowel movements)?" E7 answered, "No one on 2nd floor has a BM doc (documentation) sheet." Surveyor asked, "How does med (medical) staff know of constipation, loose BM's, etc?" E7 answered, "Team Leader will let nursing know if loose stools or no BM." Surveyor asked, "How does nursing know how long since last BM?" E7 answered, "Nursing notes document about BM's on some of those." Surveyor asked, "Is there a protocol to inform nursing of BM condition?" E7 answered, "No, staff will let nursing know." Per interview on 1/19/11 at 3:17 PM with E6, Registered Nurse, surveyor asked, "Is there BM (bowel movement) monitoring?" E6 answered, "3rd floor, report of no BM's, and we (nursing) ask if watching someone special." Surveyor asked, "Any formal documentation of BM's?" E6 answered, "Not as far as I knowing it." Surveyor asked, "Is there a policy?"	W9999		

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E6 answered, "I don't think so."

3. A) R4, according to 8/25/10 Individual Service Plan, has an IQ (Intelligence Quotient) of 60. He "is verbal and easily able to make his needs and/or wants understood." R4 "utilized complex sentences to communicate within his environment."

During 1/19/11 8:01 AM interview, R4 informed the surveyor that he spends his whole day in his wheelchair (w/c) unless he has an open area. R4 stated that he sits in his w/c from approximately 6 AM until 8 or 9 PM except for when he needs to have a bowel movement. At that time, a sit to stand lift is use to take him to the toilet. R4 stated that he cannot shift his weight around in the wheelchair because the cushion is too high. R4 stated that he wished he could get in a lounge chair if one was available. R4 continued to say that he does not think "we have the financial ability to buy enough chairs." R4 stated "I don't want to lie about it but that's the way I look at it." R4 stated that a couple of months ago he had a sore on my bottom.

Even though, R4's 8/3/10 Braden Scale assessment identifies R4 as a low risk for developing pressure sores with a score of 17, he did develop an open area on 11/8/10.

Facility's 11/8/10 "Incident Investigation" states that "On 11/8/10 at 7:45 pm, R4 presents with a small open area to his lower right buttock." There is no further description of the open area such as it's size or depth.

11/8/10 nursing note, written on "Program

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Progress Note" form states "7:45 pm Resident presents with small open area to lower right buttock. Coccyx treatment applied."

Per review of 10/10 through 12/10 medication and treatment records there is no documentation of any treatment given to R4's open area as identified on the 11/8/10 incident investigation.

License Practical Nurse, E12, during a 1/20/11 8:37 AM interview stated that if using a PRN (as needed) medication, the nurses do not document it on the treatment sheet.

Per R4's 9/10 Standing Medical Orders it states the following:
"May use skin care products/or cleaners of choice which are appropriate for dermal abrasions, minor cuts, minor sunburns, minor burns, chapped, cracked, or wind-burned skin."

B) Based on Physicians Order Sheet (POS), dated 12/02/10, R28 is a 53 year old individual who functions at a profound level of mental retardation. R28 has additional diagnoses of: Down Syndrome, Dementia, Osteopenia, a history of Pneumonia and Failure to Thrive.

Per 1/18/11 3:18 PM observation, R28 has an small open area approximately 0.2 X 0.3 cm (centimeter) without drainage on her right buttocks. Determined by this observation, R28 is unable to reposition herself.

Per review of 1/19/11 repositioning documentation, R28 is positioned from side to side, and not on her back, every 2 hours. Per review of facility documentation R28 is

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repositioned every 2 hours around the clock due to R28's inability to reposition without assistance.

The Nursing staff documented, 1/6/11 at 7:35 AM, on the program progress notes, that R28 had three dime size open areas around her anus. The nurse further documented that Calmoseptine and Mycolog were applied and that she initiated side to side repositioning. However, the nursing staff, on this progress note and those made after (from 1/6/11 through 1/14/11), did not identify any specific measurements/monitoring of these open areas nor was there documentation of what specific treatment was provided by them. For the most part, these notes stated only that the open areas continue and that treatment was applied. The surveyor was unable to determine by this documentation whether or not R28's open areas were healing or what treatment was applied.

The Licensed Practical Nurse (LPN), E5, on 01/18/11 at 2:43 PM, stated that open areas (alter skin integrity) are documented on in the nursing notes (Program Progress Note). When the surveyor asked E5 where charting is done regarding clients with open areas measurements, E5 stated, "No we don't do that here, maybe we should, huh?"

C) Based on Physicians Order Sheet (POS), dated 11/01/10, R29 is a 73 year old with profound mental retardation. R29 has the additional diagnoses of a history of a Cerebrovascular Accident, repeated Pneumonia, GI (gastrointestinal) Bleed, Constipation, and Osteoporosis.

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On the BRADEN SCALE (for Predicting Pressure Sore Risk) completed on 09/08/10, R29 has a total score of 11. The BRADEN SCALE states that a total score of less than 12 identifies those at high risk for pressure sores.

According to the "RESIDENT PROGRESS NOTE," dated and signed on 09/12/10 by Physician, Z1, R29 was admitted to this facility with no documentation of any open areas.

On 11/14/10, it was identified by PROGRAM PROGRESS NOTE that R29 has a "dime sized blistered to his testicles." Five days later, on 11/19/10, per progress notes, R29 is identified to have a quarter size open area to his (L) (left) lower buttock and was referred, 12/7/10, to the Wound Care Clinic (WCC). Per Program Progress notes from 12/31/10 through 1/04/11, R29 was hospitalized for pneumonia and readmitted back to the facility on 01/04/11 at 9:00 PM, with this open area to left buttocks. The 1/4/10 9:00 PM note states "open area continues to L (left buttock) no other open areas."

The "GENERAL ULCER ASSESSMENT" (dated 01/13/11) from the Wound Care Clinic, describes R29's open area to left buttocks at 1.1 X 0.7 X 1.0 cm (centimeter).

Per review of the nursing documentation of R29's left buttock's open area, on the Program Progress Note, from 1/4/11 to 1/17/11, there is no specific assessment of the wound's size, color or drainage.

Per interview with E8, Health Services Supervisor, on 01/10/11 at 3:38 PM, E8 stated