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	14G255	A. BUILDING _____ B. WING _____	C 08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRA ESTATES	**620 NORTH MAIN STREET HOYLETON, IL 62803**

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W 000	INITIAL COMMENTS INCIDENT INVESTIGATION Incident of 05/07/11/ IL54070	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure nursing has evaluated and identified specific interventions and documented interventions in the Individual Service Plan as the medical status changed for 1 of 3 individuals (R1) in the sample. Findings Include: Physician's Orders (POS) of 7/1/11- 7/31/11 identifies R1 as a 74 year old individual who functions at the severe range of Mental Retardation with additional diagnoses of Downs Syndrome, Alzheimer's, Hypothyroidism, Hypercholesterolemia, Esophageal Dyskinsia, Anemia, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Surgical Procedure Pacemaker Insertion and Past History of Gastric Resection. Review of document titled, "Hospitalizations-(R1's name)" (undated) given to surveyor by E3/ Licensed Practical Nurse on 8/10/11 at 2:15 PM, states that R1 was hospitalized as follows:	W 111		

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

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W 111	Continued From page 1 Admit 4/11/11 Discharged 4/15/11 Diagnosis: Pneumonia Admit 5/7/11 Discharged 5/16/11 Diagnosis: Pneumonia Admit 6/7/11 Discharged 6/13/11 Diagnosis: Aspiration Pneumonia Admit 6/29/11 Discharged 7/7/11 Diagnosis: Pneumonia / Sepis Admit 7/19/11 Discharged 7/22/11 Diagnosis: Urinary Tract Infection/ Electrolyte Imbalance Admit 8/2/11 (no discharge date/ remains hospitalized as of 8/17/11) Respiratory Abnormalities R1's Individual Service Plan (dated 10/6/10) states the following under section titled "Recommendations": " Monitor for cardiac and respiratory symptoms and report to nurse." "Due to history of UTI (urinary tract infection), monitor for symptoms of urinary tract infection." Review of R1's ISP of 10/6/10 does not specifically identify what direct care staff are to monitor. The recommendations do not specifically identify what type of cardiac, respiratory, and urinary tract infection signs and symptoms that the Direct Support Professional are to monitor and report to nursing. Consultation Form with Z2/Nurse Practitioner	W 111		

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W 111	Continued From page 2	W 111		

(dated 5/24/11) under recommendations states, "Encourage fluids frequently, report decreased urine output or continued poor fluid intake."

Review of Individual Service Plan/ ISP (dated 7/12/11) states, "Just recently R1 has had a change in her health. She has been hospitalized several times in the last six months and it's starting to be more frequent. She is usually hospitalized for aspiration pneumonia." The ISP further states, "Her liquids must be of honey consistency to ensure that she does not aspirate. She is also to have her food pureed for her convenience. She does require prompting to eat and at times will not feed herself. Staff do have to assist in feeding her when she is noncompliant. Her intake has been poor and staff are to encourage her to eat."

Review of the ISP of 7/12/11 does not state any recommendations made by the RN of specific interventions for R1's change in medical status related to the consultation of 5/24/11 or the hospitalizations from 4/11/11- 7/7/11.

Review of Nursing Notes (4/11/11-8/2/11), R1's Consultations (4/11/11-7/29/11) and Hospital Discharge Summary/ Instructions (4/15/11-7/22/11) there is no documentation made by the Registered Nurse of any further recommendations of interventions made related to R1's change in medical status.

In an interview with E2/ Residential Service Director/ RSD on 8/11/11 at 12:21 PM and 8/24/11 at 9:06 AM, when asked the facility's system on how the RN/ Registered Nurse evaluates and monitors R1's status so that she

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W 111	Continued From page 3 may make further recommendations of interventions , E2 stated "The RN does yearly assessments, she'll come in the month before the annual and will review R1's record." E2 further stated that the RN will attend special staffing's for individuals and that they had a special staffing for R1 on 7/12/11. E2 confirmed that since April 2011, the facility did not have any other special staffing meetings except the 7/12/11 related to R1's medical status. E2 confirms there was no other evidence of Z3/ RN making changes to the R1's ISP related to specific interventions for R1's change in medical status. E2 confirmed that she was unable to provide any additional evidence of written documentation made by the Direct Support Professionals/ DSP in R1's record of changes in R1's medical status or of DSP's notifying RN consultant.	W 111		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to identify specific objectives for 1 of 1 individual (R1) in the sample with recommendations from a swallow evaluation. Findings Include: Physician's Orders (POS) of 7/1/11- 7/31/11 identifies R1 as a 74 year old individual who functions at the severe range of Mental	W 227		

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W 227	Continued From page 4 Retardation with additional diagnoses of Downs Syndrome, Esophageal Dyskinsia and Gastroesophageal Reflux Disease. Discharge Summary (local community hospital) of 6/13/11 and 7/7/11 states that R1 was hospitalized for Aspiration Pneumonia. Physician's Orders At Time of Transfer (dated 7/7/11) states, "Very strict aspiration precautions." Speech Language Pathology Modified Barium Swallow Study (dated 6/30/11) under the comments section states, "Must ensure pt (patient) swallows after every bite due to delay in swallow initiation. Feed via teaspoon only. Should pt begin to show s/sx (signs and symptoms) of aspiration, recommend swallow evaluation be performed immediately and discontinue feeding." In an interview with E2/ Residential Service Director on 8/12/11 at 10:26 AM, E2 confirmed that facility did not implement an eating program to identify objective to have R1 swallow after each bite as recommended in the Swallow Study of 6/30/11.	W 227		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview the facility failed to ensure nursing services provided adequate nursing evaluation, monitoring and follow up for 1 of 3 in sample (R1) with sufficient	W 318		

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W 318	Continued From page 5 nursing interventions and recommendations to meet the medical needs resulting in multiple hospitalizations. When facility failed to: 1) Ensure thorough nursing evaluation of R1's respiratory status. 2) Follow physician's recommendations to monitor R1's voiding and oral fluid intake. 3) Implement facility's policy on contacting RN (Registered Nurse) Consultant regarding changes in R1's status. 4) Ensure facility has a system which identifies when Direct Support Staff and Licensed Practical Nurse will contact RN Consultant or Physician for R1. 5) Ensure facility has a system which identifies how/ when the RN consultant will evaluate and monitor R1's status so that she/ he may make recommendations to meet R1's medical needs. 6) Ensure nursing has evaluated and identified specific interventions in R1's Individual Service Plan/ ISP and updated R1's ISP as medical status changed. These failures resulted in an Immediate Jeopardy. Findings Include: On 8/12/11 at 2:35 PM an Immediate Jeopardy was identified to have begun on 4/15/11 when	W 318		

