

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER ALDEN ALMA NELSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1030a)1) 300.1030a)2) 300.1210b) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1030 Medical Emergencies</p> <p>a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:</p> <p>1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute</p>	S9999		
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>respiratory distress, failure, or arrest).</p> <p>2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility neglected to have a policy and procedure to ensure continuous 24 hour supervision on the Behavioral Health Secured Units. The facility failed to follow their policy and procedure for initiating CPR (Cardiopulmonary Resuscitation) immediately on a resident who was a full code status. The facility failed to follow their policy to ensure staff were alerted and</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>available when assistance was needed for residents with specialized care needs on a secured unit.</p> <p>This neglect contributed to a delay in identifying a resident requiring life sustaining treatment and failing to initiate treatment which resulted in R19's death.</p> <p>This applies to 10 of 30 residents (R4, R5, R6, R7, R8, R14, R17, R19, R24 and R27) reviewed with a full resuscitation status and 30 residents (R31-R60) in the supplemental sample.</p> <p>The findings include:</p> <p>A. On 7/23/14 at 10:52 AM, E12 (Licensed Practical Nurse - LPN) said "there was only one CNA scheduled to cover the A & E Wings (Secured Units) that night (7/19/14). E12 stated the A Wing had been left unattended. On 7/25/14 at 8:05 AM, E11 said she left the room (A22) about 9:00 PM on 7/19/14. E11 stated 9:00 PM is "rounds" time. E11 stated at that time, R19 was lying in his bed facing the wall, "punching at his pillow" as if to get comfortable. E11 said the A Wing was unsupervised from 9:00 PM until 10:15 PM when the night shift CNA came on duty.</p> <p>During interviews between 7/22/14 and 7/25/14, E5, E7 and E11 said R19 had not been seen, nor was staff present on the A Wing between 9:00 PM and 10:15 PM on 7/19/14. The 7/19/14 rounds sheets showed R19 was last seen at 9:00 PM.</p> <p>On 7/25/14 at 11:00 AM, E13 stated she was scheduled to work 10:00 PM to 6:00 AM on 7/19/14 - 7/20/14. E13 said there was no one on the A Wing (Secured Unit). E13 said she entered</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>the wing at about 10:15 PM and was met by R36. E13 said R36 told her he thought a pipe was broken down in the vending room area and wanted her to come and take a look. E13 said she stopped by the nurse 's station to put down her bags and get organized and then accompanied R36 to the vending/smoke room. E13 stated she saw something leaking under the door that was "black, coffee ground" colored. E13 stated the door lead to the bathroom of A22 so "I thought the toilet was blocked." E13 said she went into A22 and noticed that R19 was not in his bed, so she knocked on the bathroom door. E13 said she made 3 attempts to knock and get a response before opening the door to the bathroom. E13 said, "When I opened the door, (R19) was on the floor with his pants down by his ankles. He was lying on his left side with his face against the smoke (vending) room door. I realized he was already dead so I ran out (off the unit) to get the nurses." E13 stated "I only looked at R19 from the doorway of the bathroom and his face was dark colored, brownish, with stuff coming out of his mouth." When staff returned to the unit and a code blue was called, E13 said, "R19 was moved out of the bathroom and had a lot of liquid coming out of his mouth.</p> <p>E13 left R19 unattended. E13 left the room and the unit prior to calling a code blue or initiating CPR.</p> <p>The nursing note dated 7/20/14 at 1:57 AM shows the following documentation from E5 (RN): "At 10:15 p.m. (7/19/14) a 'code blue' was called. I responded to code. Upon arrival, I saw the Pt. (R19) on the floor of his bathroom off to the left side of the toilet at 45 degree angle with his pants around his knees and a brown substance that appeared to be coming from his head with a foul</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>odor...Pt (R19) was unresponsive, found no pulse and face was gray...Pt. (R19) had appeared to have even more brown fluid emptying from mouth, ears, nose on repositioning and on compressions. Two hundred cc of brown fluid was suctioned out in addition to numerous towels that had been saturated while Pt's (R19) head was turned to the side between breaths. Paramedics from 911 arrived 22:30; Paramedics applied AED, didn't detect a rhythm and left immediately at 22:39 without taking the patient..."</p> <p>The CNA round sheets document R19 was last seen at 9:00 PM on 7/19/14 "in his room." After interviews and times from persons on the A Wing the night of 7/19/14 were obtained, (E11, E13 and R36), R19 had not been seen between 9:00 PM and 10:15 PM. R36 identified the liquid contents from under the door prior to 10:00 PM when the smoke room is locked. This places R19 as having been "down" between 20 to 75 minutes.</p> <p>The facility's policy titled Behavioral Health Program Secured Units, undated, states under #1. "Alarmed doors - As there will be some residents who reside on the Behavioral Health Unit who, due to their disability, would be unsafe to be off the unit and/or outside of the facility on their own, all doors that lead off the unit will be equipped with alarms . . . Staff will be able to bypass the alarm system with either a key or number code access." The facility's policy does not specify the need for the unit to have 24 hour continuous staff supervision. On 2/25/14, the facility provided a list of A & E Wing residents who were identified as "Full Code" and thus would require life sustaining measures in an emergency. The 39 residents identified were R4-R8, R14, R17, R24, R27 and R31-R60.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>The facility's policy for Abuse/Neglect, dated 6/13, defines neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or in the deterioration of a resident's physical or mental condition."