STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	C 04/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=J	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for one of twelve residents the facility failed to consult with the resident's physician when there was a significant change in	F 157	5/22/06 POC acceptable Completion date 5/16/06 Buemb MH RN Utah Department of Health 5-15-06 MAY 17 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald R. Deeter	Administrator	5/15/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the resident's physical condition. Specifically, resident 2 had been complaining of not being able to breathe or expectorate mucus. When resident 2 experienced a change in condition (i.e. not being able to breathe) the facility nurse left the room to get some medication for resident 2, returned to resident 2's room to find resident 2 unresponsive, then left resident 2's room to go to the nurses' station and call resident 2's family. Upon returning to resident 2's room the facility nurse found resident 2 to be expired. Findings include: Resident 2 was admitted to the facility on 2/24/04 with diagnoses which included, Ileus, paralysis, Chronic Obstructive Pulmonary Disease, generalized anxiety,and major depression. Resident 2's medical record was reviewed on 4/23/06. Review of resident 2's medical record revealed a Utah Living Will. This document described the following types of "life-sustaining" procedures resident 2 was willing to undergo in case of an emergency: 1. Oxygen therapy 2. Respiratory Treatments 3. Suctioning 4. Chest Compressions 5. IV (Intravenous) fluids 6. NG/G (naso-gastric/gastronomy) tube 7. Oral, intramuscular, and intravenous antibiotics. This document was signed by resident 2 and	F 157	F-157 Resident 2 Expired on 4/22/2006 and no plan of correction was done for resident 2. 1. All residents charts have been audited for their code status to ensure the information is correct and charts reflect that information. This was completed by Social Service on April 24,2006. This audit was redone by the RN consultant following the Directed Plan of Correction. This was completed on May 8, 2006	

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F 157	Continued From page 2 witnessed on December 31, 2003. Review of resident 2's medical record revealed a nursing note entry dated 4/22/06 at 3:00 AM. The facility nurse who was assigned to resident 2 for the 10:00 PM to 6:00 AM shift wrote the following entry: "Pt. (patient) c/o (complains of) having alot of mucus in throat. given Tylenol per request earlier in shift, [at] 0300 (3:00 AM) pt. requested something more. Nurse returned to pt. room at 0310 (3:10 AM) [with] meds per request pt. was found unresponsive. Nurse returned to nurses station to notify family. Returned to room at 0315 (3:15 AM) pt. was [without] pulse or respirations. pt. is DNR (Do Not Rescuitate) status family when notified had stated "no heroic measures." 0310 (3:10 AM) pt. expired, no VS (vital signs) noted." No documentation could be found in resident 2's medical record to show the facility nurse contacted the physician during the 10:00 PM to 6:00 AM shift to consult with the physician regarding resident 2's change in condition. On 4/23/06 at 10:00 AM the nurse who was assigned to resident 2 for the 10:00 PM to 6:00 AM shift was interviewed. She stated that resident 2 had been experiencing respiratory problems for almost 1 month and had been on 2 or 3 different antibiotics. The nurse stated that resident 2 had complained of not feeling well and the the nurse had given resident 2 Tylenol and cough medicine at 12:00 AM. The nurse further stated that she could hear that resident 2 was having a hard time getting air in to, "cough it up." The nurse stated that at 2:50 AM resident 2 called	F 157	2.The Black Dot system has been put into place. The Black dot indicates that person is DNR. The Sticker is placed on the door next to the resident's name. The admission coordinator will monitor quarterly to ensure accuracy. The RN consultant included this as part of her in-service on May 8, 2006. During the resident's care plan meeting, their codes status will be addressed. DON will monitor. This item will be included in our QA meetings. 3.A list of all residents and their code status has been updated and place in the front of the Med Rand. This will be monitored quarterly by the DON.	

