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F 323	Continued From page 30 Facility Policy: Facility Procedure For The Use of Physical Restraints (undated) indicates: Prior to the implementation of a physical restraint, the facility must: 1. Complete an assessment of the resident's overall needs 2. Complete the 4-page Physical Restraint RAP Assessment of the resident's need for physical restraints and possible less restrictive alternatives. Facility Policy: Facility Procedure For The Use of Physical Restraints: Exceptions for Emergency Situations I. Identification of Emergency After less restrictive interventions to prevent the resident from doing serious harm have been proven ineffective, determine the need for an emergency physical restraint. This determination may be made by a nurse. On 5/3/13 at 3:10pm E2 DON stated "Yes, it would be considered an emergency if a resident pulled his trach tube out."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 31 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a	F9999		

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F9999	Continued From page 32 resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 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. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interview and record review the facility neglected to assess for self-harm, to adequately	F9999		

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assess and monitor restraint usage, to follow physicians orders and to monitor and provide adequate supervision for one (R12) of three residents reviewed with a tracheostomy. This failure and neglect resulted in R12 removing his mitt restraints resulting in the self-injurious action of pulling his tracheostomy tube out, being found unresponsive by staff and transport to the hospital where R12 died.

Findings include:

R12 was admitted on 2/21/13 from a local hospital with diagnosis which includes acute respiratory failure with a tracheostomy, hypertension, chronic obstructive pulmonary disorder and suicide ideation. R12 was 60 years old.
R12 was discharged on 3/5/13 to a local hospital and expired on 3/6/13 at the hospital.

Nursing Admission and Assessment Sheet dated 2/21/13 indicates Other Chronic Illness as Suicidal Ideation and Psychosocial/ Restraints used: hand restraints with Reason: history of suicidal ideation. Assessment indicates R12 was alert and oriented to person, place and time.

Nurse's Notes dated 2/21/13 at 6:30pm indicate R12 had soft hand mitten restraints.
Physicians Order Sheet/POS dated 2/21/13 indicate soft hand restraints bilateral were ordered on admission. Also ordered on admission POS were Tracheostomy care, size and continuous oxygen via tracheostomy tube.

On 5/2/13 at 4:30pm E14, Licensed Practical

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F9999	Continued From page 34 Nurse/PM shift Supervisor stated he admitted R12 on 2/21/13 and was unsure if he took a phone report from the hospital or if the admit report was previously written on R12. E14 further stated he had received no other specifics regarding the diagnosis of suicide ideation however did provide R12 with 1:1 staff supervision for the last "three or four hours of the shift because the staff didn't know R12 yet and I was being cautious due to R12 requiring bilateral mitts to prevent him from pulling out his tracheostomy (trach) tube." E14 stated at that time that he did not include the bilateral mitt restraints or R12's documented behavior of pulling his trach tube out on R12's Initial Care Plan as he didn't believe it was "an active problem" despite R12 being received at the facility with bilateral mitt restraints and an admission physicians order to continue restraints at the facility. On 5/3/13 at 1pm E2, Director of Nursing/DON stated " The mitt restraints and the behavior requiring the restraints should've been on the initial care plan. The initial care plan should be reviewed by each department within 24-72 hours of admit and updated as necessary." The initial care plan for R12 completed on 2/21/13 by E14 did not contain the problem mitt restraints or the behavior R12 exhibited requiring the use of the restraints. Hospital referral records dated 2/13/13 indicate History of Present Illness: R12 was transferred from another hospital where he was admitted with a dislodged tracheostomy tube/status post extubation, apparently dislodged; Past Medical History includes: History of suicide attempt, circumstances of which are not clear;	F9999		