</p> <p>On 7/22/14 at 10:35 AM, E10 (Behavioral Health Unit Coordinator) stated there "should be 1 nurse and 1 CNA (Certified Nursing Assistant) on each wing, (A & E Wings), each shift." E10 stated the units should never be left unattended.</p> <p>On 7/22/14 at 1:20 PM, E4 (Assistant Director of Nursing-ADON) stated she schedules the CNA's in the facility. E4 stated the staffing should be 1 CNA on the A & E (Secured) Wings for each unit each shift. E4 said that she "tries to have 1 CNA on all wings at any given time but with call off's, the A & E (Secured Wings) sometimes will have to share 1 CNA." E4 stated if there is only 1 CNA between the two wings, the nurse must be on the wing if the CNA needs to leave the unit.</p> <p>On 7/22/14 at 1:30 PM, R5 stated, "It can take between 5 minutes and 1 hour for a call light to be answered "depending on the shift and staffing. Sometimes at night, there is no one (staff) on the wing."</p> <p>On 7/22/14 at 1:45 PM, R17 said, "There is no staff at night. It can be bad. We (residents) can wait up to an hour for assistance." R17 said he asked for a pain pill and "but the nurse never came on the floor so I had to wait." R17 said "I waited between 2-3 hours for the pain pill." R17 said "the nurses are never on the unit."</p> <p>On 7/22/14 at 2:00 PM, R8 stated, "there is no one here at night. You have to put on your light</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>and wait or you go to the door at the lobby, (secured wing doors), and knock for help.</p> <p>On 7/22/14 at 2:00 PM, R27 stated "They (staff) go back and forth between units and sometimes at night no one is on the unit." R27 stated a nurse "forgot to give me my meds. I put on the call button but no one came so I went to the end of the wing and banged on the doors to get someone's attention." Sometimes the wing is left unattended completely." R34 said, after passing the medications, "the nurses leave the unit never to return." R34 said sometimes the residents have to go to the front door of the unit and knock on the door to get the attention of the staff and/or request the attention of a nurse. R34 said, "We never know when we (residents) are going to have 'an episode' (behaviors/agitation), with or without staff so it is a big concern that no staff is on the unit."</p> <p>Interviews conducted between 7/22/14 and 7/25/14 with E5 (Registered Nurse - RN), E6 (RN), E7 (LPN), E8 (LPN), E11 (CNA) and E12 all stated, when there are 4 nurses scheduled to cover the 5 long term care wings, the A Wing residents are divided up amongst the 4 nurses to provide the medications. All nurses enter the A Wing at the same time to dispense the medication and then leave the unit and do not return. On 7/25/14 at 8:05 AM, E11 (CNA) stated she was the only CNA on duty 7/19/14 from 2:00 PM until 10:00 PM to care for the A & E (Secured) Wings. E11 stated there are times when a unit is left unattended for periods of time. E11 states she is typically the only CNA for both (A & E) wings on her scheduled weekends to work. E7 stated the one nurse/one CNA splitting the A & E Wings occurs approximately 85% of the time on the weekends. E12 said the A Wing is short a</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>nurse "more than we would like." E8 said she works 2 double (16 hour) shifts a week and the staffing is this way, (1 nurse and 1 CNA for the A & E Wings), 50% of the time she works. E5 stated he observed the A Wing to be left unsupervised for extended periods of time on 7/19/14 during the PM shift. E6 said "there are times when no staff are present on the A Wing at any given time."</p> <p>The schedule for the night of 7/19/14 showed only one CNA had been scheduled to cover the A & E Wings. The schedule also showed a nurse call off which was not replaced leaving the remaining nurses to split the A Wing with no designated nurse coverage.</p> <p>On 7/25/14 at 1:30 PM, E2 (Director of Nursing) said staffing is done by "myself and the ADON. E2 said they try to find replacements when people call off but "we can't always find someone." E2 said "if we have to, we split a wing and it is the locked (secured) units." On 7/25/14 at 9:30 AM, E1 (Administrator) and E3 (Corporate Consultant) verified that the secured units are to have at least one staff member present at all times.</p> <p>B. The facility policy titled Code Blue/Medical Emergency Protocol dated 11/13 shows "If unresponsive, initiate CPR (Cardiopulmonary Resuscitation) following American Heart guidelines per resident's code status. Remember the CAB's: Chest Compressions, Airway and Breathing....staff to stay with resident at all times until additional help arrives"</p> <p>On 7/23/14 at 1:00 PM, R36 stated on Saturday, (7/19/14), he saw brown liquid coming out from</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>under a door into the vending/smoke room before 10:00 PM. R36 said and he was on his way to smoke 1/2 of a cigarette he had kept from earlier in the day before the 10:00 PM smoking deadline. R36 stated no staff was on the unit when he went to smoke, and upon his return from smoking, R36 stated he noticed the amount of brown liquid on the floor in/near the vending room had increased. R36 said he headed down the hallway to try to get someone's attention. R36 said about that time, E13 entered the unit. R36 said "I told her I thought a pipe broke and was leaking in the vending room and asked her to come look at it." R36 said E13 went into room A22. R36 said after a short time, E13 came out of the room, quickly went down the hall and off of the unit. R36 said "I guess the guy died."</p> <p>On 7/23/14 at 11:30 AM, E7 stated she was the last nurse on the A Wing the night/PM of 7/19/14. E7 stated she finished her medication pass to the portion of the A Wing she was covering at 8:20 PM. E7 stated she left the A Wing at 8:20 PM. E7 stated she was unaware of any staff being on the A Wing after she departed at 8:20 PM. E7 stated she had no interaction with R19 and was not his assigned nurse throughout the shift (2:00 PM - 10:00 PM) on 7/19/14. E7 stated she and E8 were the first to respond to the wing when E13 "alerted us to the unit." When the bathroom door in room A22 was opened, legs were the first thing to be seen and then R19's "Royal Blue face. It was clear he (R19) had been deceased for sometime. He was covered head to toe in body fluids." E7 stated she was unaware when 911 was called. We had done at least 4-5 sets of CPR and suctioning when the ambulance arrived. The ambulance hooked up the AED (Automated External Defibrillator) and there was no rhythm."