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	IL6012983	A. BUILDING: _____ B. WING _____	C 01/06/2015

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TRAFFORD ESTATES	813 WEST CENTER FAIRFIELD, IL 62837

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Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1060e) 350.1210 350.1430a)2) 350.1430d) 350.3220f) 350.3240a) 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 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1430 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 350.1620.) d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record. Section 350.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with	Z9999		

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Z9999	Continued From page 2 such orders. (Section 2-104(b) of the Act) 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) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to develop and implement policies and procedures to prohibit mistreatment, neglect or abuse for 1 resident (R1) when the facility failed to: 1) Have a medical care plan or behavioral plan to monitor and prevent R1 from causing self injury to her eyes. 2) Have a medical care plan to monitor nutritional status when R1 had poor appetite and diet changes and weight loss. 3) Assure that all staff are authorized to administer medications. 4) Ensure medications prescribed by the physician were administered as ordered. 5) Follow their policy and procedures on Incident Reporting regarding follow up on emergency room visits. Findings Include: Per the Physician Order Sheet (POS) dated 12/2014, R1 is identified as a 46 year old female that functions within the Profound level of	Z9999		

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Z9999	Continued From page 3 individuals with intellectual disabilities (IID). Additional diagnosis include seizure disorder, hypothyroidism, insomnia, anemia, hx of evisceration (lt) eye, corneal lesion. Per the Facility's undated policy on Client Protections: Section: Protection of Client's Rights Subject: Definition and Safeguards e) " Neglect refers to any failures by facility to carry out required/appropriate services, habilitation or treatment as ordered by authorized personnel. Neglect means failure to provide goods or services necessary to avoid physial or psychological harm." 1) R1's record review, documents a history of eye infections and a pattern of R1 having a behavior of causing self injury to her eyes. Documentation as follows: 1/22/2014- Facility Physician Visit consult-History of Present Illness: "eyes matted, with green"gunk." "Has a history of this problem." 2/11/2014 Nurses Notes: "Reviewed Dr. order 1/22/12 due to self injury of eye when sleeping." 3/11/2014 Nurses note : "bil eye red, lids swollen, Rubs her face in sheets at nite, inverts her lids." 5/7/2014 Nurses note: "eyes red, no discharge, lids less puffy." 6/5/2014 -Consult with physician Assistant - History of present illness: "Fever. Onset 1 day ago. Associated symptoms include decreased appetite, decreased fluid intake and nausea. Additional information very lethargic, urine strong-good output. Rubbing eyes frequently (flips eye lids occ) Dx. Acute conjunctivitis, Plan-cortisporin ophthalmic soln. Try to keep patient from rubbing the eyes as much as possible. Patient to see optometrist if persist. Rx. cortisporin ophthalmic oint ½ inch ribbon of	Z9999		

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ointment every 3-4 hours to both eyes."
6/9/2014 Nurses Note: " Reviewed Dr. Orders...prescription for eye irritation, still rubs face...eyelid red thick."
7/7/2014 Nurses Note: "...eye red, lids inverted."
8/6/2014 Nurses note..."eye red no drainage."
9/1/2014 Emergency Room visit: Presenting complaint: "is here with caregiver complaining of R1's left eye being matted and irritated, States it has been going on for more than a month and that they have been putting drops in the eye but there has not been any improvements." ED course: "I suspect R1 has gotten allergy from the neo and therefore has not ever gotten better, will stop this and try some tobrex." Prescription for Cilaxan-instill 2 drop by ophthalmic route 6 times per day for 5 days." R1 discharged from the emergency room at 0:950am.
Per review of R1's universal notes dated 9/1/2014 at 9:30am, written on 9/2/2014 documents " R1 was taken to local hosp (hospital) ER this morning due to her L eye red and swollen, Dr. treated R1 for conjunctivitis and was prescribed cilaxan drops 6 x per day for 5 days. later that night facility nurse directed evening staff to take R1 back to local ER due to R1 eye being more red and swollen. ER DR. told staff to continue with eye drops and is to see her eye dr." note signed my E2 (medical team leader).
9/2/2014 universal notes document R1 was taken to the eye doctor. Consult documents: "Chief Complaint/History of Present Illness: 46 year old female complains of was taken to local ER, eyes are matting shut, pt rubs eyes a lot and flips lids up, eyes are swelling in both eyes for 3 days. The timing is described as constant, Modifying factors are reported as medication. Patient described the following signs and symptoms: rubbing, mattering, swelling." Assessment: Abscess of eyelid (cellulitis) Plan: Augmentin 875mg twice a

