STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G039	A. BUILDING _____ B. WING _____	R 01/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROTHER JAMES COURT	**2508 ST. JAMES ROAD SPRINGFIELD, IL 62707**

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{W 000}	INITIAL COMMENTS First follow up to Annual Certification Survey of 9/08/16 First follow up to Incident Investigation of 8/27/16/IL88209/ 9/08/16 W103, W153, W154 citations cleared	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's governing body failed to employ and revise policies and procedures to prevent neglect for 2 of 3 individuals (R11 and R12) who are presently hospitalized with Pneumonia when the facility failed to: 1) Develop and implement a policy for the use of pulse oximetry that identifies abnormal levels that require medical interventions. 2) Implement the facility's policy on Change of Condition by notifying the physician of R11's abnormal vital signs. 3) Ensure the facility's policy on Change of Condition clearly identifies the parameters of unstable vital signs. 4) Develop and implement a policy that ensures 911 is called immediately when an individual is in a medical distress (R11). Findings Include:	{W 104}		2/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/06/2017

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{W 104}	Continued From page 1	{W 104}		

1. R11 is a 72 year old male admitted to the facility on 8/18/16. A diagnoses list dated 7/21/16 includes Moderate Intellectual Disabililty, Brief Psychotic Disorder, Obsessive Compulsive Disorder, Diabetes Mellitus, Hypertension and Dementia.

T Logs (Electronic Nurses Notes) documents that on 12/29/16 at 12:05 AM, R11's SpO2 (peripheral capillary oxygen saturation) level was 70% and the physician and/or emergency personnel were not notified. On 12/29/16 at 4:04 AM, R11's SpO2 level was documented as 80% and on 12/29/16 at 5:20 AM, R11's SpO2 level was documentd as 70%. The physician and/or emergency personnel were not notified. There were no other nursing notes written on 12/29/16. On 12/30/16, there is only one electronic nursing note written related to R11's condition. The next eletronic nursing note is written on 12/31/16 at 9:28 PM when E11/LPN/ Licensed Practical Nurse documented bilateral wheezing noted upon auscultation with no oxygen levels documented. On 12/31/16 at 10:46 PM, R11's Respirations were documented at 40 with an inability to obtain a SpO2 and hear a Blood pressure. At 12:30 AM on 1/1/17, R11's respirations were 44 and nurse was not able to obtain SpO2. There was no further documentation that R11 had been assessed by the night shift E8/ LPN. E6/LPN came on duty on 1/1/17 at 6:00 AM and was informed by E9/ Direct Support Person that R11 did not look right. E6 assessed R11 at 6:15 AM and found R11 unresponsive with a SpO2 of 65%. R11 was transported to the local hospital emergency department by non emergency ambulance on 1/1/17 arriving at 7:17 AM. R11 was intubated and admitted to the ICU (Intensive Care Unit).

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{W 104}	Continued From page 2 2. Physician's Orders (dated 1/1/17-1/31/17) identifies R12 as a 60 year old individual who functions at the Moderate level of Intellectual Disabilities with additional diagnoses of Congestive Heart Failure, Sleep Apnea, Cardiac Enlargement and Asthma. T-Log /Electronic Nurses Notes (dated 11/4/16-1/2/17) documents that R12 left for a home visit on 12/22/16. R12 was taken to a local health clinic on the morning of 12/26/16 by his family and was prescribed Amoxicillin for diagnoses of Pneumonia and Upper Respiratory Infection. R12 was taken back to the facility on 12/26/16 at approximately 2:00 PM. and assessed by nursing at 9:00 PM and had a temperature of 99.4, SpO2 (peripheral capillary oxygen saturation)= 91%, in no respiratory distress at this time, Lung sounds are (slightly) wheezy (especially) upper lobes. The note dated 12/27/16 at 12:00 AM also documents,"episode of loose, mushy yellowish-brown stool, attempted to get to bathroom and fell, hit mid forehead and left side of nose. Small goose egg to mid forehead. Radial pulse is 60, unable to detect B/P, respirations 16 and regular, no cyanosis noted. Very lethargic, PEARL (pupils equal and reactive to light), but verbally unresponsive, responsive slightly to physical stimuli. 911 was called at 1:18 AM on 12/27/16 and arrived at 1:35 AM." R12 was admitted to the hospital with Septic Shock and Pneumonia. In review of the T-Log Notes, nursing did not do an assessment of R12 when he returned to the facility from his home visit until approximately 7 hours later. Nursing did not do a full set of vitals inclusive of pulse, respirations and blood pressure. 3) In an interview with E1, Administrator on	{W 104}		