</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>On 7/25/14 at 8:05 AM, E11 said she responded to R19's room after the code blue was called 7/19/14 at 10:15 PM. E11 said R19 had a "blood" substance leaking from his mouth. E11 described the "blood" as "dark feces colored blood with a foul odor." E11 said R19's face was blue in color and his pants were around his ankles. E11 said R19 was lying on the bathroom floor still in a somewhat seated position (45 degree angle). E11 said the left side of R19's face was leaning against the smoke room/bathroom door.</p> <p>On 7/23/14 at 2:45 PM, E6 stated when she arrived to room A22 on 7/19/14, "(R19) was placed on his back and his head turned to the side because he was fluid filled. His face was grayish purple. The staff was trying to suction out the rust colored fluid."</p> <p>On 7/24/14 at 11:45 AM, Z4 (Emergency Medical Systems Coordinator - 911 response team) stated 6 people arrived on scene for the 911 call regarding R19. The ambulance, containing the two primary Paramedics had a response time of 2 minutes and 53 seconds. Z4 stated the report documented R19 was found in a "supine", (on his back), position with CPR in progress by facility staff. Z4 stated it was reported R19 had an "unknown down time." Z4 said the AED was applied showing "asystole" (no heart rhythm). R19's body was "cold to the touch."</p> <p>On 7/24/14 at 2:30 PM, Z3 (Paramedic) described R19's appearance as "face and neck brown & dusky with a distended abdomen." Z4 stated the AED was applied and showed asystole. Z3 said R19's body was cold to the touch and his pupils were fixed and dilated. Z3 stated the staff could not give any time frame for how long R19</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>may have been down. Z3 then re-emphasized that R19's skin had "no resemblance of warmth to it. It was cold." Z3 stated he observed a large amount of gastric contents on the floor.</p> <p>On 7/15/14 at 1:00 PM, Z6 and Z7 (911 response team/paramedics) were interviewed. Z7 stated upon arrival to the facility, R19 was lying on the floor with fluid coming out of his mouth. Z7 stated R19's face was "purple" and "looked as if he had been down a long time." Z6 stated "no one" (staff) "had the same amount of time he, (R19), was last seen" by facility staff.</p> <p>E11 stated she last saw R19 at 9:00 PM. R36 identified seeing the brown liquid contents from under the vending/smoke room door prior to 10:00 PM when the smoke room is locked. E13 states she was notified of the liquid identified by R36 at 10:15 PM. This places R19 as having been "down" between 20 to 75 minutes.</p> <p>On 7/25/14 at 10:15 AM, Z5 (Nurse Practitioner) stated for residents who are a "Full Code" status, CPR should be initiated as soon as they go down. Z5 said "I would have stayed with the resident and used my phone to call for assistance." Z5 stated any delay in the initiation of CPR could decrease the possibility of recovery. Z5 stated had someone been on the unit and found R19 sooner, CPR could have been initiated sooner and that would give him the best chances for the best possible outcome. Z5 stated, the longer time a person is down before initiation of life sustaining measures, the risk of death increases. Z5 said, "the quicker the response, the increased likelihood of a better outcome." Z5 said when a person requiring life sustaining treatment has no</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER ALDEN ALMA NELSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108
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S9999	<p>Continued From page 11</p> <p>one is available to respond, within minutes, the result could be death.</p> <p>C. The facility policy titled Use of Call Light dated 6/13 states the purpose is to "respond promptly to a resident's call for assistance." Under the procedure section the policy states: "All facility personnel must be aware of call lights at all times."</p> <p>On 7/25/14 at 8:05 AM, E11 said there was no one (staff) on the A Wing so no one would have heard him go down. E11 said if he had his call light on or even was yelling for help, he would not have been heard from outside of the secured doors. E11 said the call lights do not ring or light up in the main (fishbowl) nursing area located off the secured units. E11 said that unless staff "happened" to look down the wing and see a call light on, there would be no way of knowing someone needs assistance.</p> <p>On 7/25/14 at 8:30 AM, E11 pulled the call light in room A14 which is close to the secured doors at the front of the A-unit. This surveyor stepped off the unit and went to the main nursing area (fishbowl). The light could not be heard nor seen. R19's room (A22) is located at the farthest end of the unit, away from the secured entrance doors. On 7/25/14 at 11:00 AM, E10 verified that call lights on the secured units do not ring or light up at the main nurse ' s station off the secured units.</p> <p>According to the Long Term Care Nursing Desk Reference, Second Edition, "Brain death begins within four minutes of the time of cardiac or respiratory arrest or occlusion of the airway." Because of the narrow time frame, emergency procedures need to be implemented immediately.</p>	S9999		