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F 157	Continued From page 3 and said she was having trouble coughing up mucus and that she could not breathe. She stated that she went to the medication cart to find something to give to resident 2. She stated that she was searching for something she could, "legally" give resident 2 and decided she would give resident 2 phenergan and mucinex to try and dry up the secretions even though resident 2 did not have a physician's order for these medications. The nurse stated that she returned to resident 2's room at 3:00 AM to find resident 2 to be unresponsive. She stated that she left the room to go and get the aides (Certified Nursing Assistants), the aides went into resident 2's room and she went to the nurses' station to call the family. The nurse reported going back to resident 2's room at 3:05 AM, after calling the family, to find that resident 2, "was gone." The nurse further stated that resident 2 had been sent two other times to the hospital, "for not being able to cough mucus out of bronchioles." When questioned about an assessment on resident 2 the nurse reported that she tried to get an oxygen saturation on resident 2 at 12:30 AM but was unable to obtain a reading on a brand new finger pulse oximetry instrument. She further reported that she thought she was unable to get an oxygen saturation due to a system malfunction with the new equipment. The nurse further stated that she did not attempt to get any other vital signs at the time she tried to get the oxygen saturation. The nurse stated that she tried to get a complete set of vital signs at 3:00 AM. The nurse further reported that resident 2 did not appear to be in distress. The nurse stated during her interview that she only called the family to see what they wanted her to do. She stated that the family told her not to be aggressive.	F 157	4. The DON did an in-service on April 25, 2006. Discussed Vitals sheets, pain assessments, change of condition forms that are now in the Med Rand for each resident. See in-service material and sign in sheet. 5. DON completed an in-service on May 3rd with the nurses discussing the Chart Alert system that triggers nurses to follow up with residents who have changes in condition. A new 24 hour shift report was introduced in in-service as well as a new incident report forms. The DON will monitor. See in-service material and sign in sheet. per telephone conversation w/ Administrator on 5/21/06 DON to monitor weekly x 4	

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F 157	Continued From page 4 On 4/23/06 at 9:35 AM one of the Certified Nursing Assistants who was assigned to resident 2 during the 10:00 PM to 6:00 AM shift was interviewed. She stated that resident 2 was on her call light alot the night of her death. The CNA stated that resident 2 was complaining of not being able to breathe. She stated that when she went into resident 2's room later in the shift resident 2 was unresponsive and breathing poorly. She further stated that the nurse left the room and went to the nurses' station to call the family. She stated that she tried to get a blood pressure on resident 2 and the machine said "error" so the nurse wanted to do a manual blood pressure and went to retrieve a stethoscope but when the nurse returned to resident 2's room the nurse said resident 2 was already gone. On 4/24/06 at 2:37 PM resident 2's physician was interviewed via the telephone. He stated that resident 2 had problems on and off with her respiratory status and the facility had flown her out on one other occassion to a different hospital for respiratory failure. He further stated that resident 2 was paralyzed from the waist down, had poor mucle tone and did have problems with coughing up secretions. The physician stated that he did not receive a phone call over the weekend regarding resident 2 and had just been informed about her death that morning.	F 157	6. RN consultant was hired on May 1, 2006 to comply with the directed plan of correction. She has done audits on patient care which was completed on May 8, 2006. She has done an in-service on DNR status, DOT system, CPR protocol, change in condition and Dr's Notifications. Her in-service training was completed May 8, 2006. See in-service material and sign in sheet. 7. The above plan will be incorporated into QA meetings monthly. All of the above to be in effect on May 16, 2006	

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F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that for three of twelve sampled residents the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. (Residents 1, 2, and 3) The deficient practice identified for residents 1 and 2 was found to have occurred at an immediate jeopardy level. The deficient practice identified for resident 3 was found to have occurred at a harm level and will not be included in the immediate jeopardy. On 4/5/06, resident 1 was found by a facility nurse to be blue in the face and appeared to be choking on something. Facility staff initiated a call to 911 and then asked resident 1, who was unable to speak, if she wanted anything done. According to a facility nurse, resident 1 mouthed the words "no" to the nurse when she was asked if she wanted anything done. Facility staff did not initiate CPR (CardioPulmonary Rescuitation) and held resident 1's hand until she was "done". Resident 1 did have a living will in her medical record requesting that she be a no code status i.e. no CPR should be initiated, but the medical	F 309		

