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	145358	A. BUILDING _____ B. WING _____	C 02/21/2013

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F 329	Continued From page 13 other psychotropic medications until 01/21/13. R2's prior placement psychiatry progress notes dated 01/18/13 and 01/20/13 include presence of confusion, calm, pleasant behavior. Denied anxiety or depression. Only psychotropic Zoloft 50mg. Continue present management. R2's initial care plan did not include any behavior problems requiring medication intervention. R2's medical record failed to document any non-pharmacological interventions attempted prior to administering anti-psychotic or anti-anxiety medications. R2's Social service notes only included a 01/21/13 admission note. No documentation of behavior problems. During 01/15/13 interview E1 (Director of nurses), said that R2's behaviors ceased after the extubation incident 01/21/13 and R2 was transferred back to the first floor medicare unit 1-2 days after admission. No further agitation or disruptive behaviors occurred. R2 was admitted to facility for therapy.	F 329		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by	F9999		

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F9999	Continued From page 14 the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status,	F9999		

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F9999	Continued From page 15 and drug therapy. 3) Developing an up-to-date resident care plan for 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on interview, record review and observation facility failed to monitor/supervise a newly admitted resident (R2) with a tracheostomy tube (trach), who was exhibiting anxious, agitated and restless behaviors. The facility failed to have trained staff and emergency tracheostomy care equipment readily accessible when (R2) removed her tracheostomy tube. These failures resulted in R2 requiring emergency hospitalization to reinsert the tracheostomy tube.	F9999		

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F9999	Continued From page 16 This applies to 1 of 3 residents (R2) reviewed for tracheotomy tube care in the sample of 3. The findings include: R2's Nursing notes dated 1/21/13 5PM, show R2 was admitted to first floor medicare unit, alert and oriented and responsive, denies pain or discomfort. R2 was hallucinating and seeing people in her room, a bed and chair alarm were attached. On 1/21/13 at 5:30PM, R2 was noted to have severe anxiety attacks screaming and verbally aggressive to staff. R2's physician (Z4), was called and ordered new anti-anxiety medications. On 1/21/13 physician orders (POS), includes obtain psych consult, Xanax 0.25mg by mouth (PO), 3 times a day as needed, Seroquel 12.5mg now and every night at hour of sleep (HS). On 1/21/13 medication administration record (MAR), documents that R2 was administered Seroquel 12.5mg at 5PM and again at 9PM. On 1/21/13 at 9PM, R2 Nurses Notes document R2 was restless and a PRN medication was given. (R2's 1/21/13 MAR and nurses notes do not include documentation that a PRN was given for restlessness and the result of PRN administered). Nurses note continues to include "Resident noted to be a little restless". Resident noted to be anxious again after supper, she was assisted to bathroom, Certified Nurse Aide stated she left resident for 5 seconds to get the gown and saw patient with trach pulled out on her return. Z4 notified and ordered to send R2 to the	F9999		

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F9999	Continued From page 17 hospital for evaluation. R2's transfer form to hospital includes "Resident pulled out trach and Z4 ordered to send to emergency room", the form also documented R2 was at risk for falls. R2's 1/21/13 hospital emergency room report documents that R2 arrived in the emergency room at 9:45 PM. R2 accidentally pulled out her trach at 7PM tonight while pulling her shirt off. At 12:00AM Z5 (emergency room physician), attempted to reinsert the tracheostomy with respiratory therapy at the bedside, with moderate difficulty. At 12:20AM a #4.0 un-cuffed tracheostomy tube was placed and secured with trach ties by Z5. On 1/21/13 at 1:30AM, R2's nurses note document that R2 returned from hospital by ambulance. R2 was alert, verbally responsive with trach intact, size 4.0 with slight bleeding and appears tired wanting to go to sleep. On 2/15/13 at 11:00AM, E1 said that on 01/21/13 R2 was admitted to first floor , Medicare unit. R2 was agitated, restless, required one on one supervision by nursing staff. R2 was disruptive, setting off her chair alarm frequently and upsetting other first floor residents. Within two hours of admission, R2 was transferred from first floor to the second floor long term care unit. Shortly after transfer to second floor a nurse aide (E14), took R2 to the bathroom and left the resident alone on the toilet. E14 left R2 alone while E14 went to get some supplies. When E14 returned to the bathroom, R2 was observed with her trach tube extubated and resting in R2's	F9999		

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F9999	Continued From page 18	F9999		

hand. 911 was not called, we called physician and transferred R2 to hospital by ambulance.