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Z9999	Continued From page 5 day, ciloxan ung (ointment) tid, return in 1 week or sooner if worsens." 9/3/2014 2:15pm universal note documents: "Staff called eye doctor this afternoon as staff work R1 up for lunch (12:45p) the staff noticed R1 left eye was larger." R1 was taken back to the eye doctor. Consult documents: " Assessment: "Pt has MR/non verbal/extremely uncooperative slit lamp exam and visual acuity impossible, bacterial conjunctivitis OU(both eyes), corneal ulcer OS (left eye) with cornea thinning-rubbed the eye extremely hard and caused corneal bulge OS(left eye) if R1 continues rubbing, risk of corneal perferation." Plan: Discussed with R1's mother at length, risks and complications of procedure and prognosis, Explained to mother the seriousness of condition and inspite of best efforts R1 may lose the eye. R1 will be seen in Operating room under general /heavy sedation then DR. will decide to do the procedure/possible conjuctival flap to cover cornea to prevent corneal perferation. Covered left eye wit shield to prevent rubbing of the eye." Review of the Operative Report dated 9/4/2014 documents: "Procedure: 1. exam under anesthesia, injection of subconjuctiva antibiotics, Left eye. Operative note:...."The left eye was examined under the microscope and found to be perforated through the central cornea. It was difficult to assess if this was related to trauma from repeated eye rubbing vs. progression of the corneal infection. There was uveal tissue just posterior to the corneal perforation, plugging the hole. The remaining cornea was examined and found to be very necrotic. It was felt that the necrotic cornea would not do well with primary closure given that the sutures may just tear through necrotic tissue. Surgical repair of the cornea would require corneal tissue for a full thickness or amellar graft, however there was	Z9999		

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corneal tissue immediately available. The family was updated on the clinical situation as well as to discuss options. After explaining to the family that the clinical situation was very severe and that there did not appear to be very much salvageable vision in the left eye, a decision was made to obtain a surgical consultation in (Out of state) hospital to explore options for attempting to save the eye." R1 was transferred to out of state hospital by facility staff.
9/5/2015 Operative note: Pre-op Diagnosis: "lt. eye wound. Post-op Diagnosis: corneal ulcer with perforation. Procedure: Ocular evisceration.(eye removal) Description of Procedure: ocular evisceration, prosthetic implantation,periocular antibiotic injection, temporary tarsorrhaphy."
On 12/29/2014 at 10.20am, E1(Administer/Qualified Intellectual Disability Professional) and E6 (RN Consultant) were interviewed. When asked if R1 had a medical care plan or a behavioral plan to monitor R1's history of eye infections and to prevent R1 from causing self injury to her eyes? Both E1 and E6 stated "no".

2) Per record review documents R1's IBW (ideal body weight) 93#.
Review of R1's 2013 annual Dietary Data History documents a 14# weight loss that year.
Review of R1's 2014 Dietary Data History documents a 11# weight loss that year.
Review of R1's nutritional progress documents: "2/13/2014, weight 92 pounds. 3/24/2014 weight 91 pounds., 4/21/2014 weight 82 pounds, down 9 pounds in 1 month....reviewed intake with staff....continue to monitor weight and notify RD (Registered Dietician) in sig (significant) change." R1's recorded weight in May 2014 was 80 pounds.
On 5/30/2014 a Swallowing Evaluation was