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{W 104}	Continued From page 3 1/4/17 at 2:40 PM, when asked if the facility had a policy on pulse oximetry, E1 showed surveyor the facility's Change of Condition policy which identifies sudden onset of shortness of breath. E1 confirmed the facility does not have a policy specific to the pulse oximetry that identifies what the abnormal levels would be that would be reported to the physician or require medical interventions. 4. On 1/4/17 at 4:35 PM, E2, DON (Director of Nursing) when asked if the facility had parameters to identify when a doctor should be notified regarding O2 saturation levels and respirations. E2 responded, "Nothing in writing but normal is 12-20 respirations and below 90% for O2 sat." When asked what the nurses should do if they were unable to obtain a Blood Pressure. E2 responded, "Notify the physician." E2 stated, "If a resident is in distress, the nurse should call 911 then notify the physician. There is no need to get permission from the doctor to send out." 5) In an interview with E8 on 1/5/17 at 12:30 PM, E8 /LPN confirmed that she did not report R11's abnormal vital signs to the physician. 6) Facility policy Change of Condition (revised 10/22/15) documents that immediate notification of medical emergencies may include, "Significant change in/or unstable vital signs." In further review of the facility's policy there was no definition of significant change or unstable vital signs. There are no specific parameters of what vital signs would require physician notification or medical intervention. 7).On 1/5/17 at 1:00 PM, Z1, Physician stated,	{W 104}		

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{W 104}	Continued From page 4 "(The facility) has never asked for parameters for Oxygen saturation levels or respirations or any vital signs." 8) E6/ Licensed Practical Nurse completed the General Event Report (dated 1/1/17 at 6:15 AM) documents, "Staff reported that resident was breathing funny. Writer went into his room to find him breathing fast and shallow, his (oxygen) was 65 and he was unresponsive. (Primary Care Physician) was notified and resident sent to (local hospital) emergency room." The form documents that Z1/ Physician was notified at 6:20 AM. 9) On 1/4/17 at 5:15 PM, E6, LPN, stated, "Called the PCP (Primary Care Physician) and asked if she wanted (R11) sent out. The PCP responded yes. Ambulance was called." 10). In an interview with E1/ Administrator on 1/5/17 at 1:45 PM, E1 confirmed that the Change of Condition policy does not clearly identify that staff are to call 911 when an individual is in medical distress. E1 confirmed the facility does not have a specific policy regarding calling 911.	{W 104}		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to develop policies and procedures to prevent neglect for 2 of 3 individuals (R11 and R12)who developed pnuemonia. R11 was hospitalized and intubated due to pneumonia.	W 149		2/6/17

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W 149	Continued From page 5 R12 was hospitalized and diagnosed with pneumonia. The facility failed to ensure that nursing services provided adequate nursing staff, nursing assessment, monitoring, follow up of pulmonary status, physician notification and notification of 911. The facility failed to take appropriate actions to ensure that a system to monitor for abnormal vital signs and a system for 911 (emergency personnel) notification has been developed and implemented when the facility did not: 1. Ensure a thorough nursing assessment of R11 and R12 pulmonary status. 2. Ensure documentation of pulmonary status is complete. 3. Ensure the physician is notified when vital signs are abnormal or unattainable. 4. Ensure that a medical emergency was identified. 5. Ensure nursing staff provides medical care according to code status. 6. Ensure adequate staffing of nurses in order to provide thorough assessments, monitoring and medical interventions. Findings include: 1. R11 is a 72 year old male admitted to the facility on 8/18/16. A diagnoses list dated 7/21/16 includes Moderate Mental Retardation, Brief Psychotic Disorder, Obsessive Compulsive Disorder, Diabetes Mellitus, Hypertension and Dementia.	W 149		

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W 149	Continued From page 6 IDPH/DNR/POLST (dated 9/12/16) documents that R11 wants full Cardiopulmonary Resuscitation and Full Treatment. T Logs (Electronic Nurses Notes) documents that on 12/29/16 at 12:05 AM, R11's SpO2 (peripheral capillary oxygen saturation) level was 70% and the physician and/or emergency personnel were not notified. On 12/29/16 at 4:04 AM, R11's SpO2 level was documented as 80% and on 12/29/16 at 5:20 AM, R11's SpO2 level was documentd as 70%. The physician and/or emergency personnel were not notified. There were no other nursing notes written on 12/29/16. On 12/30/16, there is only one electronic nursing note written related to R11's condition. The next eletronic nursing note is written on 12/31/16 at 9:28 PM when E11/LPN/ Licensed Practical Nurse documented bilateral wheezing noted upon auscultation with no oxygen levels documented. On 12/31/16 at 10:46 PM, R11's Respirations were documented at 40 with an inability to obtain a SpO2 and hear a Blood pressure. At 12:30 AM on 1/1/17, R11's respirations were 44 and nurse was not able to obtain SpO2. There was no further documentation that R11 had been assessed by the night shift E8/ LPN. E6/LPN came on duty on 1/1/17 at 6:00 AM and was informed by E9/ Direct Support Person that R11 did not look right. E6 assessed R11 at 6:15 AM and found R11 unresponsive with a SpO2 of 65%. R11 was transported to the local hospital emergency department by non emergency ambulance on 1/1/17 arriving at 7:17 AM. R11 was intubated and admitted to the ICU (Intensive Care Unit). Nurses Schedule (dated 1/1/17- 1/14/17)	W 149		