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S9999	<p>Continued From page 12</p> <p>(AA)</p> <p>300.610a) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>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.</p> <p>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:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure residents daily skin checks were completed and that changes in a resident's skin were reported. The facility failed to implement preventative measures to reduce</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>the risk of developing pressure ulcers and failed to ensure wound assessments were completed.</p> <p>This applies to 2 of 6 residents (R11, R12) reviewed for pressure ulcers in a sample of 30.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. R12's Minimum Data Set of 6/11/14 shows R12 has severe cognitive impairment, and requires extensive assistance from two staff members with changing position in bed, and toilet use. The 6/11/14 MDS shows R12 is incontinent of bowel and bladder. <p>R12's 7/24/14 Physician Order Sheet (POS) shows diagnoses to include Alzheimer's Disease, Senile Dementia, Chronic Venous Embolism and Thrombosis of Deep veins of Upper Extremity.</p> <p>R12's 6/9/14 Skin Assessments shows R12 is at mild risk for acquiring a pressure ulcer.</p> <p>R12's Alteration in Skin Integrity Care Plan initiated on 7/9/14 shows "Weekly wound progress assessment by nurse".</p> <p>R12's 7/24/14 Physician Order Sheet (POS) shows "Triad Cream to buttock" ordered on 1/23/14.</p> <p>R12's 9/25/13 Wound assessment shows a left buttock stage 2 pressure ulcer 0.6 cm (centimeter) (Length) x 0.2 cm (Width) x 0.1 cm (Depth).</p> <p>R12's 10/23/13 wound assessment shows shows 100% epithelialization (healing) to the left buttock.</p> <p>On 7/23/14 at 9:30 AM, E27 and E28 provided incontinence care to R12. E27 and E28 raised</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>R12 to a standing position with a mechanical stand lift, and E27 washed R12's bottom. E27 said R12 did not have any open areas to her bottom. After care was completed, R12 was noted to have a nickel sized red open area to her left buttock. E27 said "it looks like there was a patch of dry skin and when I wiped, it came off and now it's open".</p> <p>On 7/23/14 at 11:20 AM, E26 (Licensed Practical Nurse- LPN) said R12 had a "scab to her bottom" that the nurses were applying a prescription cream to. E26 said the CNA reported to her the scab came off during care and the area was now open. E26 said the scab was from a previously healed Pressure Ulcer to R12's left buttock.</p> <p>R12' 7/23/14 at 5:17 PM, wound assessment shows stage 2 to left buttock "superficial stage two noted to scar tissue area". No other wound assessments were documented of R12's left buttock, and no documentation was made of a scab to the left buttock prior to it opening on 7/23/14. Weekly assessment for the buttock were not documented, where the prescription cream is applied. No evidence of an assessment or monitoring being done was documented after the 10/23/13 wound assessment.</p> <p>On 7/24/14 at 9:45 AM, E2 (Director of Nursing-DON) said there should be continued monitoring of a pressure sore after it is healed. E2 said if a scab is present the wound is not fully healed and weekly assessments should be documented until completely resolved. E2 said a scab could fall off and the wound could re-open and should be monitored with each application of the cream and assessed and documented on weekly.</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>The facility 6/13 "Prevention and Treatment of Skin Breakdown" policy states "Complete weekly documentation regarding progress of skin impairments. Utilize WASA form for documenting progress of pressure, diabetic, arterial, and venous wounds....Develop a plan of care to promote healing of skin impairments and prevention of wounds..."</p> <p>2. On 7/23/14 at 9:30 AM, E18 (Licensed Practical Nurse - LPN) changed the pressure ulcer dressings for R11. E18 stated she was the first to assess the wound on R11's left heel about 2 months ago. It had been reported by the CNA to look at his heel. She charted about the open wound. E18 could not recall the size of the wound when she first saw it, but remembered that E18 stated a few days later, an opening on R11 right heel was found. The dressing was removed from the left heel and a strong offensive odor was noted. The dime sized wound was surrounded with pale white macerated tissue and the wound bed was covered with 90% slough. The dressing was changed to the right heel by E18. A small pinpoint size opening was noted without drainage or slough. At the tip of the heel a small 1/2 inch size dark circle was noted on the skin. E18 stated she had not observed the dark area before today.</p> <p>E29 (Certified Nursing Assistant - CNA) assisted E18 with R11's dressing change. On 7/23/14 at 9:45 AM, E29 stated R11 receives a bed bath daily and a shower twice a week. E29 stated any change in a resident's skin condition is immediately reported to the nurse.</p> <p>On 7/23/14 at 9:45 AM, E18 stated the waffle heel boots were initiated after the wounds were identified to relieve pressure. E18 stated the wounds occurred because R11's legs were stiff and he would often push down with his feet into</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>the mattress.</p> <p>The Physician Order Sheet (POS) dated 7/23/14 shows R11 was admitted to the facility on 4/22/14 with diagnoses to include Atrial Fibrillation, Congestive Heart Failure, Hypertension, Difficulty Walking, Muscle Weakness, Pressure Ulcer Heel, Closed Fracture of Pubis, Cellulitis, Coronary Artery Disease and Dementia. The POS diagnoses do not show R11 has venous or arterial insufficiency disorders.</p> <p>The POS dated 4/23/14 (Admission orders) state, " Head to toe body assessment to assess for any new skin alterations every night shift for 1 month starting on the 22nd ". The order dated 5/1/14 states, " Keep Heels off of bed every shift " . The first wound treatment orders were dated 6/19/14 (7 days after the wound was initially identified).</p> <p>The Braden Scale Assessment (Score to determine risk of developing pressure) on 4/22/14 was 15 indicating mild risk for R11.</p> <p>The skin integrity care plan initiated on admission (4/23/14) identified R11 has friction due to constant movement, and decreased mobility. There were no specific interventions on admission to reduce the friction on his feet due to constant movement or his decreased mobility. Interventions to float R11's heels as prescribed by the physician on 5/1/14 were not listed.</p> <p>The Minimum Data Set of 5/20/14 shows R11 is at risk for pressure and did not have any unhealed pressure ulcers or healed ulcers since the prior assessment. R11 did not have any venous or arterial wounds. R11 requires extensive assistance of 2 staff for bed mobility and transfers and R11 did not ambulate in his room or corridor. R11 requires extensive assistance from staff for bathing and personal hygiene. R11's BIMS (Brief Interview for Mental Status) score is 12. (8-12 shows moderate</p>	S9999		