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F 309	Continued From page 6 record inidicated that resident 1 was a full code status, i.e. CPR should be initiated. On 4/22/06, the medical record of resident 2 documented complaints of not being able to breathe or expectorate mucus. When resident 2 requested something more to aide with not being able to breathe or cough up the mucus, the nurse left the room and went to get resident 2 some medication. Upon returning to resident 2's room, the facility nurse found resident 2 to be unresponsive. The facility nurse left resident 2's room to call the family for instructions. When the facility nurse returned to resident 2's room she discovered that resident 2 had expired. The physician of resident 2 was not notified of resident 2's difficulty with breathing nor was the physician notified when resident 2 expired. Resident 3 experienced a fall on 4/2/06. Resident 3 complained of weakness and pain in her right leg for the next three days. Facility staff reported that the right leg of resident 3 was swollen on 4/3/06. Facility staff did not obtain an x-ray of resident 3's leg until 4/5/06. The x-ray results showed that resident 3 had a supracondylar fracture of the right femur. No documentation could be found to show that facility staff conducted an assessment after the fall nor did documentation show that facility staff administered pain medication for the three days after the fall when resident 3 was complaining of pain. Findings include: A. Resident 1	F 309	F-309 Resident 1 chart was closed when she expired on 4/05/2006. No plan of correction was done for resident 1. 1. All residents charts have been audited for their code status to ensure the information is correct and charts reflect that information. This was completed by Social Service on April 24,2006. This audit was redone by the RN consultant following the Directed Plan of Correction. This was completed on May 8, 2006	

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F 309	Continued From page 7 Resident 1 was admitted to the facility on 12/23/03 with diagnoses which included, asthma and bronchitis. Resident 1's medical record was reviewed on 4/19/06. Review of resident 1's medical record revealed a bright pink piece of construction paper behind the advance directives tab of the medical record. This piece of paper contained two orange stickers. The stickers indicated resident 1's cardiopulmonary resuscitation (CPR) status and her allergies. One of the orange stickers indicated that resident 1 was a "Full Code" meaning that resident 1 would want staff to initiate CPR in an emergency situation. Resident 1's "Advance Directive Statement" was found directly behind the bright pink piece of construction paper. The document which was signed by resident 1 and witnessed by the facility Social Worker on 10/19/04 indicated that resident 1 did want to be transferred to the hospital for evaluation but resident 1 did not want CPR or mechanical ventilation. Facility staff completed an annual comprehensive assessment for resident 1 on 11/28/05. Facility staff identified resident 1 as having a durable power of attorney, a family member who was responsible for resident 1 and that resident 1 was responsible for herself. Facility staff marked none of the above in the Advanced Directives section and did not indicate that resident 1 had a living will or whether or not she was a Full Code or No Code status. Review of nursing notes revealed a nursing note	F 309	2.The Black Dot system has been put into place. The Black dot indicates that person is DNR. The Sticker is placed on the door next to the resident's name. The admission coordinator will monitor quarterly to ensure accuracy. The RN consultant included this as part of her in-service on May 8, 2006. During the resident's care plan meeting, their codes status will be addressed. DON will monitor. This item will be included in our QA meetings. 3.A list of all residents and their code status has been updated and place in the front of the Med Rand. This will be monitored quarterly by the DON.	