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W 318	Continued From page 6 facility failed to ensure adequate nursing evaluation, monitoring and follow up for R1 who had been discharged from a hospitalization of pneumonia. These failures resulted in R1 being readmitted to the hospital with further occurrences of pneumonia, sepsis, urinary tract infection and electrolyte imbalance. This resulted in an Immediate Jeopardy. On 8/23/11 at 2:35 PM, E1/ Administrator was notified that the Immediate Jeopardy was removed. Refer to deficiency cited at: W331 The facility must provide clients with nursing services in accordance with their needs.	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: 1. Based on record review and interview the facility failed to ensure nursing services provided adequate nursing evaluation, monitoring and follow up for 1 of 3 in sample (R1) with sufficient nursing interventions and recommendations to meet the medical needs resulting in multiple hospitalizations. When facility failed to: 1) Ensure thorough nursing evaluation of R1's respiratory status. 2) Follow physician's recommendations to	W 331		

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W 331	Continued From page 7 monitor R1's voiding and oral fluid intake. 3) Implement facility's policy on contacting RN (Registered Nurse) Consultant regarding changes in R1's status. 4) Ensure facility has a system which identifies when Direct Support Staff and Licensed Practical Nurse will contact RN Consultant or Physician for R1. 5) Ensure facility has a system which identifies how/ when the RN consultant will evaluate and monitor R1's status so that she/ he may make recommendations to meet R1's medical needs. 6) Ensure nursing has evaluated and identified specific interventions in R1's Individual Service Plan/ ISP and updated R1's ISP as medical status changed. 2. Based on record review and interview the facility failed to ensure preventative care for 1 of 1 individual (R3) identified with a Stage two decubitus ulcer that was acquired at the facility. Findings Include: 1. On 8/12/11 at 2:35 PM an Immediate Jeopardy was identified to have begun on 4/15/11 when facility failed to ensure adequate nursing evaluation, monitoring and follow up for R1 who had been discharged from a hospitalization of pneumonia. These failures resulted in R1 being readmitted to the hospital with further occurrences of pneumonia, sepsis, urinary tract infection and electrolyte imbalance. These failures resulted in an Immediate Jeopardy. E1/	W 331		

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W 331	Continued From page 8 Administrator was notified on 8/12/11 at 2:35 PM. The Immediate Jeopardy was removed on 8/23/11 at 2:35 PM. Physician's Orders (POS) of 7/1/11- 7/31/11 identifies R1 as a 74 year old individual who functions at the severe range of Mental Retardation with additional diagnoses of Downs Syndrome, Alzheimer's, Hypothyroidism, Hypercholesterolemia, Esophageal Dyskinsia, Anemia, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Surgical Procedure Pacemaker Insertion and Past History of Gastric Resection. Review of document titled, "Hospitalizations-(R1's name)" (undated) given to surveyor by E3/ Licensed Practical Nurse on 8/10/11 at 2:15 PM, states that R1 was hospitalized as follows: Admit 4/11/11 Discharged 4/15/11 Diagnosis: Pneumonia Admit 5/7/11 Discharged 5/16/11 Diagnosis: Pneumonia Admit 6/7/11 Discharged 6/13/11 Diagnosis: Aspiration Pneumonia Admit 6/29/11 Discharged 7/7/11 Diagnosis: Pneumonia / Sepis Admit 7/19/11 Discharged 7/22/11 Diagnosis: Urinary Tract Infection/ Electrolyte Imbalance Admit 8/2/11 (no discharge date/ remains hospitalized as of 8/17/11) Respiratory Abnormalities	W 331		

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W 331	Continued From page 9 1) Review of R1's Discharge Summary's from local hospital for hospitalizations (dated 4/11/11-7/22/11) states that R2 was admitted for Pneumonia on 4/11/11, 5/7/11, 6/7/11 and 6/29/11. Review of R1's Nursing Notes 3/25/11- 4/10/11, the only documentation of assessing respiratory status was on 4/10/11 at 8:30 AM stating, "Lungs Clear." and on 4/10/11 at 4:00 PM stating, "No respiratory difficulties." There was no other evidence of nursing thoroughly assessing R1's lung sounds. R1's Nursing Notes continues with the following entries: 4/11/11 8:00 AM- "Bilateral Wheezing noted -no respiratory distress noted.Weak- unable to stand without assist. Swelling noted (right) calf and ankle." 4/11/11 9:00 AM- "To (local hospital) for ER (emergency Room) evaluation per car." 4/11/11 1:20 PM- "Admitted to (hospital with diagnosis) pneumonia." 4/15/11 5:00 PM- Readmit to Terra Estates ....to continue same meds and add (1)Plavix 75 mg daily, (2) Zpack (Zithromycin) 3 pack 250 mg times 4 days , (3) Ceftin 500 mg BID (twice a day) times 5 days (4) Nebulizer tx (treatment) albuterol. Ipratropium Bromide (every 6 hours while awake and PRN (as needed).....Lungs congested (with) raspy occasional cough. .....Nebulizer treatment given per order."	W 331		

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W 331	Continued From page 10 (There was no additional assessment documented on how or if the treatment was effective.) Reviewed Nurses Notes 4/16/11-5/6/11 with only the following documentation of nursing evaluating R1's respiratory status: 4/16/11 10:45 (no documentation AM or PM) Lungs congested. Has occasional cough." 4/17/11 15:00 (3:00 PM) "Occasional cough -noted.....Breathing treatment given at noon....." 4/1811 8:00 AM- "moist cough noted non productive" No further documentation of assessing R1's respiratory status or response to ordered nebulizer treatment or the need to provide additional nebulizer treatments documented in the Nursing Notes from the 4/19/11 to 5/6/11. R1's Nurse's Notes on 5/7/11 state, 9:30 AM , "Resident stood up from seated position on couch and collapsed. Resident unresponsive, eyes rolled back, irreg (irregular) resp (respiration)" 9:40 AM "Resp labored but not irregular." 9:50 AM "First responder here pulse ox (oximetry) 74%. Applied (oxygen) (increased) pulse ox 84%" 9:55 AM Transported to (local community hospital)." Nurse's Notes on 5/16/11 in summary, states that R1 was admitted back to Terra Estates from the hospital with a diagnosis of Clostridium Difficile and Pneumonia. R1 was sent home with new med Flagyl 500mg by mouth every eight hours	W 331		

