STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145694	A. BUILDING _____ B. WING _____	C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

(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 1172274 / IL53851- No deficiency 1172388 / IL53979- F224, F309, F333, F501 Incident of 6/17/11- IL54014- F279, F309, F501 A partial extended survey was conducted	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to thoroughly verify a new resident's name was listed correctly on the hospital transfer sheet and all the hospital medication administration records prior to transcribing the medication orders from these records to the facility's Physician's Order Sheet. This is for 1 resident (R7) out of 11 reviewed for physician admission orders, in the total sample of 20. This failure resulted in R7 receiving multiple medications prescribed for another patient at the hospital from where she was discharged. R7 continued to receive these medications for five days after her admission. This caused an elevation of R7's potassium to a critical level. R7 was admitted to the intensive care unit in serious	F 224		8/16/11

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

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F 224	Continued From page 1 condition with diagnoses of Hyperkalemia, Acute Renal Failure and Bradycardia. This failure has the potential to affect all residents admitted to the facility. The findings include: R7 was admitted to the facility on 4/6/11 from a local hospital according to nursing notes dated 4/6/11. The hospital erroneously sent medication documentation for another patient from the hospital (Z3) along with medication documentation for R7. R7 and Z3's names are very similar, but there birth dates are different. R7's name and birth date appear on the top of the "Medication Administration Record" followed by a list of R7's medications. Z3's name and birth date appear on the top of the "Medication Reconciliation/Physician Order Form" followed by a list of Z3's medications. E8 (Nurse) was the admitting nurse according to documentation on the facility's Physician's Order Sheet (POS). On 8/3/11 at 2:00 PM E8 confirmed she did not verify R7's name and birth date on the medication documents sent from the hospital. E8 said she transferred the orders from the Physician Order Form (Z3's medications) onto the facility's POS. E8 said she noticed additional medications were listed on the Medication Administration Record (R7's medications) and called Z2 (Physician/Medical Director) for clarification of the orders. E8 said she pointed out to Z2 that R7 did not have a diagnosis for some of the medications listed on the Physician's Order Form (Z3's medications). E8 said she also questioned the multiple orders for diuretics. E8	F 224		

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F 224	Continued From page 2	F 224		

said that when she told Z2 the medications did not make sense, Z2 said, 'I am the doctor and you are the nurse and told her to continue the medications. E8 combined the medications on the two lists and wrote them on the facility's POS. E8 said she still felt strongly the medications were not right and passed on her concerns to the next shift. E8 said she did not inform the Director of Nursing about her concerns and did not follow-up or pursue her concerns any further.

On 8/11/11 at 8:50 AM E2 (Director of Nursing) stated she expects her staff to contact her when they suspect inconsistencies in residents medication orders. E2 said if E8 had contacted her she would have called the supervisor at the hospital to obtain additional information and clarification regarding R7 medications.

According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were transcribed from Z3's hospital physician transfer orders:

- Metoprolol Succinate (Toprol XL) 100 mg at 8:00 AM on 4/9, 4/10 and 4/11/11.
- Lisinopril 20 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10; and at 8:00 AM on 4/11/11.
- HCTZ 50 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Duricef 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Lactulose 20 mg/30 mL at 4:00 PM and 8:00 PM on 4/7/11; and 8:00 AM, 11:00 AM, 4:00 PM and 8:00 PM on 4/8/11. (R7 did not have a diagnosis of Constipation)
- Ranitidine 150 mg at 8:00 AM on 4/7, 4/8, 4/9/

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F 224	Continued From page 3 4/10 and 4/11/11. - Janumet 1000 mg/50 mg at 7:00 AM and 4:00 PM on 4/7, 4/8, 4/9/11; and 7:00 AM on 4/10/11 and 4/11/11. (This order was changed on 4/10/11 to reduce the 4:00 PM dose to 500 mg/ 50 mg). R7 received Janumet 500/50 mg on 4/11/11 at 4:00 PM. (R7 did not have a diagnosis of Diabetes) According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were from R7's hospital physician transfer orders: - Furosemide (Lasix) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Spironolactone (Aldactone) 50 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10, 4/11/11. - Metolazone (Zaroxolyn) 5 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10, and 4/11/11. - Potassium Chloride 20 mEq at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Allopurinol 300 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Enoxaparin (Lovenox) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Gabapentin (Neurontin) 300 mg at 8:00 AM, 11:00 AM and 8:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Magnesium-oxide (Mag-Ox) 400 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Alendronate Sodium (Fosamax) 70 mg at 6:00 AM on 4/8/11. - Vitamin D 2800 units at 6:00 AM on 4/8/11 - Naproxen 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Fentanyl 100 mcg/patch at 6:00 AM on 4/9/11.	F 224		

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F 224	Continued From page 4 - Multivitamin with mineral at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Prostat 64 30 mL at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. R7 received the incorrect medications for a period of 5 days. R7 was sent to the emergency room on 4/11/11 at 6:30 PM because of a critically elevated Potassium level of 7.8 (3.7 - 5.1 mEq/L) according to nursing note documentation and the laboratory report dated 4/11/11. In the emergency room R7's Potassium level was 8.6 mEq/mL, her Blood Urea Nitrogen level was 84, and her Creatinine level was 4.4 according to the emergency department notes dated 4/11/11. R7 was admitted to the intensive care unit in serious condition with diagnoses of Acute Renal Failure, Hyperkalemia and Bradycardia according to the 4/11/11 Emergency Department note. E2 (Director of Nursing) was interviewed on 8/3/11 regarding the facility's system for verifying residents identification. E2 said the nurses use a Nurse Admission Checklist when admitting a new resident. Additionally, E2 said there is a DON Admission Checklist that is to be completed by the DON. E2 confirmed neither of these forms contain a requirement to check the resident's name and birth date. E2 said both forms are currently being revised to include a requirement to check the resident's name and birth date. E2 said the DON Admission Checklist was completed for R7 the day after R7's admission (4/7/11) but the error was not identified. Elsevier (2011) warns against using an ACE inhibitor (Lisinopril) concomitantly with Spironolactone citing, "Coadministration of ACE	F 224		

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F 224	Continued From page 5 inhibitors and spironolactone, even in the presence of a diuretic, has been associated with severe hyperkalemia." Elsevier also warns about drug to drug interactions between Lisinopril and Furosemide, and Lisinopril and Naproxen. The Nursing 2011 Drug Handbook (Lippincott) also warns combining Lisinopril with potassium sparing diuretics (Spironolactone) or Potassium Supplements (Potassium Chloride), may cause hyperkalemia. Lippincott also identifies a drug to drug interaction with Allopurinol. Lippincott is the nursing drug handbook used at the facility. On 8/3/11 at 11:30 AM R7 was interviewed in her room. R7 stated she does not remember much from her stay at the nursing home between 4/6 - 4/11/11 other than she was tired all the time.	F 224		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		8/25/11

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F 279	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observation the facility failed to develop care plans with specific interventions to address aspiration precautions for residents assessed by speech therapy to have dysphagia/difficulty swallowing. This is for 3 of 3 residents reviewed for aspiration precautions (R6, R8, and R10), in the total sample of 20. The findings include: -Review of R6's nursing notes dated 6/17/11 at 10:00 A.M. documents "Reported trouble swallowing to Z4 (Speech Therapist) on AM shift after RN on nights mentioned she had trouble swallowing with thin liquids." Z4's swallowing evaluation dated 5/6/11 shows R6's treatment diagnosis was Dysphagia-plan of treatment included patient/staff training of skilled competencies techniques for safe swallow with 100% return demonstration. Weekly progress notes from 5/24/11 through 6/17/11 documents the following: swallow delay- YES, 2-3 seconds gurgly vocal quality- YES, audible swallow at times Skilled therapy techniques- compensatory	F 279		

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swallow techniques/aspiration precautions, cues to orally transit bolus/masticate/cues to swallow, cues verbal/visual/tactile

Review of R6's daily record of treatment shows Dysphagia treatment was completed on 6/1/11, 6/2/11, 6/3/11, 6/6/11, 6/7/11, 6/8/11, 6/9/11, 6/10/11, 6/12/11, 6/13/11, 6/15/11, 6/16/11, and 6/17/11.