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W 149	Continued From page 7 documents that E6 and E7 worked 6:00 AM-12:00 PM on 1/1/17. On 1/4/17 at 4:35 PM, E2, DON (Director of Nursing) stated, "Vital signs are documented on the T-Log and/or vital signs data view." E2 was asked what a nurse should do if unable to obtain SpO2. E2 responded, "Try to warm resident up, try other areas of the body, assess quickly if symptoms of distress." E2 was asked if the facility had parameters to identify when a doctor should be notified regarding O2 saturation levels and respirations. E2 responded, "Nothing in writing but normal is 12-20 respirations and below 90% for O2 sat." E2 was asked what the nurses should do if they were unable to obtain a Blood Pressure. E2 responded, "Notify the physician." E2 stated, "If a resident is in distress, the nurse should call 911 then notify the physician. There is no need to get permission from the doctor to send out." On 1/4/17 at 5:15 PM, E6, LPN, stated, "On 1/1/17, I came in to work, clocked in and got my keys. E9, DSP (Direct Support Person) reported (R11) was breathing funny. I grabbed the pulse oximeter and Spo2 level was 65%. I went and grabbed the oxygen and tubing and called the PCP (Primary Care Physician) and asked if she wanted (R11) sent out. The PCP responded yes. Ambulance was called." E6 stated she could not recall getting a report from the night shift nurse as the nurse was still passing medications then everything happened so quickly. On 1/5/17 at 9:45 AM, E4, LPN, stated with current staffing levels, it is "Very difficult to get all required work done."	W 149		

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W 149	Continued From page 8 On 1/5/17 at 11:40 AM, E10, DSP (Direct Support Person) stated he had worked the night of 12/31/16. E10 stated, "E8, LPN reported (R11) was not doing well and to make a point of checking in on him. Breathing was labored. (I) wasn't sure if he was going to make it through the night." On 1/5/17 at 12:15 PM, E7, LPN stated, "I was working the morning of 1/1/17. The overnight nurse reported (R11) had not done well overnight, was glassy eyed and lemon glycerin swabs were used to keep mouth moist. The day nurse (E6) went down and got vitals then made decision to send (R11) out. I helped get paperwork ready. (E6) called (Local non-emergency ambulance)." On 1/5/17 at 12:30 PM, E8, LPN stated, "Basically, I was monitoring (R11) as he had been in and out of the emergency room over the last 24 to 48 hours and they were not doing anything. They kept sending him back. Was trying to make (R11) as comfortable as possible. Monitor to get oxygen level up. I could not hear (R11's) Blood pressure. Did mouth care. I did not call the doctor." E8 confirmed she was aware R11 was a full code. E8 stated on the night of 12/31/16, "I was checking (R11) every 30 minutes and had DSP (direct support person) checking him often, telling them to let me know if anything changes. I honestly did not think (R11) was going to live." E8 stated she would normally notify the doctor if an O2 sat dropped below 80%. E8 stated normal respirations are 18-20. E8 confirmed she did not contact the DON (Director of Nursing) or the administrator. E8 was asked about staffing levels at night. E8 stated, "Work with 2 nurses until about 9 PM then I am by myself for the whole building. Another	W 149		

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nurse stays to help with the 8 PM medication pass then leaves." E8 stated, "There is not enough time to get all the work done." E8 stated she has complained about lack of night shift nursing staff to the Director of Nursing.

On 1/5/17 at 12:55 PM, Z2 Office Manager for local ambulance service stated, a non-emergency call came in at 6:45 AM on 1/1/17 to transport (R11) from the facility to a local hospital.

On 1/5/17 at 1:00 PM, Z1, Physician, stated, "I was on call over the New Year's holiday. The facility did not notify me of R11's condition following the Emergency Room visit on 12/28/16. If I had gotten a call related to low O2 sat levels or the inability to obtain a Blood pressure, I would have given the order to send R11 back to the emergency room. R11 is a full code." Z1 stated she would expect to be notified if O2 sat levels were below 90% or Respirations were above 30. Z1 stated, "Someone should have called 911. Someone should have been notified." Z1 was asked if the delay in treatment for R11 could have contributed to the current condition including intubation. Z1 responded, "Yes. Most definitely."

2. Physician's Orders (dated 1/1/17-1/31/17) identifies R12 as a 60 year old individual who functions at the Moderate level of Intellectual Disabilities with additional diagnoses of Congestive Heart Failure, Sleep Apnea, Cardiac Enlargement and Asthma.

T-Log /Electronic Nurses Notes (dated 11/4/16-1/2/17) documents that R12 left for a home visit on 12/22/16. R12 was taken to a local health clinic on the morning of 12/26/16 by his family

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and was prescribed Amoxicillin for diagnoses of Pneumonia and Upper Respiratory Infection. R12 was taken back to the facility on 12/26/16 at approximately 2:00 PM. and assessed by nursing at 9:00 PM and had a temperature of 99.4, SpO2 (peripheral capillary oxygen saturation)= 91%, in no respiratory distress at this time, Lung sounds are (slightly) wheezy (especially) upper lobes. The note dated 12/27/16 at 1:45 AM also documents,"episode of loose, mushy yellowish-brown stool, attempted to get to bathroom and fell, hit mid forehead and left side of nose. Small goose egg to mid forehead. Radial pulse is 60, unable to detect B/P, respirations 16 and regular, no cyanosis noted. Very lethargic, PEARL (pupils equal and reactive to light), but verbally unresponsive, responsive slightly to physical stimuli. 911 was called at 1:18 AM on 12/27/16 and arrived at 1:35 AM." R12 was admitted to the hospital with Septic Shock and Pneumonia. In review of the T-Log Notes, nursing did not do an assessment of R12 when he returned to the facility from his home visit until approximately 7 hours later. Nursing did not do a full set of vitals inclusive of pulse, respirations and blood pressure.