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F9999	Continued From page 35 Assessment and Plan: Respiratory failure status post extubation and remains on a tracheostomy collar and History of suicide attempt, circumstances which are not very clear; Depression and psychosis. Hospital referral records dated 2/20/13 indicate Restraints: Non-emergent restraint: Hand mitten restraint and monitoring, bilateral hands. On 5/3/13 at 1:00pm E2, DON stated "The facility's expectation when reviewing the admissions referral is to go through every page and every line and to place all pertinent information on top of the referral so everyone is aware. We don't like to take residents from the hospital with restraints. We would have asked the hospital not to send the resident with restraints without a trial of any restraints for 48-72 hours." Social Service Progress Notes/Admission Note dated 2/25/13 (4 days after R12 was admitted), indicates R12 has attempted to remove tubes multiple times since admission. On 5/1/13 at 12:50pm E16, Psych Rehabilitation Services Coordinator/PRSC stated "Today is the first I saw R12's admission records. It wasn't presented to me when he was admitted and I didn't see it, but I am ultimately responsible for reviewing it on admission. It would have triggered a self-harm assessment given R12's history." E16 also stated she did not complete some of the initial assessments on R12 due to his inability to speak and was waiting to talk with his family. E16 stated she spoke with R12's family member on 2/27/13 and documented that conversation in a progress note however did not request information to complete assessments or discuss R12's behavior of pulling trach tube.	F9999		

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On 5/1/13 E16 further stated that on 3/4/13 a nurse (unable to recall staff's name), let her know about R12's attempts to remove his tracheostomy tube and that it was becoming a behavior. E16 went on to state that she even went into R12's room and R12 was in the process of attempting to remove a mitt on one hand with his teeth and then attempted to remove the other mitt with his free hand. E16 stated that she and the nurse discussed the repeated behavior of R12 removing his mittens and attempting to pull his trach tube. E16 went on to state " I told the nurse the only thing I could imagine was to have someone with him all the time to stop him from doing it. The nurse agreed. I thought nursing was handling it after that."

On 5/2/13 at 10:40am E17 Assistant Social Services Director stated "E16 got a report from a nurse that R12 pulled or attempted to pull his trach tube and I asked her if she let the nurse know and E16 stated 'yes the nurse was aware.' I told E16 to be sure to care plan it." E17 went on to state that the expectation would be to make a note, document the discussion and observation of residents behavior in the chart. That would have been the action that needed to take place to communicate concerns."
No documentation was found or presented to indicate E16's observations and/or conversations with staff were documented or communicated verbally to other staff. R12's care plan did not include revisions, updates or a plan to address R12's behavior of removing mitten restraints or attempts to pull his trach tube by nursing or social services.

On 5/2/13 at 10:21 E7 Psych Rehabilitation

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Services Director/PRSD stated "A Self Harm/Suicide Risk Assessment should've been done for this resident (R12) due to the triggers. E16 should have reviewed the hospital transfer records prior to interviewing the resident. E16 never spoke to me regarding R12 or his behaviors."

On 5/3/13 at 1:00pm E2 DON stated "I agree initial investigation into R12's history of suicide attempt and suicide ideation and his behaviors and restraints should have been done."

Facility policy Screening for Evaluating Self-Harm/Suicide Risk Protocol/Assessment Objective indicates: It is the facilities policy to assess, evaluate and investigate statements voiced by residents or otherwise communicated (via behavior symptoms) that may be threatening to themselves or others and pose a risk to safety. The facility will provide appropriate follow-up interventions based upon the individual ' s needs. Procedure: It is advisable to screen new admissions using this tool, especially when:
B. There is a history of self-directed aggression.
E. The person is an older adult who has experienced multiple personal and physical losses/multiple medical issues.

Nurse's Notes dated 2/22/13,7am indicates R12 was received awake with right soft mitten to hand, trying to pull on tracheostomy collar. Resident reminded not to pull tubing.
Nurse's Notes dated 2/23/13,7pm indicates while staff was 'rounding' observed R12 removed trach inner cannula, staff reinserted tube. Staff reeducated importance of not removing tube.
Nurse's Notes dated 2/23/13,9pm indicates while