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F 309	Continued From page 8 entry dated 4/4/06. The following entry was documented by a facility nurse: "Res (resident) [down] in room - reported by CNA (Certified Nursing Assistant)... that res O2 (oxygen) sat (saturation) [check] was [less than] 85% - noted [at] 76%. Assessment yielded audible wheezing upon entering the room. Auscultated lungs inspiratory/expiratory wheezing noted [with] a temp. (temperature) of 100.8. Call to MD who gave order for res to be shipped to ER (Emergency Room) for eval. (evaluation)" Nursing note documentation revealed that resident 1 returned from the hospital on 4/4/06 at 11:00 AM with new orders for antibiotics. Review of the medical record revealed paperwork sent back with resident 1 on 4/4/06 and signed by the treating emergency room physician. The "Progress" section of the paperwork indicated the following: "A - 1) flare of COPD (Chronic Obstructive Pulmonary Disease) 2) fever - ? UTI Plan - Cont. (continue) Pulmocort, Avelox 400 QD (every day) # 7, Albuterol MDI (metered dose inhaler) [plus] airochamber, and f/u (follow up) any worsening." Review of nurse's notes revealed the following documentation: "4/5/06 (1100) 11:00 AM Pt (patient) sitting on bed c/o (complains of) abd (abdominal) pain. Wheezing SaO2 (oxygen saturation) 98% Requests cough syrup. Cough syrup 10 ml	F 309	4. The DON did an in-service on April 25, 2006. Discussed Vitals sheets, pain assessments, change of condition forms that are now in the Med Rand for each resident. See in-service material and sign in sheet. 5. DON completed an in-service on May 3rd with the nurses discussing the Chart Alert system that triggers nurses to follow up with residents who have changes in condition. A new 24 hour shift report was introduced in in-service as well as a new incident report forms. The DON will monitor. See in-service material and sign in sheet, per telephone conversation w/ Administrator on 5/2/06 DON will monitor weekly, mc 6. RN consultant was hired on May 1, 2006 to comply with the directed plan of correction. She has done audits on patient care which was completed on May 8, 2006. She has done an in-service on DNR status, DOT system, CPR protocol, change in	

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F 309	Continued From page 9 (millileters) given po (by mouth) {up} to bath room [and} back to bed. Sleeping. Resp. (respirations) 16 reg. (regular) non-labored. O2 (oxygen) [at] 2.5 L/M (liters per minute) per NC (nasal cannula). 4/5/06 (1400) 2:00 PM Continues on ABX (antibiotics) for URI (upper respiratory infection) [No] adverse reaction noted [at] this time. "4/5/06 1710 (5:10 PM) - Pt. expired after seizure, indicated that she wanted to be left to go at this time-" On 4/19/06 at 4:25 PM CNA 2, who was present at the time resident 1 expired, was interviewed. She stated that she was standing at the nurses' station when a little boy came up to her and told her that they needed help in Room 105. She stated that she looked down the hall and saw the RN's (Registered Nurse) cart. CNA 2 stated that she went down the hall and when she got into resident 1's room, resident 1 was rolled on her side, her face was blue, and, "she was choking on something." CNA 2 stated that the RN instructed her to go and grab resident 1's chart. CNA 2 stated that she ran up the hall and grabbed resident 1's chart and returned to the room. She stated that when she returned, the RN looked through resident 1's chart and instruced her (CNA 2) to go and call 911 and the niece of resident 1. CNA 2 stated that she ran up the hall and told staff at the nurses' station to call 911 and then she returned to resident 1's room. CNA 2 stated that when she returned to resident 2's room the RN instructed her to go and retrieve a stethoscope. She stated that she left to go and get the stethoscope and upon returning to resident 1's room the RN looked at CNA 2 and	F 309	condition and Dr's Notifications. Her in-service training was completed May 8, 2006. See in-service material and sign in sheet. 7. The above plan will be incorporated into QA meetings monthly. All of the above to be in effect on May 16, 2006	