Interview with Z4 on 8/4/11 at 11:00 A.M., Z4 stated, "R6 was frail, weak and had an audible swallow. It was an effort for her to chew and swallow, took her along time, she had trouble eating, ongoing difficulty with swallowing. This is why she was on aspiration precautions. R6's swallow evaluation indicated staff was to provide compensatory swallowing techniques. This means staff was to cut up her food, supervise her in the ADR (assisted dinning room), cue her to alternate diet with solids and liquids and aspiration precautions were to be implemented."

E9 (Dietary Service Supervisor) stated on 8/4/11 at 1:00 P.M., " I give my CAA (Care Area Assessment) to data entry and I'm done. I am not responsible for the plan of care."

E3 (Nurse-care plan coordinator) stated on 8/4/11 at 12:45 P.M., "Each discipline is to complete a care plan input sheet and then submit it to data entry. E9 wrote the CAA for R6 and she should have developed a plan of care relating to R6's difficulty with swallowing, but it was R6 required feeding or cueing during meals."

E12(RN) stated on 8/4/11 at 1:12 P.M., "I get my information for developing interim care plans from

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the physician order sheet, hospital transfer sheet-no where else. If we get telephone orders and update the interim care plans. R6's interim care plan did not include swallowing precautions."

E2 (DON) stated on 8/4/11 at 1:55 P.M., "Dietary is responsible for care planning swallowing problems identified on the CAA's. Aspiration precautions should have been listed in R6's care plan but it was not."

E4 (RN) stated on 8/3/11 at 2:30 P.M., "R6 was alert and orientated, frail, fed herself, no adaptive equipment or aspirations precautions required. I have been working with R6 for about one year. R6 did have a diagnosis of swallowing difficulty, was on a soft diet but it was nothing to worry about."

R6's Minimum Data Set (MDS) dated 5/24/11 under section K-swallowing/nutritional status assessed R6 as having "complaints of difficulty or pain with swallowing." Care Area Assessment (CAA) dated 5/25/11 shows R6 has functional problems that affect ability to eat: Swallowing problem; proceed to care plan. R6's MDS dated 6/3/11 documents she requires supervision and setup to eat. Review of R6's interim plan of care and plan of care dated 6/14/11 did not include interventions related to her swallowing difficulty. R6's plan of care shows she received a mechanical diet and allow adequate time to chew/swallow. No further interventions were included or implemented. Review of the speech therapy evaluation dated 5/6/11 recommends to cut up her food, supervise her in the ADR, cue her to alternate diet with solids and liquids and aspiration precautions, these recommendations

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F 279	Continued From page 9 were not included in R6's care plan. -R10 is a 75 year old female admitted to the facility on 7/13/11 with diagnoses which included Dysphagia and oropharyngeal. Review of R10's interim care plan shows she required a comprehensive assessment and management for the following conditions/diagnoses which included dysphagia. R10's interim care plan (only care plan developed) did not include interventions related to dysphagia or aspiration precautions. R10's most recent MDS dated 7/20/11 documents R10 is independent with eating but requires assistance with setup. R10's MDS under section K-swallowing/nutritional status assessed R10 as having "complaints of difficulty or pain with swallowing." Care Area Assessment (CAA) dated 7/25/11 shows R10 has functional problems that affect ability to eat: Swallowing problem; proceed to care plan. Review of R10's therapy progress note dated 7/27/11 documents the treatment diagnosis is dysphagia-swallowing delay is yes, mild gurgly sound and her cough/throat is not clear. R10 is on a mechanical soft diet with thin liquids- to continue with dysphagia goals. The pink card on the dietary door in the ADR read: R10 - diet is level puree with thin liquids, small sips/bites (1/2 tsp.), alternate between liquid/food, check dentures are in and fitting well-encourage intake. Review of R10's speech therapy progress notes documents R10's diet order changed 7/20/11 - "add a plate guard for all meals." Observation on 8/4/11 at 12:20 P.M. to 12:35	F 279		

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P.M., E11 (CNA) was observed sitting at the table with R10. R10 took six bites of chocolate pudding, one bite of meat, four drinks of coffee and three drinks milk from a cup. R10's food was presented in bowls, not on a plate with a plate guard. E11 did not provide any cues or encouragement to R10 during this meal observation. E11 then removed R10 from the dining and took her to her room and removed R10's denatures. E11 said, " I know R10 is on aspiration precautions and she's supposed to alternate between liquids and solids-every other bite. I did not give her any cues today because she does not feel good."

E3 said on 8/4/11 at 12:38 P.M., "Swallowing precautions was not developed on R10 interim care plan. Restorative nurse does the initial care plan, E12 did R10's care plan. No swallowing care plan has been developed."

R8 was admitted to the facility on 6/3/11 with multiple diagnoses, including Dysphagia according to the 6/13/11 Minimum Data Sets (MDS). R8 has a history of aspiration precautions and is seen by the Z4 (Speech Therapist) for a diagnosis of Dysphagia according to the Speech Progress Note dated 8/2/11. Z4 recommended specific aspiration precautions for R8, including the recommendation to sit upright at a 90 degree angle while eating and for 30 minutes after a meal, snack or drink; alternating between liquid and food; chin tuck with every liquid swallow, and no straws, according to documentation on ASPIRATION PRECAUTIONS form completed by Z4 and posted at the point of meal service. R8's care plan only documents two

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F 279	Continued From page 11 of the four interventions recommended by Z4. On 8/4/11 at 12:38 PM E3 (Care Plan Coordinator) confirmed R8's care plan did not include all of the aspiration precaution interventions recommended by Z4. R8 was interviewed in her room on 8/4/11 at 12:20 PM. R8 said she had just finished eating some food her niece had brought her. When R8 was asked if there was anything she had to be aware of when eating, she responded she only has to tuck her chin when swallowing.	F 279		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, 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 interview and record review the facility failed to thoroughly verify a new resident's name was listed correctly on the hospital transfer sheet and all the hospital medication administration records prior to transcribing the medication orders from these records to the facility's Physician's Order Sheet. This is for 1 resident (R7) out of 11 residents reviewed for physician admission orders, in the total sample of 20, and has the potential to affect all new residents admitted to the facility.	F 309		8/12/11

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This failure resulted in R7 receiving someone else's medications, in addition to her own, for 5 days. This caused an elevation of R7's potassium to a critical level. R7 was admitted to the intensive care unit in serious condition with diagnoses of Hyperkalemia, Acute Renal Failure and Bradycardia.

E1 (Administrator) was notified of an immediate jeopardy at F309 on 8/3/11 at 2:45 PM. The immediate jeopardy began on 4/6/11 and was removed on 8/3/11 at 7:30 PM. Although the immediacy was removed on 8/3/11, the facility remains out of compliance at a severity level 2 due to the need to evaluate the implementation of the new nursing admission checklist and the DON Admission Checklist audit tool.

The findings include:

R7 was admitted to the facility on 4/6/11 at 9:15 PM from a local hospital according to nursing notes dated 4/6/11. The hospital erroneously sent medication documentation for another patient from the hospital (Z3) along with medication documentation for R7. R7 and Z3's names are very similar, but their birth dates are different. R7's name and birth date appear on the top of the "Medication Administration Record" followed by a list of R7's medications. Z3's name and birth date appear on the top of the "Medication Reconciliation/Physician Order Form" followed by a list of Z3's medications.

E8 (Nurse) was the admitting nurse according to documentation on the facility's Physician's Order Sheet (POS). On 8/3/11 at 2:00 PM E8

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confirmed that she did not verify R7's name and birth date on the medication documents that were sent from the hospital. E8 said she transferred the orders from the Physician Order Form (Z3's medications) onto the facility's POS. E8 said she noticed that additional medications were listed on the Medication Administration Record (R7's medications) and called Z2 (Physician/Medical Director) for clarification of the orders. E8 said she pointed out to Z2 that R7 did not have a diagnosis for some of the medications listed on the Physician's Order Form (Z3's medications). E8 said that she also questioned the multiple orders for diuretics. E8 said that when she told Z2 that the medications did not make sense, Z2 said, 'I am the doctor and you are the nurse' and told her to continue the medications. E8 combined the medications on the two lists and wrote them on the facility's POS. E8 said that she still felt strongly that the medications were not right and passed on her concerns to the next shift. E8 said that she did not inform the Director of Nursing about her concerns.