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W 331	Continued From page 11 times five days. Nurse documented, "Lungs slightly congested, occ (occasional) cough noted." Review of Nurse"s Notes (5/17/11-6/7/11) has the following documentation of nursing auscultating lung sounds to assess thoroughly R1's respiratory status: 5/18/11 12:00 (noon) "Occ (occasional) moist cough with (right) sided wheeze noted." 5/19/11 8:00 AM- "Wheeze/ rub noted (right) upper lobe" 5/20/11 8:00 AM- "(no) wheezing noted" 5/21/11 8:20 AM- "Found per staff member unresponsive, drooling fine jerking noted to upper extremity. Pulse ox (oximetry) 89%. Transported to ER (emergency room) per ambulance." 5/21/11 3:30 PM- "Returned from)local community hospital) Drowsy. Received med's for seizures. ....Pulse ox 82% Lungs clear, occ (occasional congested cough)." 5/22/11 2 PM- "Pulse Ox (oximetry) 89% Loose congested cough at times." No evidence of written documentation that nursing assessed respiratory status thoroughly for R1 by auscultating lung sounds from 5/23/11-6/5/11. There was no written evidence that the facility staff notified the RN consultant or physician for recommendations. R1's Nurse's Notes states the following:	W 331		

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W 331	Continued From page 12 6/6/11 11:00 AM- "Lungs congested bil (bilaterally). BR (breathing) treatment cont (continue)." 6/7/11 9:00 AM- "To (physician's office) for FU (follow up) (arrow pointing down/ decreased) appetite and fluid intake. Transferred to (local community hospital) via ambulance." Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 6/7/11- 6/13/11 for aspiration pneumonia. 6/13/11 7:00 AM- "Reported by DSP (Direct Support Professional) - readmitted to facility last PM at 8:30 PM. .....moist cough noted- non productive...." 6/13/11 1:00 PM- (no) respiratory distress noted. Resp (respiration) 16- shallow continues to have loose moist cough." Review of Nurse's Notes (6/14/11- 6/28/11) there is no evidence that nursing assessed R1's respiratory status thoroughly by auscultating lungs. R1's Nurse's Notes states the following: 6/29/11 2:30 PM-"Reported by staff- in recliner- diaphoretic unresponsive." 6/29/11 2:45 PM- "Responders (911) at facility transferred to (local community hospital)." 6/29/11 (no time) - "DSP reports admitted to (local community hospital) with Dx (diagnosis) of	W 331		

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W 331	Continued From page 13 SOB (Shortness of Breath)." There is no evidence that the facility staff contacted the RN or the Physician prior to R1 being sent out by ambulance. Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 6/29/11- 7/7/11 for pneumonia/ sepsis. Review of Nurse's Notes (7/7/11-8/1/11) has the following documentation of nursing auscultating lung sounds: 7/17/11 4:00 PM- "Lungs congested today, loose cough at times." 7/22/11 4:30 PM- "Lungs moist sounds. Non productive cough." 7/23/11 9:00 AM- "Lung sounds diminished." 7/24/11 16:50 PM- "DSP reported to this nurse that resident was wheezing. Lungs checked. Gurgling heard in both lower lobes.Repositioned. Encouraged to cough frequently." There was no further written documentation that nursing assessed R1's respiratory status thoroughly by auscultating lungs from 7/7/11-8/1/11. There was no evidence that facility staff contacted the RN or the Physician for further recommendations. R1's Nurse's Notes dated 8/2/11 states the following: 8/2/11 1:00 PM- "Congested- loose cough bil	W 331		

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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
W 331	Continued From page 14 (bilateral) wheeze noted- slow to respond..... (Ambulance) called for transport to (local community hospital)." 8/3/11 late entry- "Admitted to (local community hospital) 8/2/11 with DX (diagnosis) of breathing abnormalities" In an interview with E3/ Licensed Practical Nurse on 8/11/11 at 11:35 AM, E3 stated that all documentation regarding assessing respiratory status would be found in the Nursing Notes. E3 confirmed that she has no other written evidence that nursing assessed R1's respiratory status thoroughly by auscultating lung sounds. E3 stated that Z3/Registered Nurse would assess R1's respiratory status once a year with the annual assessment. E3 confirmed that she was unable to provide written evidence that she had called the RN Consultant regarding health care issues for R1 to obtain further recommendations/ interventions to provide for R1, to potentially prevent further hospitalizations. In an interview with Z3/ Registered Nurse on 8/12/11 at 3:16 PM, when asked what she would expect the Licensed Practical Nurses at the facility to assess regarding R1's history of hospitalizations with Pneumonia, Z3 stated, "Assess respiratory status and document every shift they are there." When asked if she would expect the LPN's to auscultate R1's lungs to assess respiratory status thoroughly, Z3 stated "Yes." When asked if she felt she should be notified of changes in R1's medical status, Z3 stated "Yes." 2) Consultation Form with Z2/Nurse Practitioner	W 331		

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(dated 5/24/11) under recommendations states, "Encourage fluids frequently, report decreased urine output or continued poor fluid intake."

In review of R1's Nurse's Notes (5/24/11-7/19/11) for written evidence of facility monitoring of R1's voiding, there was only two entries documented that stated, "voided good amount" on 7/7/11 and 7/14/11.

In review of R1's Nurse's Notes (5/24/11-7/19/11) nursing did not document what R1's daily oral fluid intake in consistent measurable amounts to assess what R1's total daily fluid intake was.

R1's Nurse's Notes dated 7/19/11 state the following, "To (physician's office) for F/U (follow up) appointment. Sent to ER (emergency room) from (physician's office) for evaluation R/T (related to) dehydration.

Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 7/19/11- 7/22/11 for Urinary Tract Infection/ Electrolyte Imbalance.

In an interview with Z2/ Nurse Practitioner on 8/16/11 at 9:34 AM, when asked about R1's status when brought to the office on 7/19/11, Z2 stated, "R1 had mottling of the skin, respiratory distress, diarrhea through the weekend, only eating bites. I flat out asked, why did you bring her here." Z3 confirmed that E1 should have been taken directly to hospital and that E1 required 24 hour nursing care.