During a 02/15/13 1:00PM phone interview, E14 said the following;
01/21/13 was the first time she had ever worked with R2. At approximately 7PM, R2 was taken to the bathroom per R2's request. R2's gown was wet, so E14 left R2 in the bathroom, went out into the hall to get a clean gown from linen cart in the hallway. Upon return to bathroom R2 was observed with her trach tube in her hand. E14 immediately notified E10 (nurse), whom notified E9 (nurse).

On 2/15/13 at 2PM, E10 said that E14 came to her with R2's trach saying that R2 pulled it out. E10 called E1 and Z4. E10 said there was no emergency equipment at R2's bedside. All extra trach's are kept in the supply room. E10 also said she was not familiar with care of trach's and all the different types of trach tubes. E10 said R2 was the first trach patient she had cared for since working at facility. E10 also said if a residents trach came out she would not re-insert one and E10 did not know if the registered nurses in facility would re-insert a new trach either.

On 2/15/13 at 2:10 PM, E9 said that on 01/21/13 evening shift, E10 called for assistance with R2. R2 had pulled out her trach tube. E9 said Respiratory therapy sets up bedside trach supplies. All extra trach's are kept in the clean utility room. E9 said he did not know what emergency supplies for trach patients should be at the bedside. E9 said since date of hire in September 2012, he had not taken care of any residents with trach's.

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F9999	Continued From page 19 On 2/15/13 at 12:13PM, observation of the second floor clean utility room showed there were no bedside trach supply set-ups. Surveyor observed boxes of different sized trachs in bulk boxes, suction catheter kits in another box, suction machines on a cabinet behind a cart. The facilities 01/21/13 staffing schedule documents E9 and E10 were the second floor nurses on the 2:30PM - 10:30PM shift. On 2/19/13 at 10:05AM, E1 said E13 (Respiratory therapist), works one day a week at the facility on Thursdays and Z2 (Pulmonologist), also comes to facility on Thursdays. E1 also said the facility has a nurse practioner on staff Monday through Friday from 8:30AM to 5PM. R2's trach was extubated at 7PM on a Monday (1/21/13). E1 said that as of 2/18/13 the facility has one nurse on day shift (6:30AM-2:30PM) and one nurse on night shift (10:30PM-6:30AM), that are trained on re-inserting trachs. E1 said that facility currently has no one on PM shift (2:30PM-10:30PM), that is trained in re-inserting trachs. On 2/19/13 at 1:25PM, during a telephone interview, Z2 (R2's Pulmonologist), said the nurses at facility are not trained on re-inserting trach tubes in residents. This is why R2 required emergency room treatment 01/21/13. The 1/24/13 Pulmonologist progress note documents, R2 has failed nocturnal capping of her trach tube due to Hypercapnia. Needs #4 un-cuffed trach tubes, history of Aspiration Pneumonia, continue un-capped trach with	F9999		

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F9999	Continued From page 20 humidification at night. The respiratory therapist initial evaluation dated 1/22/13 documents R2's trach was initially inserted 12/20/12. History of OSA (obstructive sleep apnea), Hypercarbic, Respiratory failure, diaphragmatic dysfunction. Facilities Tracheostomy Care policy and procedure includes : a sterile tracheostomy tube of the same size shall be readily available at the bedside. An obturator of the same size, suction equipment and supplies shall be maintained at the patients bedside at all times for emergency use. (B)	F9999		