The following physician transfer orders were for Z3, but were transcribed to R7's POS on admission to the facility:
Metoprolol Succinate 25 mg (Toprol XL), dose = 100 mg daily
Lisinopril 20 mg, dose = 20 mg twice daily
Hydrochlorothiazide 50 mg (HCTZ), dose = 50 mg daily
Duricef 500 mg, dose = 500 mg twice daily
Venlafaxine Hydrochloride 75 mg (Effexor XR), dose = 75 mg three times daily
Lactulose 20 gm/30 mL, dose = 20 gm four times daily
Ranitidine Hydrochloride 150 mg, dose = 150 mg

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F 309	Continued From page 14 daily Sitagliptin-Metformin 1000/50 mg (Janumet), dose - 1 tab twice daily The following physician transfer orders were R7's and were also added to R7's POS on admission to the facility: Furosemide 40 mg (Lasix), dose = 40 mg daily Spironolactone 25 mg (Aldactone), dose = 50 mg twice daily Metolazone 5 mg tab (Zaroxolyn), dose = 5 mg daily Potassium Chloride 10 mEq, dose = 20 mEq twice daily Allopurinol 300 mg (Zyloprim), dose = 300 mg daily Enoxaparin 40 mg/0.4 mL syr (Lovenox), dose = 40 mg daily Gabapentin 300 mg cap (Neurontin), dose = 300 mg daily Magnesium-oxide 400 mg tab (Mag-Ox), dose = 400 mg twice daily Alendronate Sodium 70 mg (Fosamax), dose = 70 mg once a week Vitamin D 400 units tab, dose = 2800 units once a week Naproxen 250 mg tab, dose = 500 mg twice daily Fentanyl 100 mcg/patch, dose = every 72 hours R7 also had physician transfer orders for Prednisone 10 mg tablet daily; Keflex 500 mg every 6 hours; Famotidine (Pepcid) 20 mg twice daily; and Lidocain Hcl 5% patch (Lidoderm patch) to each knee - on 12 hours, off 12 hours, but these orders were not added to the facility's POS on admission and there was no documentation explaining why they were discontinued. The facility's Nurse Admission	F 309		

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F 309	Continued From page 15 Checklist dated 4/3/09 directs, "If physician dc's an order, adds an order or changes an order from the transfer sheet, write these orders on the admission POS." However, none of these medications appeared on R7's admission POS. According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were transcribed from Z3's hospital physician transfer orders: - Metoprolol Succinate (Toprol XL) 100 mg at 8:00 AM on 4/9, 4/10 and 4/11/11. - Lisinopril 20 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10; and at 8:00 AM on 4/11/11. - HCTZ 50 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Duricef 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Lactulose 20 mg/30 mL at 4:00 PM and 8:00 PM on 4/7/11; and 8:00 AM, 11:00 AM, 4:00 PM and 8:00 PM on 4/8/11. - Ranitidine 150 mg at 8:00 AM on 4/7, 4/8, 4/9/ 4/10 and 4/11/11. - Janumet 1000 mg/50 mg at 7:00 AM and 4:00 PM on 4/7, 4/8, 4/9/11; and 7:00 AM on 4/10/11 and 4/11/11. (This order was changed on 4/10/11 to reduce the 4:00 PM dose to 500 mg/ 50 mg). R7 received Janumet 500/50 mg on 4/11/11 at 4:00 PM. According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were from R7's hospital physician transfer orders:	F 309		

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F 309	Continued From page 16 - Furosemide (Lasix) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Spironolactone (Aldactone) 50 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10, 4/11/11. - Metolazone (Zaroxolyn) 5 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10, and 4/11/11. - Potassium Chloride 20 mEq at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Allopurinol 300 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Enoxaparin (Lovenox) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Gabapentin (Neurontin) 300 mg at 8:00 AM, 11:00 AM and 8:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Magnesium-oxide (Mag-Ox) 400 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Alendronate Sodium (Fosamax) 70 mg at 6:00 AM on 4/8/11. - Vitamin D 2800 units at 6:00 AM on 4/8/11 - Naproxen 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Fentanyl 100 mcg/patch at 6:00 AM on 4/9/11. - Multivitamin with mineral at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Prostat 64 30 mL at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. R7 was sent to the emergency room on 4/11/11 at 6:30 PM because of a critically elevated Potassium level of 7.8 (3.7 - 5.1 mEq/L) according to nursing note documentation and the laboratory report dated 4/11/11. In the emergency room R7's Potassium level was 8.6 mEq/mL, her Blood Urea Nitrogen level was 84, and her Creatinine level was 4.4 according to the emergency department notes dated 4/11/11. R7 was admitted to the intensive care unit in serious	F 309		

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condition with diagnoses of Acute Renal Failure, Hyperkalemia and Bradycardia according to the 4/11/11 Emergency Department note.

Z7 (Renal Specialist) attended to R7 during her April 2011 hospital stay. Z6 was interviewed by telephone on 8/12/11. Z6 had R7's hospital record to refer to during this interview. Z7 stated that R7's potassium was at a life threatening level when she was admitted to the hospital. Z7 said that the combination of the multiple diuretics and R7's diarrhea likely caused dehydration, acute renal failure, decreased blood pressure and high potassium. Z7 pointed out that the medications of Toprol, Lisinopril, Spironolactone and Potasium Chloride all contributed to R7's critically elevated potassium. Z7 said that R7's acute renal failure resolved once she was re-hydrated and some of the diuretics were discontinued.

Elsevier (2011) warns against using an ACE inhibitor (Lisinopril) concomitantly with Spironolactone citing, "Coadministration of ACE inhibitors and spironolactone, even in the presence of a diuretic, has been associated with severe hyperkalemia." Elsevier also warns about drug to drug interactions between Lisinopril and Furosemide, and Lisinopril and Naproxen. The Nursing 2011 Drug Handbook (Lippincott) also warns that combining Lisinopril with potassium sparing diuretics (Spironolactone) or Potassium Supplements (Potassium Chloride), may cause hyperkalemia. Lippincott is the nursing drug handbook used at the facility.

E2 (Director of Nursing) was interviewed on 8/3/11 regarding the facility's system for verifying residents identification. E2 said that the nurses

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use a Nurse Admission Checklist when admitting a new resident. Additionally, E2 said there is a DON Admission Checklist that is to be completed by the DON. E2 confirmed that neither of these forms contain a requirement to check the resident's name and birth date. E2 said that both forms are currently being revised to include a requirement to check the resident's name and birth date. E2 said that the DON Admission Checklist was completed for R7 the day after R7's admission (4/7/11) but the error was not identified.

The DON Admission Checklist for R7 was completed by Z5 (Corporate Nurse Consultant)on 4/7/11. The Checklist identified that the orders did not match the admit orders on the transfer sheet. On 8/10/11 at 10:40 AM Z5 confirmed that she completed the DON Admission Checklist on R7. Z5 stated that she does not recall if she checked R7's name and birth date because it was 4 months ago. Z5 said that she would have identified that the names and birth dates were different if she had checked them.

As of 8/3/11 the facility did not have a Nursing Admission Checklist or DON Admission Checklist that included a requirement to verify the resident name and birth date.

On 8/3/11 at 11:30 AM R7 was interviewed in her room. R7 stated that she does not remember much from her stay at the nursing home between 4/6 - 4/11/11 other than that she was tired all the time. R7 is alert and oriented with no cognitive impairment according to the Minimum Data Sets dated 5/24/11.