In an interview with Z3/ Registered Nurse on

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W 331	Continued From page 16 8/12/11 at 3:16 PM, when asked what she would expect staff to do related to the recommendation to monitor R1's voiding and oral fluid intake, Z3 stated, "They could count R1's attends and measure intake. They could show DSP's how many cc's there are in different items." Z3 confirmed that she would expect direct care staff to record R1's voids and oral fluid intake as per nurse practitioner's recommendations. In an interview with E3/ LPN (Licensed Practical Nurse) on 8/11/11 at 11:35 AM, E3 gave surveyor a three ring binder from the kitchen area that had documentation of oral intake of residents. Review of the book provided, there was no consistent documentation of what R1's daily oral fluid intake was as per Nurse Practitioner's recommendations. E3 confirmed that the Nurse's Notes would be the only place that documentation of R1's voiding would be found. E3 was unable to provide any further evidence of documentation of R1's voiding outside of the two entries made in Nurse's Notes for 7/7/11 and 7/14/11. 3) Facility's Policy titled, "Contacting RN (Registered Nurse) protocol" (dated March 2007) states the following: "When should I contact the RN?" 4. Any significant change in condition. 5. When the individual is not acting as usual, or appears to be ill. 6. Anytime someone is hospitalized or discharged from the hospital.	W 331		

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W 331	Continued From page 17 Review of document titled, "Hospitalizations-(R1's name)" (undated) given to surveyor by E3/ Licensed Practical Nurse on 8/10/11 at 2:15 PM, states that R1 was hospitalized on 4/11/11, 5/7/11, 6/7/11, 6/29/11 for Pneumonia, 7/19/11 for Urinary Tract Infection and 8/2/11 for Respiratory Abnormalities. In an interview with E3/ Licensed Practical Nurse on 8/11/11 at 11:35 AM, when asked when she contacts Z3/ RN, E3 stated, "If I have a question, I'll call her by phone." When asked where she would document communications with RN, "In the Nurses Notes." When asked how the RN is notified of hospitalizations, Emergency Room visits or changes in R1's status,states "She would know through Therup (computer based communication system). E3 confirmed that she does not notify Z3 per direct verbal communication. E3 confirmed that she was unable to provide evidence of notifying Z3 of changes in R1's medical status to get further recommendations. In an in an interview with Z3/ Register Nurse on 8/11/11 at 12:06 PM, when asked how facility notifies her of changes in R1's status, states "Notify by therup and E-mail." When asked how facility notifies her of changes in R1's status, states "This home is lacking in notifying about doctor's visits and emergency room visits." When asked if LPN's communicate with her about changes in R1's status, states "Sometimes they call per telephone with changes and questions." When asked where this would be documented, states "We don't document." When asked if the Direct Support Professionals call her with changes in R1's status, states "I think they're	W 331		

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W 331	Continued From page 18 reporting to LPN's." In an interview with E2/ Residential Service Director on 8/12/11 at 10:26 AM, when asked for documentation of Direct Support Professionals and LPN's contacting RN for changes in residents health status states, "They will call and she'll tell them what to do." E2 confirmed that she was unable to provide written evidence of DSP's and LPN'S contacting the RN as per facility policy. 4) Facility's Policy titled, "Contacting RN (Registered Nurse) protocol" (dated March 2007) states the following: "When should I contact the RN?" 3. Anytime vital signs are not within normal limits. 4. Any significant change in condition. 5. When the individual is not acting as usual, or appears to be ill. 6. Anytime someone is hospitalized or discharged from the hospital. 9. Anytime you feel uncomfortable with an individual's situation or have questions about an individual's disease or condition. 13. Anytime you feel a medical problem with an individual is not being taken care of. Please Note: Keep a log of your concerns and calls. It will help with quality assurance and documentation with other staff on other shifts to know what is going on and what the RN has been contacted on. It will also help when relaying information if the RN is unable to return your call on your shift. Review of facility's policy, "Contacting the RN	W 331		

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W 331	Continued From page 19 protocol" (dated March 2007), the policy does not clearly identify who will contact the RN. This policy does not identify if DSP's, LPN's and the RSD will contact the RN. This policy does not identify who will contact the physician if R1's status changes prior to a scheduled appointment so that interventions may be put in place to avoid a possible hospitalization. The policy does not state where staff are to document their contacts with RN or where the RN will document contact made by staff and her recommendations. Review of Nurse's Notes 4/11/11- 8/2/11, there was no documentation that RN had been called related to changes in R1's status by LPN, RSD or DSP. There was no documentation that nursing staff had called Physician's office to notify of changes in R1's status. In an interview with E2/ Residential Service Director on 8/10/11 at 9:18 AM and 8/17/11 at 10:51 AM, E2 stated that the facility has coverage by the LPN's Monday through Friday 7:00 AM- 9:00 PM and on weekends 7:00 AM- 5:00 PM. E2 stated that when the LPN's are not at the facility the RN consultant is available. E2 confirmed that the LPN's are not on call when off duty. When asked who staff would call when LPN's are not at the facility, states RN would be notified. E2 confirmed that she was unable to provide written evidence of DSP's or LPN's staff contacting the RN directly regarding R1's medical status. E2 was unable to provide what the facility's system is in regards to specifically who, when and how the DSP's, LPN's and RSD would contact the RN. The facility also was unable to provide the facility's system on who would call the Physician whenever their was a change in residents	W 331		

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W 331	Continued From page 20 medical status. 5) In review of R1's Nurse's Notes (4/11/11-8/2/11) their was no written documentation made by the RN or of the staff reporting to the RN regarding changes in R1's status. R1's Quarterly Nursing Reviews where completed by the E3/ LPN for 6/17/11, 3/15/11 and 12/9/10. There was no evidence that the RN consultant had reviewed the quarterly nursing assessments as they were done. In review of R1's Hospital Discharges (4/15/11-7/7/11) there was no evidence that the RN had evaluated or monitored R1's medical status. In interviews with Z3/ RN on 8/11/11 at 12:06 PM and 8/12/11 at 3:16 PM, when asked who would assess R1 when she was discharged from the hospital, Z3 stated, " LPN's will assess." When asked when she would review R1's consults, Z3 stated, "With the annual." When asked when she did a physical assessment of R1, Z3 stated, "Once a year with the annual." Z3 stated, "About a month before the annual is due, I review the whole record. I review all the quarterlies, labs, consults everything that's in the record." Z3 confirmed that she did not review quarterlies, labs, consults, discharges as they occurred or as they changed, but once a year at the annual. In an interview with Z2/ Nurse Practitioner on 8/16/11 at 9:34 AM, when asked if she would expect the RN to be informed of R1's status so that the RN could make recommendations and assessments, Z3 stated "Yes."	W 331		

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W 331	Continued From page 21 In an interview with E2/ Residential Service Director/ RSD on 8/11/11 at 12:21 PM and 8/24/11 at 9:06 AM, when asked the facility's system on how the RN/ Registered Nurse evaluates and monitors R1's status, E2 stated "The RN does yearly assessments, she'll come in the month before the annual and will review R1's record." E2 further stated that the RN will attend special staffing's for individuals and that they had a special staffing for R1 on 7/12/11. E2 confirmed that since April 2011, the facility did not have any other special staffing meetings except the 7/12/11 related to R1's medical status. 6) R1's Individual Service Plan (dated 10/6/10) states the following under section titled "Recommendations": " Monitor for cardiac and respiratory symptoms and report to nurse." " Due to history of UTI (urinary tract infection), monitor for symptoms of urinary tract infection." Review of R1's ISP of 10/6/10 does not specifically identify what direct care staff are to monitor. The recommendations do not specifically identify what type of cardiac, respiratory, and urinary tract infection signs and symptoms that the Direct Support Professional are to monitor and report to nursing. Consultation Form with Z2/Nurse Practitioner (dated 5/24/11) under recommendations states, "Encourage fluids frequently, report decreased urine output or continued poor fluid intake." Review of Individual Service Plan (dated 7/12/11)	W 331		

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states, "Just recently R1 has had a change in her health. She has been hospitalized several times in the last six months and it's starting to be more frequent. She is usually hospitalized for aspiration pneumonia. .....Her liquids must be of honey consistency to ensure that she does not aspirate. She is also to have her food pureed for her convenience. She does require prompting to eat and at times will not feed herself. Staff do have to assist in feeding her when she is noncompliant. Her intake has been poor and staff are to encourage her to eat."