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Z9999	Continued From page 7 completed and documents: "Chief complaints: Losing liquids from mouth. Oral motor exam: Dentition; unable to participate; severe oral motor dysfunction. Current Nutritional Intake Diet: Mechanical soft with ground meat/thin liquids. Diet recommendations/precautions: Honey Liquid Consistency-liquids by spoon for honey, R1 can be offered thin liquids by straw if she is awake and alert and her trunk/head in midline. Swallowing precautions: eat slowly. Comments: R1 has severe oral motor dysfunction and loses thin liquids frequently due to her inability to coordinate oral transit. With honey she is able to better manage oral coordination of movement. No signs/symptoms of aspiration noted." 6/5/2014 -Consult with physician Assistant - "History of present illness: Fever. Onset 1 day ago. Associated symptoms include decreased appetite, decreased fluid intake and nausea. Additional information very lethargic, urine strong-good output. Rubbing eyes frequently (flips eye lids occ) Dx. Acute conjunctivitis, Plan-cortisporin ophthalmic soln. Try to keep patient from rubbing the eyes as much as possible. Patient to see optometrist if persist. Rx. cortisporin ophthalmic oint ½ inch ribbon of ointment every 3-4 hours to both eyes. Will obtain labs to evaluate for organic cause of behavioral changes and decreased appetite." 7/24/2014 nutritional notes documents: "Weight 76 pounds. Is down 5 pounds/1 month. down 6 pounds/3 months, down 8 pounds/6 months. Is assisted hand fed-eats well at times....MD notified of weight loss...weigh weekly x 4. will follow up if on improvement." 8/25/2014 R1's weight is documented at 81 pounds per the nutritional progress note. R1's Annual Dietary Data History documents: "11 pound weight loss from previous year. Current weight 81 pounds. Reported appetite	Z9999		

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good....continue to hand feed and encourage intake."
10/23/2014 nutritional progress record documents: "Weight 78 pounds. down 3 pounds this month. ....is hand fed....has periods of increased lethargy and history of tongue thrust (poor intake at times)...suggest ST(speech therapy) review diet textures. E1(administrator) indicated staff have been educated in special meeting to continue to offer foods when R1 is awake (also to return to offer foods if she is asleep at meals)."
10/28/2014 Swallowing evaluation documents: "Chief Complaints: Holds food in her mouth; nutritional intake varies, poor oral movement. Oral motor exam: Notable dysarthria(difficulty controlling muscles when you speak). Patient status: lethargic. Assessment: poor postural control, anterior spillage-poor oral motility and bolus formation varies from holding her head up for intake to poor head and oral control holds food. Liquids: poor head control, anterior spillage; poor oral mobility and bolus formation. Holds liquids. Recommended diet change: pureed diet with nectar consistency liquids. Level of supervision: full assistance/supervision all meals. Comments: R1 was very lethargic today, Head control was poor. Limited oral movement noted. R1's postural control and nutritional intake varies with each meal."
Review of R1's weekly weight in November 2014 documents "weight of 78 pounds on 11/3/14, 11/11/14, &11/18/14. On November 25th 2014, R1's documented weight was 73 pounds."
Review of R1's Universal notes on 11/25/2014 document: " R1 was taken to (local hospital) regarding low body temp and holding liquids/food in mouth."
Review of R1's emergency room evaluation on 11/25/2014 documents: "Presenting complaint:

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Caregiver reports no urine output for 24 hours, hasn't eaten in 24 hours. General : Appears ill...Not eating anything. Onset: The symptoms/episode began/occurred yesterday with no output today and restless with hypothermia. Disposition: Transfer ordered to out of state hospital- Diagnosis are Hypernatremia, Dehydration, Hypothermia, Sepsis,Urinary Tract Infection, and Hypotension.' R1 was admitted to the Intensive Care Unit of a out of state hospital.
ON 12/23/2014 at 10:30am, E3 Certified Habilitation Technician (CHT) was interviewed. E3 stated "R1 did not eat very good Saturday 11/23/14 or Sunday morning 11/24/2014."
ON 12/23/2014 at 2:30pm, E2 (Medical Team Leader) was interviewed. E2 stated " R1 did not eat lunch at daytraing on Monday 11/24/2014 and I was told she ate minimal amount on Monday evening." E2 was then asked if there was a system in place to monitor and record R1's intake and output so to make sure R1 was getting proper nutrition and hydration? E2 stated "no there's no record of it, we just ask on a daily basis."
ON 12/29/2014 at 10.20am, E1(Administrator/Qualified Intellectual Disabilities Professional) and E6(RN Consultant) were interviewed. When asked if R1 had a medical care plan with interventions on monitoring and documenting R1's intake and output related to her history of weight loss and poor appetite? E1 and E6 both stated "no".
3)Per record review of R1's chart on 12/22/2014 documents a physician order from the emergency room on 9/1/2014 for a prescription for Cilaxan-instill 2 drops by ophthalmic route 6 times per day: 1 container.