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F 309	Continued From page 19 On 8/9/11 at 1:50 PM Z2 stated that he expects the nurses to verify a resident's name and birth date on admission to the facility, saying, "It must be done." The surveyor confirmed that the facility took the following actions to remove the immediacy of the situation on 8/3/11: - On 8/3/11 all licensed nursing staff in the building were in-serviced on the new Nurse Admission Checklist that specifically mentions checking the resident name and birth date. All off duty staff will be in-serviced prior to starting their next scheduled shift. - On 8/3/11 a new DON Admission Checklist, that specifically mentions checking the resident name and birth date, has been issued and will be immediately instituted as of 8/3/11. - Training of all newly hired licensed nurses will include the revised Nurse Admission Checklist, referencing checking name and birth date. - Monitoring of resident identification will be accomplished via completion of the new Nurse Admission Checklist and the new DON Admission Checklist which are retained for one month per facility policy. Based on observation, interview, and record review the facility failed to: -Have a system in place to ensure residents who have been identified with aspiration precautions have individual and specific interventions developed in the care plan -Ensure communication relating to the residents aspiration precautions are going to all disciplines and direct care staff to ensure residents safety	F 309		

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F 309	Continued From page 20 -Ensure direct care staff implements resident's aspiration precautions and are monitored/trained -Ensure a policy and procedure is developed and implemented As the result of this failure, during the evening meal, R6 choked on breaded fish she was eating. This occurred in the facility's assistive dining room (ADR), where there were at least 2 staff present. E4(RN) and E10(CAN) observed R6 choking and grabbing her throat. The Heimlich Maneuver was implemented with no success. Emergency medical system (EMS) was notified, R6 was intubated on site, pieces of foreign body (food) removed. R6 sent to a near by acute care facility on 6/17/11 at 6:35 P.M., R6 expired on 6/18/11 at the acute care facility.. R6's coroner certificate of death dated 6/22/11 documents the cause of death was "ASPIRATION OF A FOOD BOLUS E1 (Administrator) and E2 (DON) were notified of an immediate Jeopardy existing at F309 on 08/4/11 at 3:00 P.M. The Immediate Jeopardy began on 6/17/11 and was removed on 08/4/11 at 6:15 P.M. Although the immediacy was removed the facility remains out of compliance at severity level 2 due to the need to evaluate the implementation of the training and education of the staff on the facility's new policy and procedure. This is for 1 resident (R6) in the sample of 3 reviewed for aspiration precautions in the total sample of 20. The findings include:	F 309		

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-The facility's incident report dated 6/17/11 at 6:00 P.M. documents "guest (R6) found in ADR (assisted dining room), choking, unable to inhale or exhale." Incident summary shows R6 was eating in ADR, when she showed the universal sign for choking; which was grabbing her throat area. Staff asked her if she could breathe and she shook her head no. At that time staff started abdominal thrusts and called 911. R6 was eating fish, which was her prescribed diet of mechanical soft. R6 was sent to the hospital, admitted, and expired on 6/18/11. R6's coroner certificate of death dated 6/22/11 documents the cause of death was "ASPIRATION OF A FOOD BOLUS."

The EMS (emergency medical system) report documented the following: Ambulance called to the scene for a 75 year old female patient that was choking, unresponsive and not breathing. CPR (cardio pulmonary resuscitation) performed, during intubation removed a foreign body that was possible obstruction and able to intubate.

E10 (CAN) stated on 8/4/11 at 2:15 P.M., "I was standing next to R6 assisting table mate when R6 starting choking, I was not assisting R6. I called for the nurse and we started performing the Heimlich Maneuver but we couldn't get anything up and R6 was going unconscious so we lowered her to the floor to perform chest thrusts until paramedics arrived. The paramedics arrived and removed fish out of R6's throat and then she went to the hospital. I don't remember if R6 was on aspiration precautions, she did not have trouble chewing. The nurses usually inform us if a resident is on aspiration precautions. R6 is suppose to take small bites and small drinks during her meals. I don't know of anything else

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F 309	Continued From page 22 R6 is to do while eating." E4 (RN) stated on 8/3/11 at 2:30 P.M., "I was the nurse in the ADR passing liquids at R6's table. Another resident was coughing and I was checking on them. R6 started choking, I attempted to do the Heimlich Maneuver. R6 continued choking so then we lowered her to the floor continuing the Heimlich Maneuver. 911 called. R6 was eating fish that had been flaked into small pieces. R6 was alert and orientated, frail, fed herself, no adaptive equipment or aspirations precautions required. I have been working with R6 for about one year. R6 did have a diagnosis of swallowing difficulty, was on a soft diet but it was nothing to worry about." E8 (RN) stated on 8/4/11 at 2:30 P.M., "I was in the main dining room when I heard the staff calling for help. I ran into the ADR to offer assistance. When the paramedics arrived they were able to remove food from R6's mouth. R6 was intubated and transferred to the hospital. R6 did not have swallowing problems, she couldn't get the food to her mouth because she was so weak." R6 was admitted to the facility on 5/14/11 after hospitalization related to infected right sacral wound and pneumonia. R6's Minimum Data Set (MDS) dated 5/24/11 under section K-swallowing/nutritional status assessed R6 as having "complaints of difficulty or pain with swallowing." Care Area Assessment (CAA) dated 5/25/11 shows R6 has functional problems that affect ability to eat: Swallowing problem; proceed to care plan. R6's MDS dated 6/3/11 documents she requires supervision and setup to eat.	F 309		

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Review of R6's interim plan of care and plan of care dated 6/14/11 did not include interventions related to her swallowing difficulty. R6 plan of care shows she received a mechanical diet and should be allowed adequate time to chew/swallow. No further interventions were included or implemented. Review of the speech therapy evaluation dated 5/6/11 recommends to cut up her food, supervise her in the ADR, cue her to alternate diet with solids and liquids and aspiration precautions. These recommendations were not included in R6's care plan.

Review of R6's nursing notes dated 6/17/11 at 10:00 A.M. documents "Reported trouble swallowing to Z4 (Speech Therapist) on AM shift after RN on nights mentioned she had trouble swallowing with thin liquids.

Z4 swallowing evaluation dated 5/6/11 shows R6's treatment diagnosis was Dysphagia-plan of treatment included patient/staff training of skilled competencies techniques for safe swallow with 100% return demonstration. Weekly progress notes from 5/24/11 through 6/17/11 documents the following:
swallow delay- YES, 2-3 seconds
gurgly vocal quality- YES, audible swallow at times

Skilled therapy techniques- compensatory swallow techniques/aspiration precautions, cues to orally transit bolus/masticate/cues to swallow, cues verbal/visual/tactile

Review of R6's daily record of treatment shows Dysphagia treatment was completed on 6/1/11, 6/2/11, 6/3/11, 6/6/11, 6/7/11, 6/8/11, 6/9/11,

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F 309	Continued From page 24 6/10/11, 6/12/11, 6/13/11, 6/15/11, 6/16/11, and 6/17/11. Interview with Z4 on 8/4/11 at 11:00 A.M., Z4 stated, "R6 was frail, weak and had an audible swallow. It was an effort for her to chew and swallow, took her along time, she had trouble eating and ongoing difficulty with swallowing. This is why she was on aspiration precautions. R6's swallow evaluation indicated that staff was to provide compensatory swallowing techniques. This means staff was to cut up her food, supervise her in the ADR, cue her to alternate diet with solids and liquids, and aspiration precautions were to be implemented. There are two places where I post a list of residents who are on aspiration precautions. Both of the lists are in the ADR-one list is posted inside the cabinet and one list is taped on the door to dietary. I cannot remember if R6's name was on the list in June. We do not keep the lists from month to month. I let the nurses know who is on aspiration precautions and they let the CNA's know. Also when I am in the ADR and see a staff member I will tell them if a resident is on Aspiration Precautions. I do not do in-services or return demos with the staff . I was planning to extend her speech therapy to continue with aspiration precautions" E9 (Dietary Service Supervisor) stated on 8/4/11 at 1:00 P.M., " I give my CAA to data entry and I'm done. I am not responsible for the plan of care." E3 (Nurse-care plan coordinator) stated on 8/4/11 at 12:45 P.M., "Each discipline is to complete a care plan input sheet and then submit it to data	F 309		

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entry. E9 wrote the CAA for R6 and she should have developed a plan of care relating to R6's difficulty with swallowing, but it was R6 required feeding or cueing during meals."