Review of the ISP of 7/12/11 does not state any recommendations made by the RN of specific interventions for R1's change in medical status related to the consultation of 5/24/11 or the hospitalizations from 4/11/11- 7/7/11.

Review of Nursing Notes (4/11/11-8/2/11), R1's Consultations (4/11/11-7/29/11) and Hospital Discharge Summary/ Instructions (4/15/11-7/22/11) there is no documentation made by the Registered Nurse of any further recommendations of interventions made related to R1's change in medical status.

In an interview with E2/ Residential Service Director/ RSD on 8/11/11 at 12:21 PM and 8/24/11 at 9:06 AM, when asked the facility's system on how the RN/ Registered Nurse evaluates and monitors R1's status so that she may make further recommendations of interventions , E2 stated "The RN does yearly assessments, she'll come in the month before the annual and will review R1's record." E2 further stated that the RN will attend special staffing's for individuals and that they had a special staffing for

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R1 on 7/12/11. E2 confirmed that since April 2011, the facility did not have any other special staffing meetings except the 7/12/11 related to R1's medical status. E2 confirms there was no other evidence of Z3/ RN making changes to the R1's ISP related to specific interventions for R1's change in medical status.

E1/ Administrator was notified that the Immediate Jeopardy was removed on 8/23/11 at 2:35 PM when the surveyor confirmed through interview and review of facility plan that the facility took the following actions to remove the Immediate Jeopardy.

All staff including RSD(Residential Service Director), LPN's (Licensed Practical Nurse), and Dsp's (Direct Support Professionals) will be retrained on the RN (Registered Nurse) protocol to ensure that the Professional Nurse is notified if there are areas of concern, a change in condition, hospitalization admission/ discharge, and ER (emergency room) visits. Following the phone call from the RSD, LPN, or DSP, the RN will determine if a physical assessment of the individual is needed. Should a physical assessment be warranted the RN will either complete the physical assessment themselves or designate an LPN to complete the physical assessment. Once the assessment is completed the LPN will contact the RN with their findings.

The RN will review all recommendations from the Physician's Orders and consultant reports and document such review in the nurses notes sections of the chart. The RN will follow-up with a physical assessment as needed to ensure that these areas have been addressed. RN will also

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review all quarterlies within 30 days of completion and labs.

The RN will review all IPP's to ensure that specific signs and symptoms related to each diagnosis are listed in the recommendation section of the nurses annual so that both DSP's and LPN's understand what to look for and what to report to the RN.

The RN will train RSD, LPN's and DSP's on specific things to look for related to disease symptomology for each resident.

The RN is to document that she/he reviewed all physician and consultant instructions in order to re-evaluate residents upon re-admission from the hospital. RSD, LPN's and DSP's are to keep a log separated by resident, of their concerns and calls placed to RN. This shall also include any written orders, faxed orders or verbal instructions from the physician if applicable. The log shall include the date and time that the call was placed, the information being relayed to the RN and any recommendations that the RN has to offer. The log shall be reviewed by the RN during her next scheduled visit to the facility. The RN will sign off on the log sheet to indicate that she was contacted at the time of the incident and has reviewed and will provide any necessary follow-up instructions. A copy of the log will be placed in the residents file to ensure continuity of care. This will assist with quality assurance and documentation as well as provide information to other staff on other shifts to know what is going on and what the RN has been contacted for.

While the Immediate Jeopardy was removed on

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W 331	Continued From page 25 8/23/11 at 2:35 PM, the facility remains out of compliance at the time of exit, as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan. 2. The facility failed to ensure preventative care for 1 of 1 individual (R3) identified with a Stage II/ III decubiti ulcer that was acquired at the facility. Physician's Orders/ POS (dated 8/1/11- 8/31/11) identify R3 as a 82 year old individual who functions at the Severe range of Mental Retardation with additional diagnoses of Anemia, Diabetes Mellitus Type II and Edema. The POS states that R1 utilizes a wheelchair for mobility and requires assist of two for transfers. R3's Consultation Form (dated 7/28/11) under Findings states, "Stage II/ III pressure ulcer to (left) buttock." R3's Consultation Form (dated 8/1/11) states, " 1)Cleanse (left) buttocks wound with (normal saline) 2)Apply Santyl to black necrotic tissue." Wound Clinic Problem List (dated 8/1/11) states, " R3 in for evaluation of a decubitus on the left buttock measuring 0.7 x 1.1 x indeterminate. .....The area is indurated surrounding it and pale erythema is noted for about 1 cm in all directions. .....She has an eschar with surrounding erythema as described above. No drainage." In an interview with E3/ Licensed Practical Nurse on 8/11/11 at 1:43 PM, E3 confirmed that R2 acquired the decubitus ulcer to left hip while	W 331		

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W 331	Continued From page 26 receiving care at this facility.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230d)1) 350.3240a) 350.3750 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 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, 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.	W9999		

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W9999	Continued From page 27 Section 350.1230 Nursing Services 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) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on record review and interview the facility failed to ensure nursing services provided adequate nursing evaluation, monitoring and	W9999		

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W9999	Continued From page 28 follow up for 1 of 3 in sample (R1) with sufficient nursing interventions and recommendations to meet the medical needs resulting in multiple hospitalizations when facility failed to: 1) Ensure thorough nursing evaluation of R1's respiratory status. 2) Follow physician's recommendations to monitor R1's voiding and oral fluid intake. 3) Implement facility's policy on contacting RN (Registered Nurse) Consultant regarding changes in R1's status. 4) Ensure facility has a system which identifies when Direct Support Staff and Licensed Practical Nurse will contact RN Consultant or Physician for R1. 5) Ensure facility has a system which identifies how/when the RN consultant will evaluate and monitor R1's status so that she/he may make recommendations to meet R1's medical needs. 6) Ensure nursing has evaluated and identified specific interventions in R1's Individual Service Plan/ISP and updated R1's ISP as medical status changed. Findings Include: Physician's Orders (POS) of 7/1/11- 7/31/11 identify R1 as a 74 year old individual who functions at the severe range of Mental Retardation with additional diagnoses of Downs Syndrome, Alzheimer's, Hypothyroidism, Hypercholesterolemia, Esophageal Dyskinsia,	W9999		