In an interview with E2/ Director of Nursing on 1/4/17 at 10:05 AM, when asked what would be expected of nursing when an individual has a SpO2 of 91%, E2 stated, "Assess for cyanosis, take vitals and listen to lungs." E2 confirmed that vitals would be a full set inclusive of pulse, respirations and blood pressure.

In an interview with E11/ Licensed Practical Nurse on 1/4/17 at 11:40 AM, when asked if there was any other documentation of assessments or vitals, E11 stated, "No other vitals/ assessments

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W 149	Continued From page 11 outside of Nurse's Notes." Hot Chart Policy (revised 6/6/14) states, "Nurse will continue charting on the resident's condition change until the resident is free of clinical abnormal or symptom free for three consecutive shifts." 3. Resident Room Assignments (dated 12/16/16) identifies that 94 individuals reside at the facility (R1- R94). 6:00 AM Medication Count by wings (provided to surveyor per fax on 1/9/17) identifies that 64 individuals receive medications at the 6:00 AM medications administration. The form also documents there are a total of 262 medications administered at 6:00 AM. Nurse's Schedule (dated 12/18/16- 1/28/17) documents that only one nurse worked from 11:00 PM- 6:00 AM on 12/18/16, 12/25/16, 12/27/16, 12/30/16, 12/31/16 and 1/1/17. The schedule also documents that there is only one nurse scheduled to work from 11:00 PM- 6:00 AM on 1/8/17, 1/14/17, 1/15/17, 1/17/17 and 1/28/17. Open Shift Needs (dated 12/31/16-1/17/17) is a sign up sheets for nurses to fill open shifts. This sign up sheet documents needs for the 12:00 PM- 6:30 PM and 6:00 PM- 11:00 PM . The form does not identify that the facility was trying to fill the dates identified as having only one nurse from 11:00 PM- 6:00 AM. In an interview with E1/ Administrator and E2/ Director of Nursing on 1/4/17, when asked about staffing regarding nurses, E1 stated , "Nurses work 12 hour shift. We have two shifts. First shift	W 149		

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W 149	Continued From page 12	W 149		

works 6:00 AM -6:30 PM. Second shift works 6:00 PM -6:30 PM. We have a third nurse on day who works with the outside Physicians, Dentist and Medical Director who do visits to the facility." E2 stated the facility has 3 individuals with Gastrostomy Tubes, 1 individual with a colostomy, 3 individuals with suprapubic catheters and 1 individual with a urostomy. When asked about the medication administration, E1 stated that the 6:00 PM-6 :30 AM nurses are responsible for the 6:00 AM medication administration.

On 1/5/17 at 9:45 AM, E4, LPN, stated with current staffing levels, it is "Very difficult to get all required work done."

On 1/5/17 at 12:30 PM, E8 was asked about staffing levels at night. E8 stated, "Work with 2 nurses until about 9 PM then I am by myself the whole building. Another nurse stays to help with the 8 PM medication pass then leaves. E8 stated, "There is not enough time to get all the work done." E8 stated she has complained about lack of nursing staff to the Director of Nursing.

In an interview with E1 on 1/5/17 at 1:45 PM, when asked again about staffing of nursing, E1 stated two 12 hour shifts with 2 nurses on each shift. Surveyor reviewed the nurse's schedule with E1. E1 confirmed that there was only one nurse on duty from 11:00 PM on 12/31/16 to 6:00 AM on 1/1/17. When asked if only one nurse works from 11:00 PM - 6:00 AM, E1 stated, "Yes it happens." E1 confirmed that the schedule showed several dates where there was only one nurse scheduled to work. When asked who was responsible for scheduling the nurses, E2 stated, "The DON." E1 stated, "We have a problem with

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W 149	Continued From page 13 nursing schedule, we need nurses."	W 149		
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Repeat Based on observation, interview, and record review the facility failed to ensure 1 of 1 individuals on unit 200 (R10) received continuous active treatment services. Findings Include: 1) Review of the Individualized Program Plan (IPP) dated documents R10 is a 58 year old male who functions at a Moderate Level of Intellectual Disability. Continued review of R10's IPP, dated , documents, " I attend (name of day training site) for day training services. However, I do not attend daily, often refusing to go and staying back in my room and resting in my bed during day training hours. " During interview on 1/4/17 at 9:00 AM E13 (Social Service Director) stated, R10 has not attended day training since 8/6/15 and was officially discharged on 11/12/15 from day training related to his refusal to go. E13 stated, "A Weekday Schedule was developed for R10". As of 1/4/17, the facility could not produce	{W 249}		2/6/17