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S9999	<p>Continued From page 18</p> <p>impairment). On 7/24/14 at 10:00 AM, R11 and R74 (R11's wife and roommate) were interviewed. R11 stated, " They never put my legs up before I got the sores on my feet. " R74 agreed. R11 stated they brought in the boots after they started putting the dressings on his feet. The initial wound assessment of the Right heel dated 6/12/14 measures the wound size as 3.0 cm x 2.0 cm x 0.2 cm, Stage II. The open wound bed showed 80% epithelialization and 20% granulation tissue. The Right heel assessment dated 6/19/14 measures the wound size 0.5 cm x 0.5 cm x 0 cm and the wound bed is covered with 100% black eschar. The initial wound assessment of the Left heel dated 6/19/14 measures the wound as 2.0 cm x 1.8 cm and the wound bed was covered with 100% black eschar. The facility policy for prevention and treatment of skin breakdown states the facility will implement preventative measures and provide appropriate treatment modalities for skin impairments. The policy states to implement prevention protocols that are appropriate to address the individualized needs of the resident based on potential risk conditions of the resident. Prevention of skin breakdown includes to inspect the skin every shift with care for signs and symptoms of breakdown, boney prominence susceptible to pressure will be protected.</p> <p style="text-align: center;">(B)</p> <p>300.4040a)1)</p>	S9999		
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S9999	<p>Continued From page 19</p> <p>Section 300.4040 General Requirements for Facilities Subject to Subpart S</p> <p>a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S:</p> <p>1) 24 hours of continuous supervision, support and therapeutic interventions</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide continuous supervision to two secured Behavioral Care units in the building, and failed to have a system in place for residents with specialized care needs to notify staff when assistance is needed. This failure resulted in a delay in identifying and responding to a resident requiring life sustaining treatment (R19) and contributed to R19's death.</p> <p>This applies to 10 of 30 residents (R4, R5, R6, R7, R8, R14, R17, R19, R24 and R27) reviewed with a full resuscitation status and 30 residents (R31-R60) in the supplemental sample.</p> <p>The findings include:</p> <p>On 7/22/14 at 10:35 AM, E10 (Behavioral Health Unit Coordinator) stated there "should be 1 nurse and 1 CNA (Certified Nursing Assistant) on each wing, (A & E Wings), each shift." E10 stated the units should never be left unattended. E10 identified R5 and R17 as requiring physical assist of staff.</p> <p>On 7/22/14 at 1:20 PM, E4 (Assistant Director of Nursing-ADON) stated she schedules the CNA's in the facility. E4 stated the staffing should be 1 CNA on the A & E (Secured) Wings for each unit each shift. E4 said that she "tries to have 1 CNA</p>	S9999		
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S9999	<p>Continued From page 20</p> <p>on all wings at any given time but with call off's, the A & E (Secured Wings) sometimes will have to share 1 CNA." E4 stated if there is only 1 CNA between the two wings, the nurse must be on the wing if the CNA needs to leave the unit. E4 identified two residents, (R5 & R17), on the A Wing who require staff assist to complete Activities of Daily Living (ADL). E4 stated R17 requires a mechanical lift, (2 persons), assist for transfer.</p> <p>R'5s minimum data set (MDS) dated 6/25/14 shows he requires a 2 person physical assist for his ADL's. R5's care plans show the following: frequent near choking episodes; requires the use of Oxygen; is at an increased risk for and has a history of falls with the potential to hemmorrhage due to anticoagulant therapy; had decreased muscle strength, poor baance and an unsteady gait. "Uses a wheelchair for mobility." R5's medical record showed R5 had recently been hospitalized for aspiration pneumonia following a choking event.</p> <p>On 7/22/14 at 1:30 PM, R5 was seated outside in a wheelchair in the A Wing courtyard. R5 stated, "It can take between 5 minutes and 1 hour for a call light to be answered. Sometimes at night, there is no one (staff) on the wing."</p> <p>R17's MDS dated 7/8/14 shows he requires 2 persons physical assist for ADL's and the use of a mechanical lift for transfers. R17's care plans show he has "numerous problematic behaviors," which place him at risk for abuse. The care plans identify R17 as at risk for falls due to his behaviors and shows he is on anticoagulant therapy increasing his risk for hemmorrhage.</p> <p>On 7/22/14 at 1:45 PM, R17 was in his room</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>(A22) in a wheelchair. R17 said, "There is no staff at night. It can be bad. We (resident's) can wait up to an hour for assistance." R17 said he asked for a pain pill "but the nurse never came on the floor so I had to wait between 2-3 hours for the pain pill." R17 said "the nurses are never on the unit."</p> <p>On 7/22/14 at 2:00 PM, R27 stated his needs being met "Depends on staffing. They (staff) go back and forth between units and sometimes at night no one is on the unit." R27 stated a nurse "forgot to give me my meds. I put on the call button but no one came so I went to the end of the wing and banged on the doors to get someone's attention."</p> <p>On 7/22/14 at 2:00 PM, R8 stated, "there is no one here at night. You have to put on your light and wait. If no one is here, then you go to the door at the lobby, (secured wing doors), and knock for help.</p> <p>On 7/22/14 at 2:10 PM, R34 said that sometimes there are as many as 4 nurses delivering medications on the A wing because they have to "pull from the other units. Sometimes the wing is left unattended completely." R34 said the nurses will all come on the wing at the same time and pass medications. R34 said it takes less than an hour for the pass to be completed and then the nurses leave the unit never to return. R34 said the residents have to go to the front door of the unit and knock on the door to get the attention of the staff and/or request the attention of a nurse. R34 said, "We never know when we (residents) are going to have 'an episode' (behavior/agitation), with or without staff so it is a big concern that no staff is on the unit."</p>	S9999		