Review of the facilities pharmacy services, source back up on call report dated 9/1/2014 documents

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Z9999	Continued From page 10 "New order received at 10:38am. for R1. Message: Needs eye drop sent out cannot wait until tomorrow. Delivered 2:00pm. verified by E5 CHT (Certified Hab Technician)." Review of R1's record on 12/23/2014 failed to locate a Medication Administration Record (MAR) that provided documented verification that R1 had received Cilaxan eye drops 6 times a day on 9/1/2014. On 12/24/2014 at 9:05am, E4 (CHT) was interviewed related to the administration of medications on the night of 9/1/2014. E4 was questioned on the initials of M.H. documented on the Medication Administration Records of all the residents. E4 stated " I was observing E10 (CHT) pass the medications that night. She was being trained. I did not ever see a new medication protocol or a Medication Administration Record on R1 for eye drops or I would have signed it and we would have given them." On 12/24/2014 at 12:00pm, E10 CHT was interviewed related to passing medications on the evening of 9/1/2014. E10 stated " I was being observed by E4 because I was not authorized to give med's then. I did pass med's but I did not give any eye drops to R1 that night." Review of the facility's undated Policy on Health Care Services: Subject: Medication Administration Record and Required Documentation: Policy: "It is the policy of this facility to maintain an appropriate Medication Administration Record (MAR) and required documentation forms on each client. ...The medication administration record shall be competed and initialed immediately after the medication is administered by the authorized direct care staff."	Z9999		

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Z9999	Continued From page 11 Per the ILLINOIS ADMINISTRATIVE CODE: SECTION 116.40 Training and authorization of non-licensed staff by nurse-trainers. a) Only a nurse-trainer may delegate and supervise the task of medication administration to direct care staff. b) Prior to training non-licensed staff to administer medication, each nurse-trainer shall perform the following for each individual to whom medications will be administered by non-licensed staff{20 ILCS1705/15.4(c)} once they are trained and authorized direct care staff: 1) An assessment of the individuals's physical and mental status and medical history. 2) An evaluation of the medication orders and medications prescribed. c) Non-Licensed direct care staff who are authorized to administer medications under the delegation of the registered professional nurse shall meet the following criteria:... 4) satisfactorily complete the health and safety component of the direct support persons core training program or a DHS approved equivalent developmental disabilities aide training program; 5) be initially trained and evaluated by a nurse-trainer in a competency-based, standardized medication curriculum specified by DHS. 7) pass the written portion of the comprehensive examination furnished by DHS based on the information conveyed to them; and 8) Score 100% on a written or oral competency-based evaluation specifically pertinent to those medications that such staff are responsible to administer. During interview with E6 (RN Consultant) on 12/29/2014 when asked if E10 was authorized to administer medications on 9/1/2014? E6 stated	Z9999		

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Z9999	Continued From page 12 "No she was not authorized at that time." 4a) Review of R1's record documents "R1 was seen by her physician on 6/5/2014 for Acute conjunctivitis". The physicians note documents "Patient Plan: Cortisporin ophthalmic soln. Medications added Cortisporin 1% topical ointment-apply by topical route 2 times every day a thin layer to the affected area (s) for 7 days. A prescription was written for Cortisporin ophthalmic ointment 1/2 inch ribbon of ointment every 3-4 hours to both eyes." Review of R1's MAR dated 6/2014 documents: "Neo/Poly/Bac Oin/ HC 1% op (substituted med for Cortisporin 1% topical ointment) 1/2 inch ribbon of ointment every 3-4 hours (B) Both eyes." Further review of the MAR documents the medication being given once daily June 6th-June 9th. On June 9th, E6(RN Consultant) wrote underneath the order to start med three times a day. Further review documents the ointment being given three times a day from June 9th through August 1st and twice a day from August 1st through September 1st. On 12/29/2014 at 11:00am, E6(RN Consultant) was interviewed. When asked about the discrepancies related to the R1's prescription order and the physicians dictated physician plan for the use of the Cortisporin topical ointment. E6 stated " I did change it. I think we talked to the doctor about it, I have no evidence to support a change in the order but I did change it." On 12/30/2014 at 9:15am, Z3(Facility's Pharmacist) was interviewed by telephone. Z3 confirms that there has been no change in the order that was written on 6/5/2014.	Z9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAFFORD ESTATES	813 WEST CENTER FAIRFIELD, IL 62837

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4b)During record review on 12/22/2014 a universal note dated 9/1/2014 at 9:30AM (written on 9/2/2014) documents: "R1 was taken to (name of local hospital ER) this morning due to her L eye red and swollen. Dr. treated R1 for conjunctivitis and was prescribed cilaxan drops 6 x per day for 5 days. Later that night facility nurse directed evening staff to take R1 back to (name of local hospital ER) due to R1 eye being more red and swollen and bleeding. The emergency room staff told (facility) staff to continue with eye drops and to see her eye Dr."