E12(RN) stated on 8/4/11 at 1:12 P.M., "I get my information for developing interim care plans from the physician order sheet, hospital transfer sheet-no where else. If we get telephone orders and update the interim care plans. R6's interim care plan did not include swallowing precautions."

E2 (DON) stated on 8/4/11 at 1:55 P.M., "We don't have a policy and procedure on aspiration precautions or what staff is suppose to do when a resident is on aspiration precautions. Dietary is responsible for care planning swallowing problems identified on the CAA's. Aspiration precautions should have been listed in R6's care plan but it was not. I have not done any formal inservices or training with staff related to aspiration precautions. I just tell whomever I see in the ADR if a resident is on aspiration precautions."

-R10 is a 75 year old female admitted to the facility on 7/13/11 with diagnoses which included Dysphagia and oropharyngeal. Review of R10's interim care plan shows she required a comprehensive assessment and management for the following conditions/diagnoses which included dysphagia. R10's interim care plan (only care plan developed) did not include interventions related to dysphagia or aspiration precautions. R10's most recent MDS dated 7/20/11 documents R10 is independent with eating but requires assistance with setup. R10's MDS under

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section K-swallowing/nutritional status assessed R10 as having "complaints of difficulty or pain with swallowing." Care Area Assessment (CAA) dated 7/25/11 shows R10 has functional problems that affect ability to eat: Swallowing problem; proceed to care plan. Review of R10's therapy progress note dated 7/27/11 documents the treatment diagnosis is dysphagia-swallowing delay is yes, mild gurgly sound, and her cough/throat is not clear. R10 is on a mechanical soft diet with thin liquids- to continue with dysphagia goals.

Observation on 8/4/11 at 12:20 P.M. to 12:35 P.M., E11 (CNA) was observed sitting at the table with R10. R10 took six bites of chocolate pudding, one bite of meat, four drinks of coffee and three drinks milk from a cup. R10's food was presented in bowls, not on a plate with a plate guard. E11 did not provide any cues or encouragement to R10 during this meal observation. E11 then removed R10 from the dining and took her to her room and removed R10's denatures. E11 said, " I know R10 is on aspiration precautions and she's supposed to alternate between liquids and solids-every other bite. I did not give her any cues today because she does not feel good."

The pink card on the dietary door in the ADR read: R10 - diet is level puree with thin liquids, small sips/bites (1/2 tsp.), alternate between liquid/food, check dentures are in and fitting well-encourage intake. Review of R10's speech therapy progress notes documents R10's diet order changed 7/20/11 - "add a plate guard for all meals."

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F 309	Continued From page 27 E3 said on 8/4/11 at 12:38 P.M., "Swallowing precautions was not developed on R10 interim care plan. Restorative nurse does the initial care plan, E12 did R10's care plan. No swallowing care plan has been developed." Facility took the following steps to abate the Immediate Jeopardy. FACILITY ABATEMENT PLAN: 1. To ensure that a system failure does not occur, the facility has put the following measures into place: The speech therapist will communicate any needed aspiration precautions for a resident by documenting said precautions in the resident's chart, as well as providing the Restorative/Rehab Nurse and the Care Plan Coordinator with the same information. The Care Plan coordinator will ensure that the aspiration precautions are written into the resident's care plan (initial, 21 day, or quarterly). The Restorative/Rehab Nurse will complete the Aspiration Precautions cue card, place the card in the receptacle in the dining room, and inform the C.N.A.'s via writing on the dietary card that there are aspiration precautions to be observed. The Restorative/ Rehab Nurse will also place the aspiration precaution information on the residents' C.N.A. Care Plan Guide. The C.N.A.'s assisting the residents with eating will obtain the aspiration precaution cards, bring them to the table where the residents are eating and follow the precautions, offering cuing, etc. This above process of ensuring that the residents'	F 309		

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F 309	Continued From page 28 aspiration precautions are being followed during meals will be audited by the Restorative/Rehab Nurse at least three times a week. Direct care staff on duty have been in-serviced prior regarding the use of the Aspiration Precaution cards, and all remaining staff shall be in-serviced prior to returning for their next scheduled shift. Aspiration Precautions policy has been written and disseminated to staff on 08/4/11.	F 309		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow acceptable professional standards when reconciling new admission orders of multiple/excessive diuretics, and after identifying a lack of diagnoses for some of the medications ordered. This is for 1 resident (R7) out of 11 residents reviewed for medications, in the total sample of 20. This failure resulted in R7 having diarrhea after receiving medication for constipation, a diagnosis that she did not have. This failure resulted in R7 receiving excessive dosages of diuretics. This failure also resulted in R7 receiving medications that have contraindications when given concomitantly. R7 was admitted to the intensive care unit at a local hospital with diagnoses of Hyperkalemia, Acute Renal Failure and Bradycardia.	F 333		8/16/11

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F 333	Continued From page 29 This failure has the potential to affect all new residents admitted to the facility. The findings include: R7 was admitted to the facility on 4/6/11 from a local hospital according to nursing notes dated 4/6/11. The hospital erroneously sent medication documentation for another patient from the hospital (Z3) along with medication documentation for R7. R7 and Z3's names are very similar, but there birth dates are different. R7's name and birth date appear on the top of the "Medication Administration Record" followed by a list of R7's medications. Z3's name and birth date appear on the top of the "Medication Reconciliation/Physician Order Form" followed by a list of Z3's medications. E8 (Nurse) was the admitting nurse according to documentation on the facility's Physician's Order Sheet (POS). On 8/3/11 at 2:00 PM E8 confirmed she did not verify R7's name and birth date on the medication documents sent from the hospital. E8 said she transferred the orders from the Physician Order Form (Z3's medications) onto the facility's POS. E8 said she noticed that additional medications were listed on the Medication Administration Record (R7's medications) and called Z2 (Physician/Medical Director) for clarification of the orders. E8 said she pointed out to Z2 that R7 did not have a diagnosis for some of the medications listed on the Physician's Order Form (Z3's medications). E8 said she also questioned the multiple orders for diuretics. E8 said when she told Z2 that the medications did not make sense, Z2 said, 'I am	F 333		

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the doctor and you are the nurse and told her to continue the medications. E8 combined the medications on the two lists and wrote them on the facility's POS. E8 said she still felt strongly the medications were not right and passed on her concerns to the next shift. E8 said she did not inform the Director of Nursing about her concerns and did not follow-up or pursue her concerns any further.

On 8/11/11 at 8:50 AM E2 (Director of Nursing) stated that she expects her staff to contact her when they suspect inconsistencies in residents medication orders. E2 said if E8 had contacted her she would have called the supervisor at the hospital to obtain additional information and clarification regarding R7 medications.

According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were transcribed from Z3's hospital physician transfer orders:

- Metoprolol Succinate (Toprol XL) 100 mg at 8:00 AM on 4/9, 4/10 and 4/11/11.
- Lisinopril 20 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10; and at 8:00 AM on 4/11/11.
- HCTZ 50 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Duricef 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Lactulose 20 mg/30 mL at 4:00 PM and 8:00 PM on 4/7/11; and 8:00 AM, 11:00 AM, 4:00 PM and 8:00 PM on 4/8/11. (R7 did not have a diagnosis of Constipation)
- Ranitidine 150 mg at 8:00 AM on 4/7, 4/8, 4/9/ 4/10 and 4/11/11.