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staff 'rounding' staff observed R12 holding trach tube in hand. New inner cannula inserted will continue to monitor.
Nurse's Notes dated 2/24/13 (7-3) indicate R12 mitts on but trach out, put back in. Staff notified R12's physician and received orders for psychiatric evaluation, mitts to both hands and if R12 pulls trach again to send to a local hospital Emergency Room.
Nurse's Notes dated 2/25/13, 12:30am indicates R12 pulling out trach, reinserted, mittens in place.' Resident biting Velcro ties and remove mitten left hand and pull trach.' Staff explained to resident he will become short of breath if he pulls trach tube out and told R12 he would have to go to the hospital. Note indicates R12 communicated "No hospital" with staff ' closely monitoring with Certified Nursing Assistant/CNA provided.'
Nurse's Notes dated 2/26/13,7am indicates 'Please monitor resident. Resident try (tries) to pull out trach. Mittens to hand bilaterally."
Nurse's Notes dated 2/27/13,3pm indicates R12 'occasionally tries to pull trach, monitored frequently and re-directed.
Nurse's Notes dated 3/5/13, 12(noon) indicates 'R12 requires constant redirection to stop pulling out trach. R12 also removes bilateral hand mitts with his teeth. Resident redirected and monitored closely at all times.
Nurse's Notes dated 3/5/13, 9:40pm "Upon rounding writer observed residents mittens on floor and trach noted between legs. R12 was unresponsive, code blue called and Cardio Pulmonary Resuscitation initiated. R12 left the facility at 10:10pm with Emergency Services transport. Notes further indicate R12 was transferred to the Intensive Care Unit at a local hospital and was admitted with diagnosis of

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F9999	Continued From page 39 Anoxic Brain Injury. Admit/Discharge Report dated 2/26/13 to 4/26/13 indicates R12 expired at the local hospital on 3/6/13. On 5/1/13 at approximately 3:30pm E13, Licensed Practical Nurse/LPN stated "R12 was constantly taking his trach tube out, taking his oxygen off and taking his mitt restraints off. He could get them off very quickly (E13 snapped her fingers to indicate how quickly R12 could remove his restraints). I notified R12's physician however I did forget to put it on the 24 hour report sheet. I did report it to the oncoming nurse. " E13 also stated that on the day 2/24/13 that she spoke to R12's physician, he wanted R12 sent out to the hospital if R12 pulled out his trach tube again for a psychiatric evaluation because of R12's continued behavior of attempting to pull his trach tube. POS dated 2/24/13 indicates Mitts to both hands, if resident removes trach tube send to local hospital ER. On 5/1/13 at 11:40am E2, DON stated she had no knowledge that R12 was supposed to be transferred out if he pulled his trach tube again. E2 stated the order should've been placed on the 24 hour report and verbally passed to herself, the ADON and the unit manager. E2 went on to state "there has been an identified issue with communication with the nurses, myself and managers." On 5/2/13 at 12:15pm E11 ADON stated "I only received information once that R12 had pulled out his trach tube. I thought it was a one-time incident. I didn't know about the order to send	F9999		

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R12 to the hospital if he pulled his tube."
On 5/2/13 at 4:30pm E14 LPN/Supervisor stated "I was not aware of the order to send R12 to the hospital, but I did hear from other staff around 2/24/13 that R12 was still pulling his trach tube."

R12 was not sent out to the hospital per physician ' s order of 2/24/13 despite continued documentation by nursing and social service that R12 continued to attempt to pull or pulled out his trach tube after that date.
On 5/9/10 at 4:05pm E2 DON stated (via telephone interview) "We don't have any policy regarding following physicians orders. It's understood that when a physician ' s order is received that it will be carried out."

On 5/1/13 at 11:45am E2 DON stated "Staff was to monitor R12 more frequently than every 2 hours - but no specific time was designated."
On 5/3/13 at 9:40am E2 stated "We don't have any close monitoring policy. If something happens and a resident needs special precautions or monitoring then it gets passed on in the 24 hour shift report and care planned."
On 5/3/13 at 2:00pm E2 stated that in general the supervisor of the shift makes rounds and a directive for special monitoring gets determined shift to shift. E2 went on to state that there is no specific documentation other than an hourly monitoring sheet that the CNA's could use but those sheets are just a worksheet and are not kept unless there is an incident that occurs on a shift and then the sheet is reviewed at the end of the shift.
E2 also stated "We were never able to locate any hourly or special monitoring sheet for R12 for the incident that occurred on 3/5/12. Each time R12