Review of the Emergency Room notes documents: "9:47am: Presenting complaint: is here with caregiver complaining of patients left eye being matted and irritated. States it has been going on for more than a month and that they have been putting drops in the eye and there has not been any improvement. Disposition: Condition is fair. Prescriptions for Cilaxan-instill 2 ophthalmic route 6 times per day for 5 days."

Review of R1's MAR for September 1, 2014, identifies no evidence of Cilaxan eye drops being administered.

On 12/23/2014 at 09:00am, E2(Medical Team Leader) was interviewed and asked to explain the system the facility had in place to follow up on discharge instructions with medications ordered. E2 stated: " The staff that takes the resident out to the emergency room is responsible to take the discharge orders and fax them to the RN Consultant and the Pharmacy. The Pharmacy usually generates a MAR(Medication Administration Record) however it was a holiday on 9/1/2014 and our outside pharmacy would not have generated the MAR. Staff would have to call

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the RN Consultant to have her generate one." The staff are to complete a Post Hospitalization/Change in Health Status as well as a New Medication Protocol and fax the New Medication Protocol to the RN consultant."

On 12/23/2014 at 9:45am, E6 (RN Consultant) was interviewed. When asked about the 9/1/2014 events of R1 going to the emergency room twice and having a new medication order E6 voiced " I knew she had eye drops ordered, I am not sure if I generated the MAR I will have to check my records at home."

On 12/23/2014 at 10:30am, E3 CHT(Certified Habilitation Technician) that escorted R1 to the emergency room on the morning of 9/1/2014 was interviewed. E3 stated "I came in that morning and E8 told me to take R1 to the emergency room. They checked her out and gave me a prescription and discharge papers. I had E8 help me with the paper work." I know I faxed the New Medication Protocol and started the post hospitalization/change in health status form." E3 was asked Do you remember getting the medication? "I got the medicine about 2:00pm and I put them in the med cart." E3 was then asked, Do you remember having an MAR for the eye drops? E3 stated, "No, I do not remember having one or remember calling the RN consultant for it. I placed the New Medication Protocol sheet in the medication book. I did not pass medications that night."

On 12/23/2014 at 11:45am, E9 CHT was interviewed related to the events of 9/1/2014 afternoon when R1 was again taken to the emergency room. E9 states " I came in at 3:00pm. I'm not sure what time it was, I think between 4:00pm and 5:00pm... I cant really

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remember. There was bleeding coming from R1's left eye. I called E6 (RN consultant) and she told me to take R1 back to the emergency room. When we got there they did not take her inside to be examined again they just told me to continue with the orders given earlier." When asked if R1 was given any eye drops that day E9 stated " I did not pass meds that night."

On 12/23/2014 at 11:50am, E4 CHT was interviewed briefly via telephone. E4 confirms that she was present that evening coming to work at 3:00 on 9/1/2014 and passing medications. E4 stated "I do not remember administering eye drops to R1 that day."

On 12/23/2014 at 1:30pm, E7 CHT working the night shift on 9/1/2014 was interviewed. E7 stated " I knew R1 had been taken to the emergency room twice that day. I was not informed she had a change of med sheet or needed eye drops. I would have signed it. I am never really given any type of report around here. If things are not taped to the medication book or in the medication book then I don't know about it."

On 12/23/2014 at 2:30pm, E2(Medical Team Leader) was interviewed and reviewed the new Medication Protocol filled out on 9/1/2014 for the prescribed eye drops for R1. E2 stated "the information on this form was filled out incorrectly and was unable to determine if the medication had been administered to R1 as ordered."

On 12/23/2014 at 4:00pm, E6(RN Consultant) was again interviewed after going through her work files from home and states " I was only able to find the New Medication Protocol sheet that I did sign. I am unable to find where I generated a MAR, I did not know that the pharmacy did not

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generate it. The staff should have notified me and let me know it was not there." E6 was asked if after sending R1 back to the emergency room that afternoon on 9/1/2014 because of her eye bleeding and after E9 reported that the emergency room physician had not seen R1 but instructed E9 to continue with the instructions given that morning, did she inquire with E9 to ensure the eye drops had indeed began? E6 stated "No I did not."