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F 333	Continued From page 31 - Janumet 1000 mg/50 mg at 7:00 AM and 4:00 PM on 4/7, 4/8, 4/9/11; and 7:00 AM on 4/10/11 and 4/11/11. (This order was changed on 4/10/11 to reduce the 4:00 PM dose to 500 mg/ 50 mg). R7 received Janumet 500/50 mg on 4/11/11 at 4:00 PM. (R7 did not have a diagnosis of Diabetes) According to the facility's Medication Administration Record (MAR) R7 received the following medications between 4/7 and 4/11/11 which were from R7's hospital physician transfer orders: - Furosemide (Lasix) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Spironolactone (Aldactone) 50 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10, 4/11/11. - Metolazone (Zaroxolyn) 5 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10, and 4/11/11. - Potassium Chloride 20 mEq at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Allopurinol 300 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Enoxaparin (Lovenox) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Gabapentin (Neurontin) 300 mg at 8:00 AM, 11:00 AM and 8:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Magnesium-oxide (Mag-Ox) 400 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Alendronate Sodium (Fosamax) 70 mg at 6:00 AM on 4/8/11. - Vitamin D 2800 units at 6:00 AM on 4/8/11 - Naproxen 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. - Fentanyl 100 mcg/patch at 6:00 AM on 4/9/11. - Multivitamin with mineral at 8:00 AM on 4/7, 4/8,	F 333		

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F 333	Continued From page 32 4/9, 4/10 and 4/11/11. - Prostat 64 30 mL at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11. On 4/9/11 all four doses of Lactoluse were held after R7 complained of diarrhea according to documentation on the MAR. All doses of Lactoluse were also held on 4/10 and 4/11/11, but no there was no documentation as to why it was held. This was confirmed by E2 on 8/10/11. R7 received an excessive dose of Lactulose, above the recommended Geriatric and Adult dosage, according to the Lexicomp 12th ed. Geriatric Dosage Handbook p. 850. Diarrhea may indicate overdosage according to Lexicomp. Elsevier (2011) warns against using an ACE inhibitor (Lisinopril) concomitantly with Spironolactone citing, "Coadministration of ACE inhibitors and spironolactone, even in the presence of a diuretic, has been associated with severe hyperkalemia." Elsevier also warns about drug to drug interactions between Lisinopril and Furosemide, and Lisinopril and Naproxen. The Nursing 2011 Drug Handbook (Lippincott) also warns combining Lisinopril with potassium sparing diuretics (Spironolactone) or Potassium Supplements (Potassium Chloride), may cause hyperkalemia. Lippincott also identifies a drug to drug interaction with Allopurinol. Lippincott is the nursing drug handbook used at the facility. R7 was sent to the emergency room on 4/11/11 at 6:30 PM because of a critically elevated Potassium level of 7.8 (3.7 - 5.1 mEq/L) according to nursing note documentation and the laboratory report dated 4/11/11. In the	F 333		

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emergency room R7's Potassium level was 8.6 mEq/mL. Her Blood Urea Nitrogen level was 84 and her Creatinine level was 4.4 according to the emergency department notes dated 4/11/11. R7 was admitted to the intensive care unit in serious condition with diagnoses of Acute Renal Failure, Hyperkalemia and Bradycardia according to the 4/11/11 Emergency Department note.

E2 (Director of Nursing) was interviewed on 8/3/11 regarding the facility's system for verifying residents identification. E2 said the nurses use a Nurse Admission Checklist when admitting a new resident. Additionally, E2 said there is a DON Admission Checklist that is to be completed by the DON. E2 confirmed neither of these forms contain a requirement to check the resident's name and birth date. E2 said that both forms are currently being revised to include a requirement to check the resident's name and birth date. E2 said the DON Admission Checklist was completed for R7 the day after R7's admission (4/7/11) but the error was not identified.

In addition, R7 had physician transfer orders for Prednisone 10 mg tablet daily; Keflex 500 mg every six hours; Famotidine (Pepcid) 20 mg twice daily; and Lidocain Hcl 5% patch (Lidoderm patch) to each knee - on 12 hours, off 12 hours. These orders were not added to the facility's POS on admission and there was no documentation explaining why they were discontinued. The facility's Nurse Admission Checklist dated 4/3/09 directs, "If physician dc's an order, adds an order or changes an order from the transfer sheet, write these orders on the admission POS."

On 8/3/11 at 11:30 AM R7 was interviewed in her

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F 333	Continued From page 34 room. R7 stated she does not remember much from her stay at the nursing home between 4/6 - 4/11/11 other than that she was tired all the time.	F 333		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the Medical Director collaborated with the facility in the development, implementation, and evaluation of resident care policies. The facility lacked policy/procedures for aspiration precautions and to assure newly admitted residents receive the proper medications. This deficient practice has the potential to affect all 89 residents in the facility and resulted in two Immediate Jeopardy's in the areas of providing care/services for well-being. The findings include: On 8/911 at 1:50 P.M. Z2 (Medical Director) stated, "I attend almost all of the quality assurance meetings which are conducted every three months. There is nothing specific we discuss. It is whatever is brought up for concern.	F 501		8/24/11

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F 501	Continued From page 35 They have not given me anything specific for suggestions. I am not aware the facility did not have a policy and procedure for aspiration precautions. I don't make the policies and there is not any specific time when I review a policy. I do not review the policies on an regular basis, only if they bring it to my attention. I am a medical person, policies and procedures are for the administration personal." E2 (DON) stated on 8/4/11 at 1:55 P.M., "We don't have a policy/ procedure on aspiration precautions, or a policy/procedure that outlines what staff is suppose to do when a resident is on aspiration precautions. We do not have a policy/procedure that includes checking the residents name and birth date when ordering medications to ensure the correct medications are ordered and administered." Documentation verifying Z2's review and input of resident care policies and procedures with overall goals and directives to provide guidance and/or oversight for resident care policies was requested three times from facility. Facility presented a one page sheet titled "annual review" with the Administrator, Medical Director, Q.A. Committee, and Corporate Rep. initials and dated 4/6/11. No further information requested provided for review and verification.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010g)1) 300.1210a) 300.1630b) 300.1630c)	F9999		

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F9999	Continued From page 36 300.1810e) 300.1810f)1)2) 300.3240a) 300.1010 Medical Care Policies g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following: 1) An evaluation of the resident's condition, including height and weight, diagnoses, plan of treatment, recommendations, treatment orders, personal care needs, and permission for participation in activity programs as appropriate. 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. Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other	F9999		

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means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.1810 Resident record requirements

e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.
1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.
2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services shall be included in the resident's progress record when the recommendations pertain to an individual resident.

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F9999	Continued From page 38 Section 300.3240 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 interview and record review the facility failed to thoroughly verify a new resident's name was listed correctly on the hospital transfer sheet and all the hospital medication administration records prior to transcribing the medication orders from these records to the facility's Physician Order Sheet. This failure resulted in R7 receiving someone else's medications, in addition to her own, for five days. This caused an elevation of R7's potassium to a critical level. R7 was admitted to the intensive care unit in serious condition with diagnoses of Hyperkalemia, Acute Renal Failure and Bradycardia. Findings include: R7 was admitted to the facility on 4/6/11 at 9:15 PM from a local hospital according to nursing notes dated 4/6/11. The hospital erroneously sent medication documentation for another patient from the hospital (Z3) along with medication documentation for R7. R7's and Z3's names are very similar, but their birth dates are different. R7's name and birth date appear on the top of the "Medication Administration Record" followed by a list of R7's medications. Z3's name and birth date appear on the top of the "Medication Reconciliation/Physician Order Form" followed by a list of Z3's medications.	F9999		

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E8 (Nurse) was the admitting nurse according to documentation on the facility's Physician's Order Sheet (POS). On 8/3/11 at 2:00 PM E8 confirmed she did not verify R7's name and birth date on the medication documents sent from the hospital. E8 said she transferred the orders from the Physician Order Form (Z3's medications) onto the facility's POS. E8 said she noticed additional medications were listed on the Medication Administration Record (R7's medications) and called Z2 (Physician/Medical Director) for clarification of the orders. E8 said she pointed out to Z2 that R7 did not have a diagnosis for some of the medications listed on the Physician's Order Form (Z3's medications). E8 said she also questioned the multiple orders for diuretics. E8 said when she told Z2 the medications did not make sense, Z2 said, 'I am the doctor and you are the nurse and told her to continue the medications. E8 combined the medications on the two lists and wrote them on the facility's POS. E8 said she still felt strongly that the medications were not right and passed on her concerns to the next shift. E8 said that she did not inform the Director of Nursing about her concerns.