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F 309	Continued From page 10 another facility CNA with, "a look on her face, like its too late." CNA 2 stated that when the paramedics arrived at the facility resident 1 was already dead. She further stated that resident 1 was conscious during the incident and it appeared that resident 1 had vomitted an orange/beefstew material because of the towel lying on the bed next to resident 1's face. CNA 2 stated that she did not see the RN do CPR nor the Heimlich maneuver (to clear a possible obstruction). On 4/20/06 at 7:30 AM CNA 1, who was also present at the time resident 1 expired, was interviewed. She stated that on the day resident 1 expired, around dinnertime, resident 1 had her call light on. CNA 1 stated that she went down to check on resident 1 and resident 1 was complaining of her stomach hurting. She further stated that resident 1 did not have her oxygen on so she (CNA 1) put the oxygen on and left to get the vital sign equipment. She stated that when she was retrieving the vital sign equipment she asked the RN if she could go down and check on resident 1. CNA 1 stated that when she got back to the room she tried to get a blood pressure on resident 1 but was unable to, but she was able to get her temperature and it was 96.0 (degrees Fahrenheit). CNA 1 stated that she left resident 1's room to answer some other call lights and a few minutes later she saw CNA 2 come up the hall and ask for resident 1's chart. CNA 1 stated that she went down to resident 1's room and upon entering the room resident 1 was puffy and blue in the face and she (resident 1) could not get any air. She stated that the RN looked at the chart and told her to go call 911 and resident 1's niece. CNA 2 stated that she left the room and went to	F 309		

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F 309	Continued From page 11	F 309		

the nurse's station to call the niece and since the niece was not home she had left a message with the niece's son. She further stated that when she got back to resident 1's room, resident 1 was gone. CNA 2 stated that resident 1 could not talk during the incident because she was suffocating. She stated that the RN had said that resident 1 had thrown-up. When questioned about the vomit, CNA 1 stated that the vomit appeared pinkish. When questioned about whether or not the nurse had said that resident 1 did not want anything more to be done, CNA 2 stated the nurse did not say that resident 1 did not want anything done.

On 4/19/06 at 5:45 PM the RN, present at the time resident 1 expired, was interviewed. She stated that she went into resident 1's room around 5:00 PM to give resident 1 her pills. The RN stated that resident 1 was complaining of her stomach hurting and that the RN and the resident discussed that her abdomen could be hurting due to her coughing. The RN stated that resident 1 requested cough medicine so the RN left the room to retrieve the cough medicine. She stated that when she returned to resident 1's room she gave resident 1 the cough medicine and watched her swallow the medicine. The RN stated that she left resident 1's room and proceeded up the hall with her medication care. She stated that maybe two minutes after leaving resident 1's room the CNA came out of resident 1's room and told her (the RN) that something was wrong with resident 1. The RN stated that when she got into resident 1's room, resident 1's face was blue and she was having trouble breathing. She further stated that resident 1 had a white, milky substance coming out of her mouth and that

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resident 1's eyes were rolled back in her head, "it was almost like she was having a seizure." The RN stated that she told the CNA to go and get the chart. She stated that she grabbed the clothes protector that resident 1 was wearing and proceeded to wipe resident 1's mouth out and then roll resident 1 on to her side on the bed. She stated that when the CNA came back with the chart she instructed the CNA to go call 911. The RN stated that she then leaned down and looked at resident 1 and asked resident if she (the resident) wanted her (the RN) to do anything. The RN stated that resident 1 could not talk but she mouthed the words "No" to the RN. The RN further stated that she kept resident 1 comfortable and stayed with resident 1 until she was "done." When asked what resident 1's code status was the RN stated that resident 1 was a full code.

On 4/20/06 at 10:50 AM the RN was again interviewed regarding the incident with resident 1. The RN stated in her interview that if a resident is a no code status the facility will not do anything because the staff are to respect the wishes of the resident. The RN stated that if a resident if a full code the staff will do everything they can to keep the resident alive. She further stated that both CNA 1 and CNA 2 were in the room when resident 1 mouthed the words "No" to the RN. The RN stated that she gets, "excited about helping residents die" and feels that it is, "a spirtual experience."