On 12/23/2014 at 4:14pm, E1(Administrator) was interviewed, E1 confirms that the staff failed to ensure that a Medication Administration Record was generated for staff to administer the prescribed eye drops to R1 every 6 hours.

5)During record review on 12/22/2014 a universal note dated 9/1/2014 at 9:30AM (written on 9/2/2014) documents: "R1 was taken to (name of local hospital ER) this morning due to her L eye red and swollen. Dr. treated R1 for conjunctivitis and was prescribed cilaxan drops 6 x per day for 5 days. Later that night facility nurse directed evening staff to take R1 back to (name of local hospital ER) due to R1 eye being more red and swollen and bleeding. The emergency room staff told staff to continue with eye drops and to see her eye Dr."

Review of the Emergency Room notes documents: 9:47 am: Presenting complaint: is here with caregiver complaining of patients left eye being matted and irritated. States it has been going on for more than a month and that they have been putting drops in the eye and there has not been any improvement. Disposition: Condition is fair. Prescriptions for Cilaxan-instill 2 ophthalmic route 6 times per day for 5 days.

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Z9999	Continued From page 17 Review of R1's Medication Administration Record for September 1 2014 identifies no evidence of Cilaxan eye drops being administered. Review of the pharmacy transaction report dated 9/1/2014 identifies that the prescribed medication was delivered at 2:00PM to the facility. Message reads:" Needs eye drop sent out cannot wait until tomorrow." Upon further review of R1's record there is no documentation recorded within the universal notes on the events of R1 on 9/1/2014 going to the emergency room twice. The facility's undated policy provided 12/23/2014, under HEALTH CARE SERVICES: SUBJECT: Incident Reporting, Policy: This facility shall follow the procedures listed below regarding incidents/accidents. PROCEDURES: 1. Adverse Events Requiring Hospital visit (ER) or admission. A. Report immediately to supervisor or RSD (Residential Service Director).... B. Report incident to Administrator C. Report immediately to RN consultant. 1. Review original and signature at monthly visit. D. Complete incident/accident report (by staff present or discovering incident) 1. Original for supervisors review and signature. 2. Fax copy to RN consultant of incident and emergency room report. a. Complete change of health status until resolved or 3.Fax to RN consultant discharge summary and orders from hospital admission. a. Complete change of health status until resolved.	Z9999		

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Z9999	Continued From page 18 The facility's undated policy on Health Care Services:Section Health Status Monitoring: Subject: Post Hospitalization presented on 12/23/2014 documents:Policy: Facility shall monitor the health status of residents when discharged from a hospital. Procedures 1. Upon a resident's arriving home from the hospital, staff will carry out all physician's orders as stated on the transfer sheet and document the orders in the universal notes in their chart. 2. Staff will take a full set of vitals which includes temperature, blood pressure, pulse and respiration. Staff will document these in their universal notes. 3. Staff will notify the nurse consultant, resident service director and administrator upon their arrival back home from the hospital. Staff will document that these people were notified. 4. Staff will take a full set of vitals every two (2) hours for the first (8) hours. If normal, take vitals once per shift until resolved. Document in the universal notes. 5. If vitals are not within normal limits (i.e. temp over 100.5, pulse over 100, blood pressure over 150/90) or if there are other signs/symptoms (i.e. disoriented, shortness of breath, unsteady gait, etc.), notify the nurse consultant. If unavailable call physician. Document all results and who was notified in universal notes. 6. All entries in the universal notes should be timely, however; resident care is our main concern. On 12/23/2014 at 09:00am, E2(Medical Team Leader) was interviewed and asked to explain the system the facility had in place to follow up on discharge instructions with medications ordered. E2 stated: " The staff that takes the resident out	Z9999		

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to the emergency room is responsible to take the discharge orders and fax them to the RN Consultant and the Pharmacy. The Pharmacy usually generates a MAR(Medication Administration Record) however it was a holiday on 9/1/2014 and our outside pharmacy would not have generated the MAR. Staff would have had to call the RN Consultant to have her generate one. The staff are to complete a Post Hospitalization/Change in Health Status as well as a New Medication Protocol and fax the New Medication Protocol to the RN consultant."