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S9999	<p>Continued From page 22</p> <p>On 7/23/14 at 1:00 PM, R36 stated on Saturday, (7/19/14), he saw brown liquid coming out from under a door into the vending room. R36 said and he was on his way to smoke 1/2 of a cigarette he had kept from earlier in the day, before the doors were locked at 10:00 PM. R36 stated no staff were on the unit so he went to smoke. Upon his return from smoking, R36 stated he noticed the amount of brown liquid on the floor in/near the vending room had increased. R36 headed down the hallway to try to get someone's attention. R36 said about that time, E13 (CNA) entered the unit. R36 said "I told her I thought a pipe broke and was leaking in the vending room and asked her to come look at it." R36 said E13 looked at it and agreed there was a problem. R36 said E13 went into the room that connected to the vending room (A22). R36 said after a short time E13 came out of the room, quickly went down the hall and off of the unit. R36 said "I guess the guy died."</p> <p>On 7/25/14 at 11:00 AM, E13 stated she was scheduled to work 10:00 PM to 6:00 AM on 7/19/14 - 7/20/14. E13 said when she arrived, E11 (the 2:00 PM - 10:00 PM) CNA (assigned to both wings), was coming off the E Wing (Secured Unit) with trash. E13 said there was no one on the A Wing (Secured Unit). E13 said she entered the wing at about 10:15 PM and was met by R36. E13 said R36 told her he thought a pipe was broken down in the vending room area and wanted her to come and take a look. E13 said she stopped by the nurses station to put down her bags and get organized and then accompanied R36 to the vending/smoke room. E13 stated she saw something leaking under the door that was "black, coffee ground" colored. E13 stated the door lead to the bathroom of A22 so "I thought the toilet was blocked." E13 said</p>	S9999		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER ALDEN ALMA NELSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108
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S9999	<p>Continued From page 23</p> <p>she went into A22 and noticed that R19 was not in his bed. E13 said she made 3 attempts to knock and did not get a response. E13 said, "When I opened the door, (R19) was on the floor with his pant's down by his ankles. He was lying on his left side with his face against the smoke (vending) room door. I realized he was already dead so I ran out (off the unit) to get the nurses." E13 stated "I only looked at R19 from the doorway of the bathroom and his face was dark colored, brownish, with stuff coming out of his mouth." When staff returned to the unit and a code blue was called, E13 said, "R19 was moved out of the bathroom and had a lot of liquid coming out of his mouth. After it was all over I was cleaning his bed and found a towel under his pillow that had brown stains and a towel on the floor near his garbage can with stains on it."</p> <p>On 7/23/14 at 10:52 AM, E12 (Licensed Practical Nurse - LPN) said she was doing the 10:00 PM medication pass down the D Wing on 7/19/14 when E7 (LPN) "came out, (of A Wing), and told me Code Blue. CPR (Cardiopulmonary Resuscitation) was initiated and continued until the ambulance arrived." E12 stated there was 4 nurses on the long term care side to cover the 5 units. E12 stated when the schedule shows 4 nurses, the A Wing is "split" among the 4 nurses for medication pass purposes. E12 said each nurse knows what people to take on the A Wing because it is scheduled short a nurse "more than we would like." E12 said "there was only 1 CNA scheduled to cover the A & E Wings (Secured Units) that night (7/19/14).. E12 said R19's body was discovered by the oncoming night shift CNA, (E13). E12 said the PM CNA, (E11), was over on the E Wing assisting other residents. E12 stated the A Wing had been left unattended.</p>	S9999		
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S9999	<p>Continued From page 24</p> <p>On 7/23/14 at 11:30 AM, E7 (LPN) stated she was the last nurse on the A Wing the night/PM of 7/19/14. E7 stated she finished her medication pass to the portion of the A Wing she was covering at 8:20 PM. E7 stated she was unaware of anyone being on the A Wing after she departed at 8:20 PM. E7 stated the one nurse/one CNA splitting the A & E Wings occurs approximately 85% of the time on the weekends. E7 stated E6 (Registered Nurse - RN) had R19 assigned to her that night. E7 stated she and E8 were the first to respond to the wing when E13 "alerted us to the unit. E7 said "A code Blue was called and a crash cart taken to the unit." When the bathroom door in room A22 was opened, legs were the first thing to be seen and then R19's "Royal Blue face. It was clear he (R19) had been deceased for sometime. He was covered head to toe in body fluids." We had done at least 4-5 sets of CPR and suctioning when the ambulance arrived. The ambulance hooked up the AED (Automated External Defibrillator) and there was no rhythm."</p> <p>On 7/23/14 at 1:59 PM, E8 (LPN) stated she was working on 7/19/14 at the time of R19's death. E8 stated the staffing consisted of 4 nurses and 7 CNA's for the 5 (A, B, C, D & E) wings. E8 stated when this staffing ratio occurs, a nurse is assigned to the B, C, D and E wing. E8 said all four nurses split the residents down the A wing to distribute medications to them. E8 said the B, C and D wings all get 2 CNA's and the A & E (Secured) Wings share 1 CNA. E8 said she works 2 double (16 hour) shifts a week and the staffing is this way 50% of the time she works. E8 stated she had not seen R19 all evening (2:00 PM - 10:00 PM) on 7/19/14. E8 said rounds are to be done by the CNA hourly on the A & E Wings.</p>	S9999		