On 4/19/06 at 5:25 PM the former Director of Nursing (DON) of the facility was interviewed. The former DON was present at the time resident 1 expired. The former DON stated that when she got to resident 1's room, resident 1's face was red

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F 309	Continued From page 13 and purple. She stated that she told the RN that they needed to get the suction machine for resident 1. The former DON stated that the RN said, "No, No CPR, No suction, she said that she didn't want anything done." She further stated that when the RN said that resident 1 had expired that she left. On 4/19/06 at 6:40 PM an EMS (Emergency Medical Services) staff member, who responded to the 911 call for resident 1, was interviewed. He stated that when he arrived at the facility the staff were just standing around resident 1. He further stated that when they received the dispatch they (EMS staff) were told that CPR was in progress. He stated that resident 1 had expired when they got to the facility and the nurse told him that the patient stated if anything happened to her that she did not want CPR. On 4/20/06 LPN 1 (Licensed Practical Nurse) and LPN 2 were interviewed. Both nurses stated that if a resident is listed as a full code the nurses would initiate CPR and not question a resident who was unable to speak if they wanted anything more to be done. The nurses further stated that if a resident is a no code status that they would initiate CPR anyway until the family could be contacted for instructions. B. Resident 2: Resident 2 was admitted to the facility on 2/24/04 with diagnoses which included, Ileus, paralysis, Chronic Obstructive Pulmonary Disease, generalized anxiety,and major depression. Resident 2's medical record was reviewed on	F 309	F-309 Resident 2 Expired on 4/22/2006 and no plan of correction was done for resident 2. 1. All residents charts have been audited for their code status to ensure the information is correct and charts reflect that information. This was completed by Social Service on April 24,2006. This audit was redone by the RN consultant following the Directed Plan of Correction. This was completed on May 8, 2006 2.The Black Dot system has been put into place. The Black dot indicates that	

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F 309	Continued From page 14 4/23/06. Facility staff completed an admission comprehensive assessment on resident 2 on 10/18/05. Facility staff indicated on the assessment that a family member was responsible for resident 1 and resident 1 was responsible for herself. Facility staff also indicated that resident 1 had a Living Will and had a Do Not Resuscitate status. Review of resident 2's medical record revealed a Utah Living Will. This document described the following types of "life-sustaining" procedures resident 2 was willing to undergo in case of an emergency: 1. Oxygen therapy 2. Respiratory Treatments 3. Suctioning 4. Chest Compressions 5. IV (Intravenous) fluids 6. NG/G (naso-gastric/gastronomy) tube 7. Oral, intramuscular, and intravenous antibiotics. This document was signed by resident 2 and witnessed on December 31, 2003. Review of resident 2's medical record revealed a nursing note entry dated 4/22/06 at 3:00 AM. The facility nurse who was assigned to resident 2 for the 10:00 PM to 6:00 AM shift wrote the following entry: "Pt. (patient) c/o (complains of) having alot of mucus in throat. given Tylenol per request earlier in shift, [at] 0300 (3:00 AM) pt. requested	F 309	person is DNR. The Sticker is placed on the door next to the resident's name. The admission coordinator will monitor quarterly to ensure accuracy. The RN consultant included this as part of her in-service on May 8, 2006. During the resident's care plan meeting, their codes status will be addressed. DON will monitor. This item will be included in our QA meetings. 3.A list of all residents and their code status has been updated and place in the front of the Med Rand. This will be monitored quarterly by the DON. 4. The DON did an in-service on April 25, 2006. Discussed Vitals sheets, pain assessments, change of condition forms that are now in the Med Rand for each resident. See in-service material and sign in sheet.	