On 12/23/2014 at 9:45am, E6 (RN Consultant) was interviewed. When asked about the 9/1/2014 events of R1 going to the emergency room twice and having a new medication order E6 voiced " I knew she had eye drops ordered" I am not sure if I generated the MAR I will have to check my records at home."

On 12/23/2014 at 10:30am, E3 CHT that escorted R1 to the emergency room on the morning of 9/1/2014 was interviewed. E3 stated "I came in that morning and E8 told me to take R1 to the emergency room. They checked her out and gave me a prescription and discharge papers. I had E8 help me with the paper work. I know I faxed the New Medication Protocol and started the post hospitalization/change in health status form." I got the medicine about 2:00pm and I put them in the med cart." E3 was then asked, Do you remember having an Medication Administration Record for the eye drops? "No, I do not remember having one or remember calling the RN consultant for it. I placed the New Medication Protocol sheet in the medication book. I did not pass medications that night. E3 was asked if any of the above events were documented? E3 stated "No."

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On 12/23/2014 at 11:45am, E9 CHT was interviewed related to the events of 9/1/2014 afternoon when R1 was again taken to the emergency room. E9 states " I came in at 3:00pm. I'm not sure what time it was, I think between 4:00pm and 5:00pm... I cant really remember. There was bleeding coming from R1's left eye. I called E6 (RN consultant) and she told me to take R1 back to the emergency room. When we got there they did not take her inside to be examined again they just told me to continue with the orders that were given from the mornings visit." I called E6 and told her what the emergency room said. I was given no further instructions from E6." When asked if E9 had completed any paper work on the incident E9 stated " I think so." When asked if R1 was given any eye drops that day E9 stated " I did not pass med's that night." E9 was asked if the events were documented in the universal notes? E9 stated "no".

On 12/23/2014 at 11:50am, E4 CHT was interviewed briefly via telephone. E4 confirms that she present that evening coming to work at 3:00 on 9/1/2014 and passing medications. E4 stated "I do not remember administering eye drops to R1 that day."

On 12/23/2014 at 1:30pm, E7 CHT working the night shift on 9/1/2014 was interviewed. E7 states " I knew R1 had been taken to the emergency room twice that day. I was not informed she had a change of med sheet or needed eye drops. I would have signed it. I ' am never really given any type of report around here. If things are not taped to the medication book or in the medication book then I don't know about it."

On 12/23/2014 at 2:30pm, E2(Medical Team Leader) was interviewed at 2:30pm and reviewed

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the new Medication Protocol filled out on 9/1/2014 for the prescribed eye drops for R1. E2 voiced that the information on this form was filled out incorrectly and was unable to determine if the medication had been administered. E2 also stated that only one Post Hospitalization/Change in Health Status form had been completed on R1 after her first episode to the emergency room. Review of this form documents vital signs being taken every two hours beginning at 12:30pm and ending at 6:30pm. E2 was asked why continuing monitoring was not completed until situation resolved? E2 stated " We only continue this sheet if the RN consultant requests us to do so." E2 confirms that no further documentation of monitoring was completed on R2 during the evening of 9/1/2014.

On 12/23/2014 at 4:00pm, E6(RN Consultant) was again interviewed after going through her work files from home and states " I was only able to find the New Medication Protocol sheet that I did sign. I am unable to find where I generated a MAR. I did not know that the pharmacy did not generate it. The staff should have notified me and let me know it was not there." E6 was asked if after sending R1 back to the emergency room that afternoon on 9/1/2014 because of her eye bleeding and after E9 reported that the emergency room physician had not seen R1 but instructed E9 to continue with the instructions given that morning, did she inquire with E9 to ensure the eye drops had indeed began? E6 stated "No I did not" When asked if she had given any further instructions on monitoring of R1's eye or if she should come and assess R1 herself, E6 stated "No, I didn't think I could do anything, she was going to be seen by the eye doctor in the morning."