The following physician transfer orders were for Z3, but were transcribed to R7's POS on admission to the facility:
Metoprolol Succinate 25 mg (Toprol XL), dose = 100 mg daily
Lisinopril 20 mg, dose = 20 mg twice daily
Hydrochlorothiazide 50 mg (HCTZ), dose = 50 mg daily
Duricef 500 mg, dose = 500 mg twice daily
Venlafaxine Hydrochloride 75 mg (Effexor XR), dose = 75 mg three times daily

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F9999	Continued From page 40 Lactulose 20 gm/30 mL, dose = 20 gm four times daily Ranitidine Hydrochloride 150 mg, dose = 150 mg daily Sitagliptin-Metformin 1000/50 mg (Janumet), dose - 1 tab twice daily The following physician transfer orders were R7's and were also added to R7's POS on admission to the facility: Furosemide 40 mg (Lasix), dose = 40 mg daily Spironolactone 25 mg (Aldactone), dose = 50 mg twice daily Metolazone 5 mg tab (Zaroxolyn), dose = 5 mg daily Potassium Chloride 10 mEq, dose = 20 mEq twice daily Allopurinol 300 mg (Zyloprim), dose = 300 mg daily Enoxaparin 40 mg/0.4 mL syr (Lovenox), dose = 40 mg daily Gabapentin 300 mg cap (Neurontin), dose = 300 mg daily Magnesium-oxide 400 mg tab (Mag-Ox), dose = 400 mg twice daily Alendronate Sodium 70 mg (Fosamax), dose = 70 mg once a week Vitamin D 400 units tab, dose = 2800 units once a week Naproxen 250 mg tab, dose = 500 mg twice daily Fentanyl 100 mcg/patch, dose = every 72 hours R7 also had physician transfer orders for Prednisone 10 mg tablet daily; Keflex 500 mg every six hours; Famotidine (Pepcid) 20 mg twice daily; and Lidocain Hcl 5% patch (Lidoderm patch) to each knee - on 12 hours, off 12 hours, but these orders were not added to the facility's	F9999		

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POS on admission and there was no documentation explaining why they were discontinued. The facility's Nurse Admission Checklist dated 4.3.09 directs, "If physician dc's an order, adds an order or changes an order from the transfer sheet, write these orders on the Admission POS."

According to the facility's Medication Administration Record (MAR) R7 recieved the following medications between 4/7 and 4/11/2011 which were transcribed from Z3's hospital physician transfer orders:

- Metoprolol Succinate (Toprol XL) 100 mg at 8:00 AM on 4/9, 4/10 and 4/11/11.
- Lisinopril 20 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10; and at 8:00 AM on 4/11/11.
- HCTZ 50 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Duricef 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Lactulose 20 mg/30 mL at 4:00 PM and 8:00 PM on 4/7/11; and 8:00 AM, 11:00 AM, 4:00 PM and 8:00 PM on 4/8/11.
- Ranitidine 150 mg at 8:00 AM on 4/7, 4/8, 4/9/ 4/10 and 4/11/11.
- Janumet 1000 mg/50 mg at 7:00 AM and 4:00 PM on 4/7, 4/8, 4/9/11; and 7:00 AM on 4/10/11 and 4/11/11. (This order was changed on 4/10/11 to reduce the 4:00 PM dose to 500 mg/ 50 mg). R7 received Janumet 500/50 mg on 4/11/11 at 4:00 PM.

According to the facility's Medication Administration Record (MAR) R7 recieved the following medications between 4/7 and 4/11/11 which were from R7's hospital physician transfer

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orders:

- Furosemide (Lasix) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Spironolactone (Aldactone) 50 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10, 4/11/11.
- Metolazone (Zaroxolyn) 5 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10, and 4/11/11.
- Potassium Chloride 20 mEq at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Allopurinol 300 mg at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Enoxaparin (Lovenox) 40 mg at 6:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Gabapentin (Neurontin) 300 mg at 8:00 AM, 11:00 AM and 8:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Magnesium-oxide (Mag-Ox) 400 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Alendronate Sodium (Fosamax) 70 mg at 6:00 AM on 4/8/11.
- Vitamin D 2800 units at 6:00 AM on 4/8/11
- Naproxen 500 mg at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Fentanyl 100 mcg/patch at 6:00 AM on 4/9/11.
- Multivitamin with mineral at 8:00 AM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.
- Prostat 64 30 mL at 8:00 AM and 4:00 PM on 4/7, 4/8, 4/9, 4/10 and 4/11/11.

R7 was sent to the emergency room on 4/11/11 at 6:30 PM because of a critically elevated Potassium level of 7.8 (3.7 - 5.1 mEq/L) according to nursing note documentation and the laboratory report dated 4/11/11. In the emergency room R7's Potassium level was 8.6 mEq/mL, her Blood Urea Nitrogen level was 84, and her Creatinine level was 4.4 according to the

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emergency department notes dated 4/11/11. R7 was admitted to the intensive care unit in serious condition with diagnoses of Acute Renal Failure, Hyperkalemia and Bradycardia according to the 4/11/11 Emergency Department note.

Z7 (Renal Specialist) attended to R7 during her April 2011 hospital stay. Z6 was interviewed by telephone on 8/12/11. Z6 had R7's hospital record to refer to during this interview. Z7 stated that R7's potassium was at a life threatening level when she was admitted to the hospital. Z7 said that the combination of the multiple diuretics and R7's diarrhea likely caused dehydration, acute renal failure, decreased blood pressure and high potassium. Z7 pointed out that the medications of Toprol, Lisinopril, Spironolactone and Potasium Chloride all contributed to R7's critically elevated potassium. Z7 said that R7's acute renal failure resolved once she was re-hydrated and some of the diuretics were discontinued.

Elsevier (2011) warns against using an ACE inhibitor (Lisinopril) concomitantly with Spironolactone citing, "Coadministration of ACE inhibitors and spironolactone, even in the presence of a diuretic, has been associated with severe hyperkalemia." Elsevier also warns about drug to drug interactions between Lisinopril and Furosemide, and Lisinopril and Naproxen. The Nursing 2011 Drug Handbook (Lippincott) also warns that combining Lisinopril with potassium sparing diuretics (Spironolactone) or Potassium Supplements (Potassium Chloride) may cause hyperkalemia. Lippincott also identifies a potential drug to drug interaction with Lisinopril and Allopurinol. Lippincott is the nursing drug handbook used at the facility.

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E2 (Director of Nursing) was interviewed on 8/3/11 regarding the facility's system for verifying residents' identification. E2 said the nurses use a Nurse Admission Checklist when admitting a new resident. Additionally, E2 said there is a DON Admission Checklist that is to be completed by the DON. E2 confirmed that neither of these forms contain a requirement to check the resident's name and birth date. E2 said both forms are currently being revised to include a requirement to check the resident's name and birth date. E2 said the DON Admission Checklist was completed for R7 the day after R7's admission (4/7/11) but the error was not identified.

The DON Admission Checklist for R7 was completed by Z5 (Corporate Nurse Consultant) on 4/7/11. The Checklist identified the orders did not match the admission orders on the transfer sheet. On 8/10/11 at 10:40 AM Z5 confirmed she completed the DON Admission Checklist on R7. Z5 stated she does not recall if she checked R7's name and birth date because it was 4 months ago. Z5 said she would have identified that the names and birth dates were different if she had checked them.

As of 8/3/11 the facility did not have a Nursing Admission Checklist or DON Admission Checklist that included a requirement to verify the resident name and birth date.

On 8/3/11 at 11:30 AM R7 was interviewed in her room. R7 stated she does not remember much from her stay at the nursing home between 4/6 - 4/11/11 other than she was tired all the time. R7

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F9999	Continued From page 45 is alert and oriented with no cognitive impairment according to the Minimum Data Sets dated 5/24/11. On 8/9/11 at 1:50 PM Z2 stated he expects the nurses to verify a resident's name and birth date on admission to the facility, saying, "It must be done." (A) 300.1210a) 300.1220b)3) 300.1810f)2) 300.3240a) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for	F9999		

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each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

Section 300.1810 Resident Record Requirements

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services shall be included in the resident's progress record when the recommendations pertain to an individual resident.