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S9999	<p>Continued From page 25</p> <p>On 7/24/14 at 11:45 AM, Z4 (Emergency Medical Systems Coordinator - 911 response team) stated 6 people arrived on scene for the 911 call regarding R19. The ambulance, containing the two primary Paramedics had a response time of 2 minutes and 53 seconds. Z4 stated the report documented R19 was found in a "supine", (on his back), position with CPR in progress by facility staff. Z4 stated it was reported R19 had an "unknown down time." Z4 said the AED was applied showing "asystole" (no heart rhythm). R19's body was "cold to the touch."</p> <p>On 7/24/14 at 2:30 PM, Z3 (Paramedic) stated when the ambulance arrived on scene (at the facility), staff were performing CPR and suctioning of stomach contents from R19's mouth. Z3 described R19's appearance as "face and neck brown & dusky with a distended abdomen." Z4 stated the AED was applied and showed asystole. Z3 said R19's body was cold to the touch and his pupils were fixed and dilated. Z3 stated the staff could not give any time frame for how long R19 may have been down. Z3 then re-emphasized that R19's skin had "no resemblance of warmth to it. It was cold." Z3 stated he observed a large amount of gastric contents on the floor. Z3 said even after R19 was pronounced dead, a continuous flow of fluids were noted coming from his mouth and he had a "very distended abdomen."</p> <p>On 7/15/14 at 1:00 PM, Z6 and Z7 (911 response team/paramedics) were interviewed. Z7 stated upon arrival to the facility, R19 was lying on the floor with fluid coming out of his mouth. Z7 stated R19's face was "purple" and "looked as if he had been down a long time." Z6 stated staff at the facility were unable to give him R19's medical history. Z6 stated "I was unable to establish his</p>	S9999		
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S9999	<p>Continued From page 26</p> <p>medical history and therefore unable to determine what type of medical condition may be occurring. Z6 stated "no one" (staff) "had the same amount of time he, (R19), was last seen."</p> <p>On 7/25/14 at 8:05 AM, E11 (CNA) stated she was the only CNA on duty 7/19/14 from 2:00 PM until 10:00 PM to care for the A & E (Secured) Wings. E11 stated she does hourly rounds on each unit, however, there are times when a unit is left unattended for periods of time. E11 states she is typically the only CNA for both (A & E) wings on her scheduled weekends to work. E11 stated she left room A22 about 9:00 PM on 7/19/14. E11 stated at that time, R19 was lying in his bed facing the wall, "punching at his pillow" as if to get comfortable. E11 stated she completed her rounds/cares on the E Wing as E13 was coming on duty so "I stopped and gave her report." E11 said about 10:15 PM she saw E13 walking "briskly" down the hall toward the A Wing towards the smoking/vending room accompanied by R36. E11 said she began doing her charting when she heard the code blue called and responded to room A22. E11 said she saw R19 with "blood" substance leaking from his mouth. E11 described the "blood" as "dark feces colored blood with a foul odor." E11 said R19's face was blue in color and his pants were around his ankles. E11 said R19 was laying on the bathroom floor still in a somewhat seated position (45 degree angle). E11 said the left side of R19's face was leaning against the smoke room/bathroom door. E11 said there was no one (staff) on the A Wing so no one would have heard him go down. E11 said if he had his call light on or even was yelling for help, he would not have been heard from outside of the secured doors. E11 said the call lights do not ring or light up in the main, (fishbowl), nursing area located off the</p>	S9999		
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S9999	<p>Continued From page 27</p> <p>secured units. E11 said that unless staff "happened" to look down the wing and see a call light on, there would be no way of knowing someone needs assistance.</p> <p>On 7/25/14 at 8:30 AM, E11 pulled the call light in room A14 which is close to the secured doors at the front of the A-unit. This surveyor stepped off the unit and went to the main nursing area (fishbowl). The light could not be heard nor seen. R19's room (A22) is located at the farthest end of the unit, away from the secured entrance doors. On 7/25/14 at 11:00 AM, E10 verified that call lights on the secured units do not ring or light up at the main nurses station off the secured units.</p> <p>On 7/22/14 at 6:00 PM, E5 stated he was on duty 7/19/14 at the time of R19's death. E5 stated the nursing staff divided up the patient care duties for the A Wing among the 4 nurses on duty. E5 stated all nurses went to the unit at the same time to pass medications and signed the medications out under on nurses sign in. E5 stated it took between 15-30 minutes for the A Wing medications to be passed and which time all the nurses left the wing not to return. E5 stated he was in "orientation" and it was his first night on the long term care side of the building. E5 said he was following E6 who was assigned to the E Wing and also had R19 as one of her primary patients on the A Wing. E5 stated he observed the A Wing to be left unsupervised for extended periods of time.</p> <p>On 7/23/14 at 2:45 PM, E6 stated she was the nurse assigned to R19 on 7/19/14 on the PM shift. E6 stated R19 appeared "anxious" with overt leg fidgeting of his legs early in the evening. E6 stated she last visualized R19 at 7:30 PM when she gave him his night time medications.</p>	S9999		
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S9999	<p>Continued From page 28</p> <p>E6 was assigned the E Wing and the A Wing residents were divided amongst her and the other 3 nurses in the long term care section of the building. E6 stated when the scheduling is one nurse and one CNA to split the A & E wings, as it was the night of 7/19/14, there are times when no staff are present on a wing at any given time. E6 stated she did not see R19 until the code blue was called. E6 stated by the time she arrived to the room, multiple staff had arrived and initiated interventions. E6 said "(R19) was placed on his back, and his head turned to the side because he was fluid filled. His face was grayish purple. The staff were trying to suction out the rust colored fluid."</p> <p>The nursing note dated 7/20/14 at 1:57 AM shows the following documentation from E5 (RN): "At ~ 10:15 p.m. (7/19/14) a 'code blue' was called. I responded to code. Upon arrival, I saw the Pt. (R19) on the floor of his bathroom off to the left side of the toilet at ~ 45 degree angle with his pants around his knees and a brown substance that appeared to be coming from his head with a foul odor. Crash cart was in the room at this time that (E12, LPN) had brought when I arrived. Pt (R19) was unresponsive, found no pulse and face was gray. Pt. was repositioned on his back so we could attempt to resuscitate. Pt. (R19) had appeared to have even more brown fluid emptying from mouth, ears, nose on repositioning and on compressions. ~200 cc of brown fluid was suctioned out in addition to numerous towels that had been saturated while Pt's (R19) head was turned to the side between breaths. Paramedics from 911 arrived ~ 22:30; Paramedics applied AED, didn't detect a rhythm and left immediately at 22:39 without taking the patient. Pt. mother, POA (Power of Attorney) called, Coroner called, (City Name) Funeral</p>	S9999		