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{W 249}	Continued From page 14 evidence of any formal training objective that have been developed for R10 to replace day training objectives. Based on observation, interview, and record review the facility failed to ensure 1 of individuals (R10) received continuous active treatment services. Findings Include: 1) Review of the Individualized Program Plan (IPP) dated documents R10 is a 58 year old male who functions at a Moderate Level of Intellectual Disability. Continued review of R21's IPP, dated 10/8/15, documents, " I attend (name of day training site) for day training services. However, I do not attend daily, often refusing to go and staying back in my room and resting in my bed during day training hours. " R21 ' s IPP documents, " Current Program Goals 3. Work Skill I will attend (name of day training) for a portion of the day, 1 time per week, with any assistance necessary for 4 sessions a month for 3-4 consecutive months. " During observation on 8/23/16 and 8/24/16 R21 was not observed attending day training. During interview on 8/24/16 at 10:50 AM E5 (Qualified Intellectual Disability Professional) stated, R21 does not attend day training and has been discharged from day training related to his refusal to go. E5 stated, " R21 does not have a schedule for the day. He comes to us or if we are doing something we offer to let him help. "	{W 249}		
W 318	483.460 HEALTH CARE SERVICES	W 318		2/6/17

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W 318	Continued From page 15 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure that nursing services provided adequate nursing staff, nursing assessment, nursing monitoring, medical follow up of pulmonary status, physician notification and notification of 911 for 2 of 3 individuals in the sample (R11 and R12) who developed pneumonia and required medical services (R11 was hospitalized/intubated due to pneumonia & R12 was hospitalized and diagnosed with pneumonia). The facility failed to take appropriate actions to ensure that a system to monitor for abnormal vital signs and a system for 911 (emergency personnel) notification has been developed and implemented when the facility failed to: 1. Ensure a thorough nursing assessment of R11 and R12's pulmonary status. 2. Ensure documentation of pulmonary status is complete. 3. Ensure the physician is notified when vital signs are abnormal or unattainable. 4. Ensure that a medical emergency was identified. 5. Ensure nursing staff provides medical care according to DNR/code status. 6. Ensure adequate staffing of nurses in order to	W 318		

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W 318	Continued From page 16 provide thorough assessments, monitoring and medical interventions. The facility's failures to ensure adequate nursing staff, nursing assessments, monitoring, follow up of pulmonary status, physician notification and notification of 911 have the potential to affect 91 additional individuals (R1-R10 and R14-R94) who reside in the facility and require nursing services. These failures resulted in an Immediate Jeopardy. Findings include: On 1/23/17 at 11:15AM an Immediate Jeopardy was identified to have begun on 12/29/16 at 12:05 AM when: >Facility failed to ensure nursing assessment & documentation of pulmonary status for two residents (R11 & R12). >Facility failed to notify physician of abnormal vital signs & unattainable vital signs for two residents (R11 & R12). >Facility failed to identify a medical emergency and provide required medical interventions in a timely manner. >Facility failed to ensure nursing follow client DNR/code status. >Facility failed to provide adequate staffing of nurses in order to provide thorough assessment, medical monitoring & medical interventions. >Facility failed to provide a policy for monitoring and reporting abnormal vital signs. On 1/23/17 at 5:00, PM; E1 was notified that the IJ was removed.	W 318		

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W 318	Continued From page 17 Refer to deficiency cited at : W331 The facility must provide clients with nursing services in accordance with their needs.	W 318		
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Repeat Based on interview and record review, the facility failed to ensure colon cancer screenings were completed for 6 of 6 individuals (R1,R3,R4,R5, R6 and R10) in the need of colon screenings. Findings Include: Review of the Facility's Policy for Colonscopy dated 9/16/15: "Initial screening colonoscopy for colorectal cancer at 50 years of age for asymptotic, average risk men. If, negative, prescreen with any accepted modality in 10 years. Standing order for all residents to have colonoscopy as ordered by resident's physician." Review of the Physician Orders, the following individuals meet the criteria of 50 years and older to receive a colonoscopy: -R1 a 60 year old male who functions in the Mild range of Intellectual Disabilities was scheduled to receive a colonoscopy on 2/12/14. The report indicates due poor preparation the procedure had	{W 322}		2/6/17

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{W 322}	Continued From page 18 to be aborted and re-schuled. There is no evidence that the procedure was rescheduled. -R3 is a 69 year old male who functions in the Moderate Range of Intellectual Disabilities with additional diagnosis of Cerebral Palsy and Epilepsy. R3 also utilities a colostomy since 3/27/13. No evidence of a colonoscopy for R3. -R4 is a 54 year old male who functions in the Mild Range of Intellectual Disabilities. R4 has not received a colonoscopy. -R5 functions in the Severe Range of Intellectual Disabilities. R5 is 63 year old and no evidence of receiving a colonscopy. -R10 a 58 year old male who functions in the Profound Range of Intellectual Disabilities did not receive a colonscopy -R6 is a 56 year old male who functions in the Profound Range of Intellectual Disabilities. Interview with E (Licensed Practical Nurse) on 14/17, E states that R6's guardian has refused to consent for R6's procedure. The Facility Policy states: In the event that the guardian refuses and/or the guardian chooses not to proceed with a colonoscopy, the physician will be notified. a. Occult stool samples will be obtained annually monitoring for blood in stool. b. Monitoring for change of stools will be completed with quarterly assessments. c. Physician and guardian will be notified with any changes with stool.	{W 322}		