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Z9999	Continued From page 22 On 12/23/2014 at 4:14pm, E1(Administrator) was interviewed. E1 confirms that the staff did not complete incident report on the incident of R1 being taken to the emergency room the morning of 9/1/2014 and failed to ensure that a Medication Administration Record was generated for staff to administer the prescribed eye drops to R1 every 6 hours. E1 confirms that neither an incident report or a change of health status was completed when R1's left eye began bleeding and when she was again taken to the emergency room later that afternoon on 9/1/2014. E1 confirms that there was no documentation written in the universal notes of any description of monitoring of the condition of R1's eyes throughout the day of 9/1/2014. (A)	Z9999		

350. 620a)
350. (d)(e)
350. 1210
350. 1430a)2)
350. 3220F)
350. 3240a)

Imposed
PLAN OF CORRECTION
TRAFFORD ESTATES
Survey date 1/6/15

Plan of Corrective Action

Facility QIDP and RN Consultant will be responsible to assess all individuals for medical and or behavioral issues which have the potential to cause a detriment to their health. Facility QIDP and RN Consultant will develop appropriate medical and or Behavior care plans to address any such need that is identified based upon these assessments. This measure will occur on an on-going and consistent basis.

Facility QIDP will work in conjunction with Registered Dietician to implement a nutritional intake plan for proper measurement of such. This measure will be implemented on an as needed basis dictated at the direction of the Registered Dietician based upon nutritional needs of targeted individuals. Facility QIDP will monitor to insure this standard is completed on an on going basis.

RN Consultant has revised current training and certification methods . Employees will only be permitted to administer medications upon successful completion of the certification process. RN Consultant will be responsible to insure that compliance with this standard being met on an on-going basis.

RN Consultant will review the Physician Order Sheets and compare them with current Medication Administration Records to insure that all medications are administered as they are ordered. RN will complete this review RN Consultant will insure this standard is met on a monthly basis and monitor on an on-going basis.

Attachment B
Imposed Plan of Correction

Facility QIDP and RN Consultant have reviewed the facilities policies and procedures for incident reporting in regards to emergency room visit follow up. RN Consultant will be responsible to insure that all facility procedures are followed to insure that timely, concise, accurate reporting is completed so as to insure proper care is provided. RN Consultant will be responsible to insure compliance with this standard on a consistent and on-going basis.

Facility QIDP has provided training to all employees regarding the importance of timely reporting of all suspected incidents of abuse or neglect of facility clients.

This facility provides annual in-service training for Abuse/neglect policies. Facility QIDP will be responsible to Insure compliance with this standard on an on-going basis.

Facility QIDP and RN Consultant have reviewed the facilities policies and procedures for incident reporting in regards to emergency room visit follow up. RN Consultant will be responsible to insure that all facility procedures are followed to insure that timely, concise, accurate reporting is completed so as to insure proper care is provided. RN Consultant will be responsible to insure compliance with this standard on a consistent and on-going basis.

Facility QIDP and RN Consultant will be responsible to assess all individuals for medical and or behavioral issues which have the potential to cause a detriment to their health. Facility QIDP and RN Consultant will develop appropriate medical and or Behavior care plans to address any such need that is identified based upon these assessments. This measure will occur on an on-going and consistent basis.

Facility QIDP will work in conjunction with Registered Dietician to implement a nutritional intake plan for proper measurement of such. This measure will be implemented on an as needed basis dictated at the direction of the Registered Dietician based upon nutritional needs of targeted individuals. Facility QIDP will monitor to insure this standard is completed on an on going basis.

RN Consultant has revised current training and certification methods Employees will only be permitted to administer medications upon successful completion of the certification process. RN Consultant will be responsible to insure that compliance with this standard being met on an on-going basis.

RN Consultant will review the Physician Order Sheets and compare them with current Medication Administration Records to insure that all medications are administered as they are ordered. RN will complete this review RN Consultant will insure this standard is met on a monthly basis and monitor on an on-going basis.

Facility QIDP and RN Consultant have reviewed the facilities policies and procedures for incident reporting in regards to emergency room visit follow up. RN Consultant will be responsible to insure that all facility procedures are followed to insure that timely, concise, accurate reporting is completed so as to insure proper care is provided. RN Consultant will be responsible to insure compliance with this standard on a consistent and on-going basis.

RN Consultant will review the Physician Order Sheets and compare them with current Medication Administration Records to insure that all medications are administered as they are ordered. RN will complete this review RN Consultant will insure this standard is met on a monthly basis and monitor on an on-going basis.

RN Consultant has revised current training and certification methods Employees will only be permitted to administer medications upon successful completion of the certification process. RN Consultant will be responsible to insure that compliance with this standard being met on an on-going basis.

Completion Date: 20 days from Receipt of This Notice

Attachment B
Imposed Plan of Correction