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F 309	Continued From page 15 something more. Nurse returned to pt. room at 0310 (3:10 AM) [with] meds per request pt. was found unresponsive. Nurse returned to nurses station to notify family. Returned to room at 0315 (3:15 AM) pt. was [without] pulse or respirations. pt. is DNR (Do Not Rescuitate) status family when notified had stated "no heroic measures." 0310 (3:10 AM) pt. expired, no VS (vital signs) noted." No documentation could be found in resident 2's medical record to show the facility nurse contacted the physician during the 10:00 PM to 6:00 AM shift to consult with the physician regarding resident 2's change in condition. On 4/23/06 at 10:00 AM the RN who was assigned to resident 2 for the 10:00 PM to 6:00 AM shift was interviewed. She stated that resident 2 had been experiencing respiratory problems for almost 1 month and had been on 2 or 3 different antibiotics. The RN stated that resident 2 had complained of not feeling well and the the nurse had given resident 2 Tylenol and cough medicine at 12:00 AM. The RN further stated that she could hear that resident 2 was having a hard time getting air in to, "cough it up." The RN stated that at 2:50 AM resident 2 called and said she was having trouble coughing up mucus and that she could not breathe. She stated that she went to the medication cart to find something to give to resident 2. She stated that she was searching for something she could, "legally" give resident 2 and decided she would give resident 2 phenergan and mucinex to try and dry up the secretions even though resident 2 did not have a physician's order for these medications. The RN stated that she returned to resident 2's room at 3:00 AM to find resident 2 to	F 309	5. DON completed an in-service on May 3rd with the nurses discussing the Chart Alert system that triggers nurses to follow up with residents who have changes in condition. A new 24 hour shift report was introduced in in-service as well as a new incident report forms. The DON will monitor. See in-service material and sign in sheet. Pt telephone conversation w/ Administrator on 5/21/06 DON to monitor weekly x2 6. RN consultant was hired on May 1, 2006 to comply with the directed plan of correction. She has done audits on patient care which was completed on May 8, 2006. She has done an in-service on DNR status, DOT system, CPR protocol, change in condition and Dr's Notifications. Her in-service training was completed May 8, 2006. See in-service material and sign in sheet.	

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F 309	Continued From page 16 be unresponsive. She stated that she left the room to go and get the aides (Certified Nursing Assistants), the aides went into resident 2's room and she went to the nurses' station to call the family. The RN reported going back to resident 2's room at 3:05 AM, after calling the family, to find that resident 2, "was gone." The RN further stated that resident 2 had been sent two other times to the hospital, "for not being able to cough mucus out of bronchioles." When questioned about an assessment on resident 2 the RN reported that she tried to get an oxygen saturation on resident 2 at 12:30 AM but was unable to obtain a reading on a brand new finger pulse oximetry instrument. She further reported that she thought she was unable to get an oxygen saturation due to a system malfunction with the new equipment. The RN further stated that she did not attempt to get any other vital signs at the time she tried to get the oxygen saturation. The RN stated that she tried to get a complete set of vital signs at 3:00 AM. The RN further reported that resident 2 did not appear to be in distress. The RN stated during her interview that she only called the family to see what they wanted her to do. She stated that the family told her not to be aggressive. On 4/23/06 at 9:35 AM the Certified Nursing Assistant (CNA 3) who was assigned to resident 2 during the 10:00 PM to 6:00 AM shift was interviewed. She stated that resident 2 was on her call light alot the night of her death. The CNA 3 stated that resident 2 was complaining of not being able to breathe. She stated that when she went into resident 2's room later in the shift resident 2 was unresponsive and breathing poorly. She further stated that the nurse left the	F 309	7. The above plan will be incorporated into QA meetings monthly. All of the above to be in effect on May 16, 2006	