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W9999	Continued From page 29 Anemia, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Surgical Procedure Pacemaker Insertion and Past History of Gastric Resection. Review of document titled, "Hospitalizations-(R1's name)" (undated) given to surveyor by E3/ Licensed Practical Nurse on 8/10/11 at 2:15 PM, states that R1 was hospitalized as follows: Admit 4/11/11 Discharged 4/15/11 Diagnosis: Pneumonia Admit 5/7/11 Discharged 5/16/11 Diagnosis: Pneumonia Admit 6/7/11 Discharged 6/13/11 Diagnosis: Aspiration Pneumonia Admit 6/29/11 Discharged 7/7/11 Diagnosis: Pneumonia / Sepis Admit 7/19/11 Discharged 7/22/11 Diagnosis: Urinary Tract Infection/ Electrolyte Imbalance Admit 8/2/11 (no discharge date/ remains hospitalized as of 8/17/11) Respiratory Abnormalities 1) Review of R1's Discharge Summary's from local hospital for hospitalizations (dated 4/11/11-7/22/11) states that R2 was admitted for Pneumonia on 4/11/11, 5/7/11, 6/7/11 and 6/29/11. Review of R1's Nursing Notes 3/25/11- 4/10/11, the only documentation of assessing respiratory status was on 4/10/11 at 8:30 AM stating, "Lungs	W9999		

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Clear," and on 4/10/11 at 4:00 PM stating, "No respiratory difficulties." There was no other evidence of nursing thoroughly assessing R1's lung sounds.

R1's Nursing Notes continues with the following entries:

4/11/11 8:00 AM- "Bilateral Wheezing noted -no respiratory distress noted.Weak- unable to stand without assist. Swelling noted (right) calf and ankle."

4/11/11 9:00 AM- "To (local hospital) for ER (emergency Room) evaluation per car."

4/11/11 1:20 PM- "Admitted to (hospital with diagnosis) pneumonia."

4/15/11 5:00 PM- Readmit to Terra Estates ....to continue same meds and add (1) Plavix 75 mg daily, (2) Zpack (Zithromycin) 3 pack 250 mg times 4 days , (3) Ceftin 500 mg BID (twice a day) times 5 days (4) Nebulizer tx (treatment) albuterol. Ipratropium Bromide (every 6 hours while awake and PRN (as needed).....Lungs congested (with) raspy occasional cough. .....Nebulizer treatment given per order." (There was no additional assessment documented on how or if the treatment was effective.)

Reviewed Nurses Notes 4/16/11-5/6/11 with only the following documentation of nursing evaluating R1's respiratory status:

4/16/11 10:45 (no documentation AM or PM) "Lungs congested. Has occasional cough."

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W9999	Continued From page 31 4/17/11 15:00 (3:00 PM) "Occasional cough -noted.....Breathing treatment given at noon....." 4/1811 8:00 AM- "moist cough noted non productive." No further documentation of assessing R1's respiratory status or response to ordered nebulizer treatment or the need to provide additional nebulizer treatments documented in the Nursing Notes from the 4/19/11 to 5/6/11. R1's Nurse's Notes on 5/7/11 state, 9:30 AM, "Resident stood up from seated position on couch and collapsed. Resident unresponsive, eyes rolled back, irreg (irregular) resp (respiration)." 9:40 AM "Resp labored but not irregular." 9:50 AM "First responder here pulse ox (oximetry) 74%. Applied (oxygen) (increased) pulse ox 84%" 9:55 AM Transported to (local community hospital)." Nurse's Notes on 5/16/11, in summary, state that R1 was admitted back to Terra Estates from the hospital with a diagnosis of Clostridium Difficile and Pneumonia. R1 was sent home with new med Flagyl 500mg by mouth every eight hours times five days. Nurse documented, "Lungs slightly congested, occ (occasional) cough noted." Review of Nurse"s Notes (5/17/11-6/7/11) has the following documentation of nursing auscultating lung sounds to assess thoroughly R1's respiratory status: 5/18/11 12:00 (noon) "Occ (occasional) moist	W9999		

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cough with (right) sided wheeze noted."

5/19/11 8:00 AM- "Wheeze/ rub noted (right) upper lobe."

5/20/11 8:00 AM- "(no) wheezing noted."

5/21/11 8:20 AM- "Found per staff member unresponsive, drooling fine jerking noted to upper extremity. Pulse ox (oximetry) 89%. Transported to ER (emergency room) per ambulance."

5/21/11 3:30 PM- "Returned from)local community hospital) Drowsy. Received med's for seizures. ....Pulse ox 82% Lungs clear, occ (occasional congested cough)."

5/22/11 2 PM- "Pulse Ox (oximetry) 89% Loose congested cough at times."

No evidence of written documentation that nursing assessed respiratory status thoroughly for R1 by auscultating lung sounds from 5/23/11-6/5/11. There was no written evidence that the facility staff notified the RN consultant or physician for recommendations.

R1's Nurse's Notes states the following:

6/6/11 11:00 AM- "Lungs congested bil (bilaterally). BR (breathing) treatment cont (continue)."

6/7/11 9:00 AM- "To (physician's office) for FU (follow up) (arrow pointing down/decreased) appetite and fluid intake. Transferred to (local community hospital) via ambulance."

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W9999	Continued From page 33 Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 6/7/11- 6/13/11 for aspiration pneumonia. 6/13/11 7:00 AM- "Reported by DSP (Direct Support Professional) - readmitted to facility last PM at 8:30 PM. .....moist cough noted- non productive...." 6/13/11 1:00 PM- "(no) respiratory distress noted. Resp (respiration) 16- shallow continues to have loose moist cough." Review of Nurse's Notes (6/14/11- 6/28/11) there is no evidence that nursing assessed R1's respiratory status thoroughly by auscultating lungs. R1's Nurse's Notes states the following: 6/29/11 2:30 PM-"Reported by staff- in recliner- diaphoretic unresponsive." 6/29/11 2:45 PM- "Responders (911) at facility transferred to (local community hospital)." 6/29/11 (no time) - "DSP reports admitted to (local community hospital) with Dx (diagnosis) of SOB (Shortness of Breath)." There is no evidence that the facility staff contacted the RN or the Physician prior to R1 being sent out by ambulance. Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 6/29/11- 7/7/11 for pneumonia/sepsis.	W9999		

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Review of Nurse's Notes (7/7/11-8/1/11) has the following documentation of nursing auscultating lung sounds:

7/17/11 4:00 PM- "Lungs congested today, loose cough at times."