Section 300.3240 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 observation, interview, and record review the facility failed to:
-Have a system in place to ensure residents who

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have been identified with aspiration precautions have individual and specific interventions developed in the care plan
-Ensure communication relating to the residents aspiration precautions are going to all disciplines and direct care staff to ensure residents safety
-Ensure direct care staff implements resident's aspiration precautions and are monitored/trained
-Ensure a policy and procedure is developed and implemented

As the result of this failure, during the evening meal, R6 choked on breaded fish she was eating. This occurred in the facility's assistive dining room (ADR) where there were at least 2 staff present. E4 (RN) and E10 (CNA) observed R6 choking and grabbing her throat. The Heimlach Maneuver was implemented with no success. Emergency medical system (EMS) was notified, R6 was intubated on site, pieces of foreign body (food) removed. R6 was sent to a nearby acute care facility on 6/17/11 at 6:35 P.M., and expired on 6/18/11 at the acute care facility. R6's coroner certificate of death dated 6/22/11 documents the cause of death was "Aapriation of a Food Bolus."

Findings include:

The facility's incident report dated 6/17/11 at 6:00 P.M. documents "guest (R6) found in ADR (assisted dining room), choking, unable to inhale or exhale." Incident summary shows R6 was eating in ADR, when she showed the universal sign for choking; which was grabbing her throat area. Staff asked her if she could breathe and she shook her head no. At that time staff started abdominal thrusts and called 911. R6 was eating fish, which was her prescribed diet of mechanical

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soft. R6 was sent to the hospital, admitted, and expired on 6/18/11. R6's coroner certificate of death dated 6/22/11 documents the cause of death was "ASPIRATION OF A FOOD BOLUS."

The EMS (emergency medical system) report documented the following: Ambulance called to the scene for a 75 year old female patient that was choking, unresponsive and not breathing. CPR (cardio pulmonary resuscitation) performed, during intubation removed a foreign body that was possible obstruction and able to intubate.

E10 (CNA) stated on 8/4/11 at 2:15 P.M., "I was standing next to R6 assisting tablemate when R6 starting choking. I was not assisting R6. I called for the nurse and we started performing the Heimlich Maneuver but we couldn't get anything up and R6 was going unconscious so we lowered her to the floor to perform chest thrusts until paramedics arrived. The paramedics arrived and removed fish out of R6's throat and then she went to the hospital. I don't remember if R6 was on aspiration precautions, she did not have trouble chewing. The nurses usually inform us if a resident is on aspiration precautions. R6 is suppose to take small bites and small drinks during her meals. I don't know of anything else R6 is to do while eating."

E4 (RN) stated on 8/3/11 at 2:30 P.M., "I was the nurse in the ADR passing liquids at R6's table. Another resident was coughing and I was checking on them. R6 started choking, I attempted to do the Heimlich Maneuver. R6 continued choking so then we lowered her to the floor continuing the Heimlich Maneuver. 911 called. R6 was eating fish that had been flaked

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	145694	A. BUILDING _____ B. WING _____	C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	**3401 HENNEPIN DRIVE JOLIET, IL 60435**

(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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into small pieces. R6 was alert and orientated, frail, fed herself, no adaptive equipment or aspirations precautions required. I have been working with R6 for about one year. R6 did have a diagnosis of swallowing difficulty, was on a soft diet but it was nothing to worry about."

E8 (RN) stated on 8/4/11 at 2:30 P.M., "I was in the main dining room when I heard the staff calling for help. I ran into the ADR to offer assistance. When the paramedics arrived they were able to remove food from R6's mouth. R6 was intubated and transferred to the hospital. R6 did not have swallowing problems, she couldn't get the food to her mouth because she was so weak."

R6 was admitted to the facility on 5/14/11 after hospitalization related to infected right sacral wound and pneumonia. R6's Minimum Data Set (MDS) dated 5/24/11 under section K-swallowing/nutritional status assessed R6 as having "complaints of difficulty or pain with swallowing." Care Area Assessment (CAA) dated 5/25/11 shows R6 has functional problems that affect ability to eat: Swallowing problem; proceed to care plan. R6's MDS dated 6/3/11 documents she requires supervision and setup to eat. Review of R6's interim plan of care and plan of care dated 6/14/11 did not include interventions related to her swallowing difficulty. R6's plan of care shows she receives a mechanical diet and should be allowed adequate time to chew/swallow. No further interventions were included or implemented. Review of the speech therapy evaluation dated 5/6/11 recommends to cut up her food, supervise her in the ADR, cue her to alternate diet with solids and liquids and

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aspiration precautions. These recommendations were not included in R6's care plan.

R6's nursing notes dated 6/17/11 at 10:00 A.M. document, "Reported trouble swallowing to Z4 (Speech Therapist) on AM shift after RN on nights mentioned she had trouble swallowing with thin liquids."

Z4's swallowing evaluation dated 5/6/11 shows R6's treatment diagnosis was Dysphagia-plan of treatment included patient/staff training of skilled competencies techniques for safe swallow with 100% return demonstration. Weekly progress notes from 5/24/11 through 6/17/11 document the following:
swallow delay- YES, 2-3 seconds
gurgly vocal quality- YES, audible swallow at times

Skilled therapy techniques- compensatory swallow techniques/aspiration precautions, cues to orally transit bolus/masticate/cues to swallow, cues verbal/visual/tactile.

Review of R6's daily record of treatment shows Dysphagia treatment was completed on 6/1/11, 6/2/11, 6/3/11, 6/6/11, 6/7/11, 6/8/11, 6/9/11, 6/10/11, 6/12/11, 6/13/11, 6/15/11, 6/16/11, and 6/17/11.

During interview with Z4 on 8/4/11 at 11:00 A.M., Z4 stated, "R6 was frail, weak and had an audible swallow. It was an effort for her to chew and swallow, took her a long time, she had trouble eating and ongoing difficulty with swallowing. This is why she was on aspiration precautions. R6's swallow evaluation indicated that staff was

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to provide compensatory swallowing techniques. This means staff was to cut up her food, supervise her in the ADR, cue her to alternate diet with solids and liquids, and aspiration precautions were to be implemented. There are two places where I post a list of residents who are on aspiration precautions. Both of the lists are in the ADR-one list is posted inside the cabinet and one list is taped on the door to dietary. I cannot remember if R6's name was on the list in June. We do not keep the lists from month to month. I let the nurses know who is on aspiration precautions and they let the CNA's know. Also, when I am in the ADR and see a staff member I will tell them if a resident is on Aspiration Precautions. I do not do in-services or return demos with the staff. I was planning to extend her speech therapy to continue with aspiration precautions."

E9 (Dietary Service Supervisor) stated on 8/4/11 at 1:00 P.M., "I give my CAA to data entry and I'm done. I am not responsible for the plan of care."

E3 (Nurse-care plan coordinator) stated on 8/4/11 at 12:45 P.M., "Each discipline is to complete a care plan input sheet and then submit it to data entry. E9 wrote the CAA for R6 and she should have developed a plan of care relating to R6's difficulty with swallowing, but it was R6 required feeding or cueing during meals."

E12 (RN) stated on 8/4/11 at 1:12 P.M., "I get my information for developing interim care plans from the physician order sheet, hospital transfer sheet-no where else. If we get telephone orders and update the interim care plans. R6's interim care plan did not include swallowing precautions."

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F9999	Continued From page 52 E2 (DON) stated on 8/4/11 at 1:55 P.M., "We don't have a policy and procedure on aspiration precautions or what staff is suppose to do when a resident is on aspiration precautions. Dietary is responsible for care planning swallowing problems identified on the CAA's. Aspiration precautions should have been listed in R6's care plan but it was not. I have not done any formal inservices or training with staff related to aspiration precautions. I just tell whomever I see in the ADR if a resident is on aspiration precautions." (A)	F9999		