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{W 322}	Continued From page 19 There was no evidence in R6's record that any of the above information was recorded in R6's record.	{W 322}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that nursing services provided adequate nursing staff; nursing assessment; monitoring; follow up of pulmonary status; physician notification and notification of 911 for 2 of 3 individuals in the sample (R11 and R12) who developed pneumonia. R11 was hospitalized and intubated due to pneumonia. R12 was diagnosed and hospitalized with pneumonia. The facility failed to take appropriate actions to ensure that a system to monitor for abnormal vital signs and a system for 911 (emergency personnel) notification has been developed and implemented when the facility failed to: 1. Ensure a thorough nursing assessment of R11 and R12 pulmonary status. 2. Ensure documentation of pulmonary status is complete. 3. Ensure the physician is notified when vital signs are abnormal or unattainable. 4. Ensure that a medical emergency was identified. 5. Ensure nursing staff provides medical care	{W 331}		2/6/17

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{W 331}	Continued From page 20 according to DNR/code status. 6. Ensure adequate staffing of nurses in order to provide thorough assessments, monitoring and medical interventions. The facility's failures to ensure adequate nursing staff, nursing assessments, monitoring, follow up of pulmonary status, physician notification and notification of 911 have the potential to affect 92 additional individuals (R1-R10 and R14-R95) who reside in the facility that require nursing services. Resident Functioning Level Roster (dated 1/3/17) identifies that 95 total individuals (R1-R95) reside at the facility. These failures resulted in an Immediate Jeopardy. Findings include: On 1/23/17 at 11:15AM an Immediate Jeopardy was identified to have begun on 12/29/16 at 12:05 AM when the facility failed to: Ensure nursing assessment & documentation of pulmonary status for two residents (R11 & R12). Provide a policy for monitoring and reporting abnormal vital signs. Ensure nursing services follow client DNR/code status. Notify physician of abnormal vital signs & unattainable vital signs for two residents (R11 & R12). Identify a medical emergency and provide required medical interventions in a timely manner. Provide adequate staffing of nurses in order to provide thorough assessment, medical monitoring & medical interventions.	{W 331}		

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{W 331}	Continued From page 21	{W 331}		

On 1/23/17 at 5:00 PM; E1 was notified that the IJ was removed.

1. R11 is a 72 year old male admitted to the facility on 8/18/16. A diagnoses list dated 7/21/16 includes Moderate Intellectual Disability, Brief Psychotic Disorder, Obsessive Compulsive Disorder, Diabetes Mellitus, Hypertension and Dementia.

IDPH/DNR/POLST (dated 9/12/16) documents that R11 wants full Cardiopulmonary Resuscitation and Full Treatment.

R11's Health Note written by E8, LPN (Licensed Practical Nurse) dated 12/26/16 document R11 was admitted to a local hospital on 12/11/16 for Congestive Heart Failure,Sepsis and Pneumonia. R11 discharged back to the facility on 12/26/16.

Vital Signs Data View for R11, dated 12/27/16 at 11:00 PM documents Oxygen Saturation level of 85%, Temperature of 98.0 degrees, Respirations 14 and Blood Pressure 116/61. No other assessment information is documented.

R11's Health Note written by E12, LPN dated 12/29/16 document, "12/28/16, Resident had episodes of unresponsiveness and SPO2 (oxygen saturations) was in the low 70's. He was sent out to (local hospital) emergency room, to be sent back with an order for Augmentin, also full set of vital signs every 4 hours."

R11's Health Note written by E8, LPN dated 12/29/16 at 12:05 AM documents, "resting well with HOB elevated approximately 30 degrees,

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{W 331}	Continued From page 22 SpO2 70 % on room air, O2 per mask applied at 3 liters. Not noted swelling of ankles, PPP(Pedal pulses present)." R11's Health Note written by E8, LPN, dated 12/29/16 at 4:04 AM, documents, "At 1:00 AM, temp was 97.8, pulse 90, resp 20, BP 110/80, SpO2 80% has been resting well, kept taking O2 off and holding in his hand or pushing up on forehead. O2 was removed at this time." R11's Health Note written by E8, LPN, dated 12/29/16 at 5:20 AM, documents, "At 5:00AM, vital signs were temp 97.8, pulse 88, resp 20, SpO2 70%, BP 112/80, HOB remains elevated at 30 degrees, non-compliant with O2, no resp distress notes, no noted LE (lower extremity) edema PPP." The physician and/or emergency personnel were not notified. There were no other nursing notes written on 12/29/16. Vital Signs Data View for R11, dated 12/29/16 at 7:00 PM documents O2 saturation of 82%, Pulse 92, Respirations 14 and BP 114/63. Vital Signs Data View for R11, dated 12/30/16 at 9:00 PM, documents Pulse 92, BP 136/68. No other vital signs or assessments documented. R11's Health Status Note written by E11, LPN, dated 12/31/16 at 9:28 PM documents, "Bilateral wheezing noted upon auscultation." No Oxygen saturation level is documented. R11's Health Note written by E8, LPN, dated 12/31/16 at 10:46 PM documents, "At 11:00 PM, noted to have very quick, even respirations at 40, unable to obtain an SpO2 (oxygen saturation level), pulse 92, unable to hear a B/P (Blood Pressure. HOB (Head of Bed) is elevated and is resting well. Will monitor closely."	{W 331}		