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S9999	<p>Continued From page 29</p> <p>Home called per POA and took body at 1:00 AM."</p> <p>On 7/25/14 at 10:15 AM, Z5 (Nurse Practitioner) stated R19 was last seen on 7/7/14. Z5 stated for residents who are a "Full Code" status, CPR should be initiated as soon as they go down. Z5 stated, "I would have stayed with the resident and called for help on my phone. Wasn't there a phone in the room?" Z5 stated any delay in the initiation of CPR could decrease the possibility of recovery. Z5 stated had someone been on the unit and found R19 sooner, CPR could have been initiated sooner and that would give him the best chances for the best possible outcome. Z5 stated, the longer time a person is down before initiation of life sustaining measures, the risk of death increases. Z5 said, "the quicker the response, the increased likelihood of a better outcome." Z5 said when a person requiring life sustaining treatment has no one is available to respond, within minutes, the result could be death.</p> <p>Review of the schedule for the night of 7/19/14 showed only 1 CNA had been scheduled to cover the A & E Wings. The schedule also showed a nurse call off which was not replaced leaving the remaining nurses to split the A Wing with no designated nurse coverage.</p> <p>Review of the CNA round sheets document R19 was last seen at 9:00 PM on 7/19/14 "in his room." After interviews and times from persons on the A Wing the night of 7/19/14 were obtained, (E11, E13 and R36), R19 had not been seen between 9:00 PM and 10:15 PM. R36 identified the liquid contents from under the door prior to 10:00 PM when the smoke room is locked. This places R19 as having been "down" between 20 to 75 minutes.</p>	S9999		
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S9999	<p>Continued From page 30</p> <p>According to the Long Term Care Nursing Desk Reference, Second Edition, "Brain death begins within four minutes of the time of cardiac or respiratory arrest or occlusion of the airway." Because of the narrow time frame, emergency procedures need to be implemented immediately.</p> <p>According to the Mosby's Medical, Nursing, & Allied Health Dictionary, Fourth Edition, algor mortis is the reduction in body temperature and accompanying loss of elasticity that occurs after death. Also known as the death chill. The Medical Dictionary states algor mortis theoretically occurs at a rate of 1 degree Celsius (33.8 degrees Fahrenheit) per hour, assuming the decedent is an adult of normal weight and the ambient temperature is 20 degrees Celsius (68 degrees Fahrenheit). The rate of cooling is slower if the ambient air temperature is warmer.</p> <p>On 7/25/14 at 1:30 PM, E2 (Director of Nursing) said staffing is done by "myself and the ADON. E2 said they try to find replacements when people call off but "we can't always find someone." E2 stated the CNA's are union so mandating is not an option. E2 said "if we have to, we split a wing and it is the locked (secured) units." On 2/25/14, the facility provided a list of A & E Wing residents who were identified as "Full Code." The 39 residents identified as desiring emergency medical intervention as needed were R4-R8, R14, R17, R24, R27 and R31-R60.</p> <p>The facility policy titled Use of Call Light dated 6/13 states the purpose is to "respond promptly to a resident's call for assistance." Under the procedure section the policy states: "All facility personnel must be aware of call lights at all times."</p>	S9999		
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S9999	<p>Continued From page 31</p> <p>The facility policy titled Code Blue/Medical Emergency Protocol dated 11/13 shows "staff to stay with resident at all times until additional help arrives."</p> <p>The facility's policy titled Behavioral Health Program Secured Units, undated, states under #1. "Alarmed doors - As there will be some residents who reside on the Behavioral Health Unit who, due to their disability, would be unsafe to be off the unit and/or outside of the facility on their own, all doors that lead off the unit will be equipped with alarms . . . Staff will be able to bypass the alarm system with either a key or number code access."</p> <p>(B)</p>	S9999		
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Plan of Correction

Imposed Plan of Correction

1. The Behavior Health units will be supervised on a 24 hour basis and the residents will be provided assistance when needed. CPR (Cardiopulmonary Resuscitation) will be initiated immediately on a resident who is a full code status, based upon individualized needs, including R4, R5, R6, R7, R8, R14, R17, R19, R24, R27, and R31-R60.
2. The facility has installed an audio/visual alert to the exterior of the Behavior Health units located at the central nurse's station that is integrated into the call light system in order to alert staff outside of the units when assistance is needed. The schedule is being reviewed to ensure adequate staffing for 24 hour supervision. CPR (Cardiopulmonary Resuscitation) will be initiated immediately on a resident who has been identified with a full code status, based upon individualized needs.
3. To ensure proper practices continue:
 - a. An inservice has been conducted regarding providing supervision to the Behavior Health units on a 24 hour basis.
 - b. An inservice has been conducted regarding CPR (Cardiopulmonary Resuscitation), including initiating immediately, based upon individualized needs.
 - c. The director of nursing or designee is monitoring compliance with this POC by randomly reviewing the staffing schedules and auditing the code status of the residents.
4. The results of the reviews and audits completed under this POC will be reviewed at the QA Committee Meeting for review and follow up.

Completion Date: *10 days from receipt of notice.*