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F 309	Continued From page 17 room and went to the nurses' station to call the family. She stated that she tried to get a blood pressure on resident 2 and the machine said "error" so the nurse wanted to do a manual blood pressure and went to retrieve a stethoscope but when the nurse returned to resident 2's room the nurse said resident 2 was already gone. On 4/24/06 at 2:37 PM resident 2's physician was interviewed via the telephone. He stated that resident 2 had problems on and off with her respiratory status and the facility had flown her out on one other occassion to a different hospital for respiratory failure. He further stated that resident 2 was paralyzed from the waist down, had poor mucle tone and did have problems with coughing up secretions. The physician stated that he did not receive a phone call over the weekend regarding resident 2 and had just been informed about her death that morning. C. Resident 3 Resident 3 was admitted to the facility on 9/7/01 with diagnoses which included, degenerative joint disease, hemiparesis, and diabetic neuropathy. Resident 3's medical record was reviewed on 4/20/06. Review of resident 3's medical record revealed a care plan for falls dated 10/24/05. In the "Approaches" section of the care plan the following interventions are listed for nursing (licensed and unlicensed) staff to do in case of a fall: "... - Report fall to MD and family	F 309	F-309 Resident 3 returned to care center on 4/5/06. She is on q-shift charting. We are monitoring her for pain, monitoring her surgical wound, tolerance to therapies, tolerance for transfers, monitoring for change in condition. Have place in the 4. The DON did an in-service on April 25, 2006. Discussed Vitals sheets, pain assessments, change of condition forms that are now in the Med Rand for each resident. See in-service material and sign in sheet.	

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F 309	Continued From page 18 - If fall occurs - ensure safety: VS, neurochecks, ROM (Range of Motion), assess for injuries, determine cause - If fall occurs assess resident for 72 hours after fall and/or until stable ..." Review of facility incident and accident reports revealed and incident report for resident 3 dated 4/2/06. In the section where staff are to describe what happened, a facility nurse documented the following: "While being transferred from bed to chair, started to pitch forward and two aides helped her backward and gently lowered her to the floor." In the section where staff are to put the physician's name and what time the physician was notified, it was documented by a facility nurse the physicians name and that he was contacted on 3/5/06. No documentation could be found in the medical record regarding the fall on 4/2/06. No documentation could be found in the medical record to show that resident 3 was assessed after the fall for 72 hours or that the family or MD was notified of the fall. Review of resident 3's medical record revealed the following nursing note entries: "4/3/06 1300 (1:00 PM) Pt. has c/o being weak and unable to stand. Hoyer lift used to help pt. in w/c (wheel chair). 4/4/06 0700 (7:00 AM) Pt. O2 sat found to be 76. Pt started on O2 2-3 LPM (liters per minute). Will use to keep sat (oxygen saturation) [greater than] 90%..... 4/5/06 0800 (8:00 AM) Pt. continued to c/o [right]	F 309	5. DON completed an in-service on May 3rd with the nurses discussing the Chart Alert system that triggers nurses to follow up with residents who have changes in condition. A new 24 hour shift report was introduced in in-service as well as a new incident report forms. The DON will monitor. See in-service material and sign in sheet. Per telephone conversation w/ Administrator on 5/21/06 DON to monitor weekly ME 6. RN consultant was hired on May 1, 2006 to comply with the directed plan of correction. She has done audits on patient care which was completed on May 8, 2006. She has done an in-service on DNR status, DOT system, CPR protocol, change in condition and Dr's Notifications. Her in-service training was completed May 8, 2006. See in-service material and sign in sheet.	

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F 309	Continued From page 19 knee pain. Knee swollen. MD ordered pt to go for x-ray. 1130 (11:30 AM) Pt. found to have a [fracture] femur. Notified family. Will see what they want to do...." Review of the Medication Administration Record for resident 3 for April revealed that resident 3 was given no pain medication per documentation on the days following her fall. Resident 3 did have an order for Tylenol to be given every 4 hours if needed for pain. On 4/20/06 the LPN who was assigned to resident 3 on the day of her discharge was interviewed. She stated that she remembered resident 3's leg being swollen the day after the fall but that there was no bruising. She stated that she did give resident 3 extra strenght Tylenol for the pain. The LPN stated that the next day resident 3 complained of pain and then on 4/5/06 when the resident was still complaining of pain she got an order for an x-ray. Resident 3 was admitted to the hospital on 4/5/06 with the diagnosis of "Closed, severe, comminuted, osteoporotic distal femur supracondylar fracture on the right." Resident 3 did have a surgical procedure to fix the fracture during her hospital stay.	F 309	7. The above plan will be incorporated into QA meetings monthly. All of the above to be in effect on May 16, 2006	