7/22/11 4:30 PM- "Lungs moist sounds. Non productive cough."

7/23/11 9:00 AM- "Lung sounds diminished."

7/24/11 16:50 PM- "DSP reported to this nurse that resident was wheezing. Lungs checked. Gurgling heard in both lower lobes.Repositioned. Encouraged to cough frequently."

There was no further written documentation that nursing assessed R1's respiratory status thoroughly by auscultating lungs from 7/7/11-8/1/11. There was no evidence that facility staff contacted the RN or the Physician for further recommendations.

R1's Nurse's Notes dated 8/2/11 states the following:

8/2/11 1:00 PM- "Congested- loose cough bil (bilateral) wheeze noted- slow to respond..... (Ambulance) called for transport to (local community hospital)."

8/3/11 late entry- "Admitted to (local community hospital) 8/2/11 with DX (diagnosis) of breathing abnormalities"

In an interview with E3/ Licensed Practical Nurse on 8/11/11 at 11:35 AM, E3 stated that all

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W9999	Continued From page 35 documentation regarding assessing respiratory status would be found in the Nursing Notes. E3 confirmed that she has no other written evidence that nursing assessed R1's respiratory status thoroughly by auscultating lung sounds. E3 stated that Z3/Registered Nurse would assess R1's respiratory status once a year with the annual assessment. E3 confirmed that she was unable to provide written evidence that she had called the RN Consultant regarding health care issues for R1 to obtain further recommendations/interventions to provide for R1, to potentially prevent further hospitalizations. In an interview with Z3/Registered Nurse on 8/12/11 at 3:16 PM, when asked what she would expect the Licensed Practical Nurses at the facility to assess regarding R1's history of hospitalizations with Pneumonia, Z3 stated, "Assess respiratory status and document every shift they are there." When asked if she would expect the LPN's to auscultate R1's lungs to assess respiratory status thoroughly, Z3 stated "Yes." When asked if she felt she should be notified of changes in R1's medical status, Z3 stated "Yes." 2) Consultation Form with Z2/Nurse Practitioner (dated 5/24/11) under recommendations states, "Encourage fluids frequently, report decreased urine output or continued poor fluid intake." In review of R1's Nurse's Notes (5/24/11-7/19/11) for written evidence of facility monitoring of R1's voiding, there was only two entries documented that stated, "voided good amount" on 7/7/11 and 7/14/11.	W9999		

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In review of R1's Nurse's Notes (5/24/11-7/19/11) nursing did not document what R1's daily oral fluid intake in consistent measurable amounts to assess what R1's total daily fluid intake was.

R1's Nurse's Notes dated 7/19/11 state the following, "To (physician's office) for F/U (follow up) appointment. Sent to ER (emergency room) from (physician's office) for evaluation R/T (related to) dehydration.

Facility document titled "Hospitalizations - (R1's name)" (no date) states that R1 was hospitalized 7/19/11- 7/22/11 for Urinary Tract Infection/ Electrolyte Imbalance.

In an interview with Z2/Nurse Practitioner on 8/16/11 at 9:34 AM, when asked about R1's status when brought to the office on 7/19/11, Z2 stated, "R1 had mottling of the skin, respiratory distress, diarrhea through the weekend, only eating bites. I flat out asked, why did you bring her here." Z2 confirmed that R1 should have been taken directly to hospital and that R1 required 24 hour nursing care.

In an interview with Z3/ Registered Nurse on 8/12/11 at 3:16 PM, when asked what she would expect staff to do related to the recommendation to monitor R1's voiding and oral fluid intake, Z3 stated, "They could count R1's attends and measure intake. They could show DSP's how many cc's there are in different items." Z3 confirmed that she would expect direct care staff to record R1's voids and oral fluid intake as per nurse practitioner's recommendations.

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W9999	Continued From page 37 In an interview with E3/ LPN (Licensed Practical Nurse) on 8/11/11 at 11:35 AM, E3 gave surveyor a three ring binder from the kitchen area that had documentation of oral intake of residents. Review of the book provided, there was no consistent documentation of what R1's daily oral fluid intake was as per Nurse Practitioner's recommendations. E3 confirmed that the Nurse's Notes would be the only place that documentation of R1's voiding would be found. E3 was unable to provide any further evidence of documentation of R1's voiding outside of the two entries made in Nurse's Notes for 7/7/11 and 7/14/11. 3) Facility's Policy titled, "Contacting RN (Registered Nurse) protocol" (dated March 2007) states the following: "When should I contact the RN?" 4. Any significant change in condition. 5. When the individual is not acting as usual, or appears to be ill. 6. Anytime someone is hospitalized or discharged from the hospital. Review of document titled, "Hospitalizations-(R1's name)" (undated) given to surveyor by E3/ Licensed Practical Nurse on 8/10/11 at 2:15 PM, states that R1 was hospitalized on 4/11/11, 5/7/11, 6/7/11, 6/29/11 for Pneumonia, 7/19/11 for Urinary Tract Infection and 8/2/11 for Respiratory Abnormalities. In an interview with E3/ Licensed Practical Nurse on 8/11/11 at 11:35 AM, when asked when she	W9999		

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contacts Z3/ RN, E3 stated, "If I have a question, I'll call her by phone." When asked where she would document communications with RN, "In the Nurses Notes." When asked how the RN is notified of hospitalizations, emergency room visits or changes in R1's status, E3 stated "She would know through Therup (computer based communication system). E3 confirmed that she does not notify Z3 per direct verbal communication. E3 confirmed that she was unable to provide evidence of notifying Z3 of changes in R1's medical status to get further recommendations.

In an in an interview with Z3/ Register Nurse on 8/11/11 at 12:06 PM, when asked how facility notifies her of changes in R1's status, Z3 stated "Notify by therup and E-mail." When asked how facility notifies her of changes in R1's status, Z3 stated "This home is lacking in notifying about doctor's visits and emergency room visits." When asked if LPN's communicate with her about changes in R1's status, Z3 stated "Sometimes they call per telephone with changes and questions." When asked where this would be documented, Z3 stated "We don't document." When asked if the Direct Support Professionals call her with changes in R1's status, Z3 stated "I think they're reporting to LPN's."