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{W 331}	Continued From page 23 R11's Health Note written by E8, LPN, dated 1/1/17 at 12:26 AM documents, "12:30 AM, continues to rest well with HOB elevated. Breathing remains rapid at 44 but even, eyes are slightly open and glazed looking. Unable to obtain SpO2, will not register on machine. Pulse at the carotid is 92. Mouth care given, due to dryness from mouth breathing." E6 (LPN) completed the General Event Report (dated 1/1/17 at 6:15 AM) documents, "Staff reported that resident was breathing funny. Writer went into his room to find him breathing fast and shallow, his (oxygen) was 65 and he was unresponsive. (Primary Care Physician) was notified and resident sent to (local hospital) emergency room." The form documents that Z1 (Physician) was notified at 6:20 AM. R11's Health Note written by E6, LPN, dated 1/1/17 at 10:18 AM documents, "Staff reported that resident was breathing funny. Writer went into his room to find him breathing fast and shallow, his O2 (sat) was 65 and he was unresponsive. PCP (Primary Care Physician) notified and resident sent to (local hospital) Emergency Department. Administrator notified, GER (General Event Report) made, on 24 report log." R11's Health Note written by E6, LPN dated 1/1/17 at 11:19 AM, documents, "Resident intubated and admitted to ICU (intensive care unit). R11's Health Note written by E6 dated 1/4/17 at 1:37 PM, documents, "His nurse reports that he has pneumonia, is intubated and unresponsive."	{W 331}		

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{W 331}	Continued From page 24 Nurses Schedule (dated 1/1/17- 1/14/17) documents that E6 and E7 worked 6:00 AM-12:00 PM on 1/1/17. On 1/4/17 at 4:35 PM, E2, DON (Director of Nursing) stated; "Vital signs are document on the T-Log and/or vital signs data view." E2 was asked what a nurse should do if unable to obtain SpO2. E2 responded, "Try to warm resident up, try other areas of the body, assess quickly if symptoms of distress." E2 was asked if the facility had parameters to identify when a doctor should be notified regarding O2 saturation levels and respirations. E2 responded, "Nothing in writing but normal is 12-20 respirations and below 90% for O2 sat." E2 was asked what the nurses should do if they were unable to obtain a Blood Pressure. E2 responded, "Notify the physician." E2 stated, "If a resident is in distress, the nurse should call 911 then notify the physician. There is no need to get permission from the doctor to send out." On 1/4/17 at 5:15 PM, E6, LPN, stated; "On 1/1/17, I came in to work, clocked in and got my keys. E9, DSP (Direct Support Person) reported (R11) was breathing funny. I grabbed the pulse oximeter and SpO2 level was 65%. I went and grabbed oxygen and tubing and called the PCP (Primary Care Physician) and asked if she wanted (R11) sent out. The PCP responded yes. Ambulance was called." E6 stated she could not recall getting a report from the night shift nurse as the nurse was still passing medications then everything happened so quickly. On 1/5/17 at 9:45 AM, E4, LPN, stated; with current staffing levels, it is "Very difficult to get all	{W 331}		

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{W 331}	Continued From page 25 required work done." On 1/5/17 at 11:40 AM, E10, DSP (Direct Support Person) stated he had worked the night of 12/31/16. E10 stated; "E8, LPN reported (R11) was not doing well and to make a point of checking in on him. Breathing was labored. (I) wasn't sure if he was going to make it through the night. On 1/5/17 at 12:15 PM, E7, LPN stated; "I was working the morning of 1/1/17. The overnight nurse reported (R11) had not done well overnight, was glassy eyed and lemon glycerin swabs were used to keep mouth moist. The day nurse (E6) went down and got vitals then made decision to send (R11) out. I helped get paperwork ready. (E6) called (Local non-emergency ambulance)." On 1/5/17 at 12:30 PM, E8, LPN stated; "Basically, I was monitoring (R11) as he had been in and out of the emergency room over the last 24 to 48 hours and they were not doing anything. They kept sending him back. Was trying to make (R11) as comfortable as possible. Monitor to get oxygen level up. I could not hear (R11's) Blood pressure. Did mouth care. I did not call the doctor." E8 confirmed she was aware R11 was a full code. E8 stated on the night of 12/31/16, "I was checking (R11) every 30 minutes and had DSP (direct support person) checking him often, telling them to let me know if anything changes. I honestly did not think (R11) was going to live." E8 stated she would normally notify the doctor if an O2 sat dropped below 80%. E8 stated normal respirations are 18-20. E8 confirmed she did not contact the DON (Director of Nursing) or the administrator.	{W 331}		