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F9999	Continued From page 41 was removing or attempting to remove his trach tube new goals and approaches should have been added. Usually once it's identified on the care plan an hourly monitoring sheet gets generated." On 5/1/13 at 3:00pm E12 Licensed Practical Nurse/LPN stated "The supervisors put 30 minute checks in place for R12. That's what we were doing, sometimes even more frequent. I don't know if the CNA was documenting the checks. The last rounds were done at 9:00pm for R12. I made the next rounds and saw R12's mitts on the floor at each side of R12's bed and the trach between R12's legs. R12 was unresponsive to shaking and rubbing. I put the trach back in and started CPR." On 5/2/13 at 4:40pm E14 LPN/Supervisor stated "R12 was on hourly monitoring, the 24 hour report indicates R12 was on hourly monitoring. " On 5/2/13 at 3:10pm E18, Certified Nursing Assistant/CNA stated she was assigned to R12 only once and that R12 had standard monitoring of every 2 hours - no special monitoring or precautions. On 5/2/13 at 5:20pm E19, CNA stated "I was told by the nurse that R12 was on 30 minute checks the night R12 coded. I thought the CNA assigned to R12 was doing an hourly monitoring sheet. I checked on R12 for the nurse at 9pm on that night because she was busy. The nurse seemed very worried and cautious about R12 pulling out his trach tube. R12 was lying in bed at 9pm watching television. R12 made eye contact with me and I left the room. Shortly later I heard the code called to R12's room." O5/2/13 at 3:45pm E20 CNA stated she was	F9999		

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assigned to R12 only once on the night of 3/5/13, the night R12 coded. E20 stated she was unaware that night that R12 had a behavior of taking off his mitts or pulling his trach tube out and that R12 did not make any previous attempts that night prior to pulling out the trach tube after 9pm. E20 recalled R12 getting checked on by staff every 30 minutes to 1 hour however could not recall if R12 had an hourly monitoring sheet that night. E20 also stated she received no formal report from the previous shift CNA regarding R12's care needs.

24 Hour Report 2/27/13 indicates 11-7 shift note: monitor R12, keeps taking out the mask and playing with the trach, check on R12 often
3-11 shift notes: monitor for behavior, removed trach once today; will remove mittens. Needs continuous monitoring
24 Hour Report 2/28/13 indicates Trach in place, please monitor, R12 has pulled out trach on two occasions, mittens were placed on hands, needs continuous monitoring.
None of the 24Hour reports reviewed dated 2/21/13 thru 3/5/13 indicate hourly,30 minute monitoring or any type of scheduled monitoring in place for R12, only that R12 required continuous monitoring due to his behavior. There is no documentation to support any type or frequency of monitoring for R12.

On 5/2/13 at 1:20pm via phone Z2, Physician stated "Technically the staff members are supposed to call me every time a resident pulls out their tracheostomy tube. If I were notified I would send the resident out at the first hint of instability. Medically, a person can only last about a half hour without their trach tube and then

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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
F9999	Continued From page 43	F9999		

they're in trouble, and if R12 was continuing to take out his tube he also would need a psychiatric evaluation. I think this resident knew what he was doing. He had been doing it for a long time. If mitt restraints aren't working he would need 24 hour sitter to prevent resident from pulling the tube."

ON 5/1/13 at 1:50pm E21, Licensed Practical Nurse/LPN/ Falls and Restraint Nurse stated "It's unusual for a resident to come in with a restraint. I try to get assessment done within 24 - 72 hours of admission. I don't remember anyone telling me R12 could remove the mitts. I would have done a reassessment if I were told that R12 was removing the mitts."

Physical Restraint Assessment dated 2/25/13 (4 days after R12 was admitted) for R12 indicates no other alternatives were attempted and resident currently was removing oxygen and removing trach.

Facility Policy: Facility Procedure for the Use of Physical Restraints (undated) indicates: Prior to the implementation of a physical restraint, the facility must:
1. Complete an assessment of the resident's overall needs
2. Complete the 4-page Physical Restraint RAP Assessment of the resident's need for physical restraints and possible less restrictive alternatives.

Facility Policy: Facility Procedure For The Use of Physical Restraints: Exceptions for Emergency Situations
I. Identification of Emergency
After less restrictive interventions to prevent the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145625	A. BUILDING _____ B. WING _____	C 05/10/2013

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F9999	Continued From page 44 resident from doing serious harm have been proven ineffective, determine the need for an emergency physical restraint. This determination may be made by a nurse. On 5/3/13 at 3:10pm E2 DON stated "Yes, it would be considered an emergency if a resident pulled his trach tube out." (B)	F9999		