In an interview with E2/Residential Service Director on 8/12/11 at 10:26 AM, when asked for documentation of Direct Support Professionals and LPN's contacting RN for changes in residents health status E2 stated, "They will call and she'll tell them what to do." E2 confirmed that she was unable to provide written evidence of DSP's and LPN'S contacting the RN as per

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W9999	Continued From page 39 facility policy. 4) Facility's Policy titled, "Contacting RN (Registered Nurse) protocol" (dated March 2007) states the following: "When should I contact the RN? 3. Anytime vital signs are not within normal limits. 4. Any significant change in condition. 5. When the individual is not acting as usual, or appears to be ill. 6. Anytime someone is hospitalized or discharged from the hospital. 9. Anytime you feel uncomfortable with an individual's situation or have questions about an individual's disease or condition. 13. Anytime you feel a medical problem with an individual is not being taken care of. Please Note: Keep a log of your concerns and calls. It will help with quality assurance and documentation with other staff on other shifts to know what is going on and what the RN has been contacted on. It will also help when relaying information if the RN is unable to return your call on your shift." Review of facility's policy, "Contacting the RN protocol" (dated March 2007), the policy does not clearly identify who will contact the RN. This policy does not identify whether DSP's, LPN's and the RSD will contact the RN. This policy does not identify who will contact the physician if R1's status changes prior to a scheduled appointment so that interventions may be put in place to avoid a possible hospitalization. The policy does not state where staff are to document their contacts with RN or where the RN will document contact	W9999		

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made by staff and her recommendations.

Review of Nurse's Notes 4/11/11- 8/2/11, there was no documentation that RN had been called related to changes in R1's status by LPN, RSD or DSP. There was no documentation that nursing staff had called Physician's office to notify of changes in R1's status.

In an interview with E2/Residential Service Director on 8/10/11 at 9:18 AM and 8/17/11 at 10:51 AM, E2 stated that the facility has coverage by the LPN's Monday through Friday 7:00 AM-9:00 PM and on weekends 7:00 AM- 5:00 PM. E2 stated that when the LPN's are not at the facility the RN consultant is available. E2 confirmed that the LPN's are not on call when off duty. When asked who staff would call when LPN's are not at the facility, E2 stated RN would be notified. E2 confirmed that she was unable to provide written evidence of DSP or LPN staff contacting the RN directly regarding R1's medical status. E2 was unable to provide what the facility's system is in regards to specifically who, when and how the DSP's, LPN's and RSD would contact the RN. The facility also was unable to provide the facility's system on who would call the Physician whenever their was a change in residents medical status.

5) In review of R1's Nurse's Notes (4/11/11-8/2/11) their was no written documentation made by the RN or of the staff reporting to the RN regarding changes in R1's status.

R1's Quarterly Nursing Reviews were completed by the E3/LPN for 6/17/11, 3/15/11 and 12/9/10. There was no evidence that the RN consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G255	A. BUILDING _____ B. WING _____	C 08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRA ESTATES	620 NORTH MAIN STREET HOYLETON, IL 62803

(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
W9999	Continued From page 41	W9999		

had reviewed the quarterly nursing assessments as they were done.

In review of R1's Hospital Discharges (4/15/11-7/7/11) there was no evidence that the RN had evaluated or monitored R1's medical status.

In interviews with Z3/RN on 8/11/11 at 12:06 PM and 8/12/11 at 3:16 PM, when asked who would assess R1 when she was discharged from the hospital, Z3 stated, "LPN's will assess." When asked when she would review R1's consults, Z3 stated, "With the annual." When asked when she did a physical assessment of R1, Z3 stated, "Once a year with the annual." Z3 stated, "About a month before the annual is due, I review the whole record. I review all the quarterlies, labs, consults everything that's in the record." Z3 confirmed that she did not review quarterlies, labs, consults, discharges as they occurred or as they changed, but once a year at the annual.

In an interview with Z2/Nurse Practitioner on 8/16/11 at 9:34 AM, when asked if she would expect the RN to be informed of R1's status so that the RN could make recommendations and assessments, Z3 stated "Yes."

In an interview with E2/Residential Service Director/RSD on 8/11/11 at 12:21 PM and 8/24/11 at 9:06 AM, when asked the facility's system on how the RN/ Registered Nurse evaluates and monitors R1's status, E2 stated, "The RN does yearly assessments, she'll come in the month before the annual and will review R1's record." E2 further stated that the RN will attend special staffing's for individuals and that they had a special staffing for R1 on 7/12/11. E2 confirmed

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W9999	Continued From page 42 that since April 2011, the facility did not have any other special staffing meetings except the 7/12/11 related to R1's medical status. 6) R1's Individual Service Plan (dated 10/6/10) states the following under section titled "Recommendations": "Monitor for cardiac and respiratory symptoms and report to nurse." "Due to history of UTI (urinary tract infection), monitor for symptoms of urinary tract infection." Review of R1's ISP of 10/6/10 does not specifically identify what direct care staff are to monitor. The recommendations do not specifically identify what type of cardiac, respiratory, and urinary tract infection signs and symptoms that the Direct Support Professional are to monitor and report to nursing. Consultation Form with Z2/Nurse Practitioner (dated 5/24/11) under recommendations states, "Encourage fluids frequently, report decreased urine output or continued poor fluid intake." Review of Individual Service Plan (dated 7/12/11) states, "Just recently R1 has had a change in her health. She has been hospitalized several times in the last six months and it's starting to be more frequent. She is usually hospitalized for aspiration pneumonia. .....Her liquids must be of honey consistency to ensure that she does not aspirate. She is also to have her food pureed for her convenience. She does require prompting to eat and at times will not feed herself. Staff do have to assist in feeding her when she is	W9999		

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W9999	Continued From page 43 noncompliant. Her intake has been poor and staff are to encourage her to eat." Review of the ISP of 7/12/11 does not state any recommendations made by the RN of specific interventions for R1's change in medical status related to the consultation of 5/24/11 or the hospitalizations from 4/11/11- 7/7/11. Review of Nursing Notes (4/11/11-8/2/11), R1's Consultations (4/11/11-7/29/11) and Hospital Discharge Summary/ Instructions (4/15/11-7/22/11) there is no documentation made by the Registered Nurse of any further recommendations of interventions made related to R1's change in medical status. In an interview with E2/ Residential Service Director/RSD on 8/11/11 at 12:21 PM and 8/24/11 at 9:06 AM, when asked the facility's system on how the RN/ Registered Nurse evaluates and monitors R1's status so that she may make further recommendations of interventions, E2 stated, "The RN does yearly assessments, she'll come in the month before the annual and will review R1's record." E2 further stated that the RN will attend special staffing's for individuals and that they had a special staffing for R1 on 7/12/11. E2 confirmed that since April 2011, the facility did not have any other special staffing meetings except the 7/12/11 related to R1's medical status. E2 confirmed there was no other evidence of Z3/RN making changes to the R1's ISP related to specific interventions for R1's change in medical status. (A)	W9999		