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{W 331}	Continued From page 26 E8 was asked about staffing levels at night. E8 stated, "Work with 2 nurses until about 9 PM then I am by myself for the whole building. Another nurse stays to help with the 8 PM medication pass then leaves. E8 stated, "There is not enough time to get all the work done." E8 stated she has complained about lack of nursing staff to the DON. On 1/5/17 at 12:55 PM, Z2 Office Manager for local ambulance service stated, a non-emergency call came in at 6:45 AM on 1/1/17 to transport (R11) from the facility to a local hospital. On 1/5/17 at 1:00 PM, Z1, Physician, stated, "I was on call over the New Year's holiday. The facility did not notify me of R11's condition following the Emergency Room visit on 12/28/16. If I had gotten a call related to low O2 sat levels or the inability to obtain a Blood pressure, I would have given the order to send R11 back to the emergency room. R11 is a full code." Z1 stated she would expect to be notified if O2 sat levels were below 90% or Respirations were above 30. Z1 stated, "Someone should have called 911. Someone should have been notified." Z1 was asked if the delay in treatment for R11 could have contributed to the current condition including intubation. Z1 responded, "Yes. Most definitely." Based on record review and interview, the facility failed to ensure that nursing services provided adequate nursing staff; nursing assessment; monitoring; follow up of pulmonary status; physician notification and notification of 911 for 2	{W 331}		

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{W 331}	Continued From page 27 of 3 individuals in the sample (R11 and R12) who developed pneumonia. R11 was hospitalized and intubated due to pneumonia. R12 was diagnosed and hospitalized with pneumonia. The facility failed to take appropriate actions to ensure that a system to monitor for abnormal vital signs and a system for 911 (emergency personnel) notification has been developed and implemented when the facility failed to: 1. Ensure a thorough nursing assessment of R11 and R12 pulmonary status. 2. Ensure documentation of pulmonary status is complete. 3. Ensure the physician is notified when vital signs are abnormal or unattainable. 4. Ensure that a medical emergency was identified. 5. Ensure nursing staff provides medical care according to DNR/code status. 6. Ensure adequate staffing of nurses in order to provide thorough assessments, monitoring and medical interventions. The facility's failures to ensure adequate nursing staff, nursing assessments, monitoring, follow up of pulmonary status, physician notification and notification of 911 have the potential to affect 92 additional individuals (R1-R10 and R14-R95) who reside in the facility that require nursing services. Resident Functioning Level Roster (dated 1/3/17) identifies that 95 total individuals (R1-R95) reside at the facility.	{W 331}		

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{W 331}	Continued From page 28 These failures resulted in an Immediate Jeopardy. Findings include: On 1/23/17 at 11:15AM an Immediate Jeopardy was identified to have begun on 12/29/16 at 12:05 AM when the facility failed to: Ensure nursing assessment & documentation of pulmonary status for two residents (R11 & R12). Provide a policy for monitoring and reporting abnormal vital signs. Ensure nursing services follow client DNR/code status. Notify physician of abnormal vital signs & unattainable vital signs for two residents (R11 & R12). Identify a medical emergency and provide required medical interventions in a timely manner. Provide adequate staffing of nurses in order to provide thorough assessment, medical monitoring & medical interventions. On 1/23/17 at 5:00 PM, E1 was notified that the IJ was removed. 1. R11 is a 72 year old male admitted to the facility on 8/18/16. A diagnoses list dated 7/21/16 includes Moderate Intellectual Disability, Brief Psychotic Disorder, Obsessive Compulsive Disorder, Diabetes Mellitus, Hypertension and Dementia. IDPH/DNR/POLST (dated 9/12/16) documents that R11 wants full Cardiopulmonary Resuscitation and Full Treatment. R11's Health Note written by E8, LPN (Licensed	{W 331}		

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Practical Nurse) dated 12/26/16 document R11 was admitted to a local hospital on 12/11/16 for Congestive Heart Failure,Sepsis and Pneumonia. R11 discharged back to the facility on 12/26/16.

Vital Signs Data View for R11, dated 12/27/16 at 11:00 PM documents Oxygen Saturation level of 85%, Temperature of 98.0 degrees, Respirations 14 and Blood Pressure 116/61. No other assessment information is documented.

R11's Health Note written by E12, LPN dated 12/29/16 document, "12/28/16, Resident had episodes of unresponsiveness and SPO2 (oxygen saturations) was in the low 70's. He was sent out to (local hospital) emergency room, to be sent back with an order for Augmentin, also full set of vital signs every 4 hours."

R11's Health Note written by E8, LPN dated 12/29/16 at 12:05 AM documents, "resting well with HOB elevated approximately 30 degrees, SpO2 70 % on room air, O2 per mask applied at 3 liters. Not noted swelling of ankles, PPP(Pedal pulses present)."
R11's Health Note written by E8, LPN, dated 12/29/16 at 4:04 AM, documents, "At 1:00 AM, temp was 97.8, pulse 90, resp 20, BP 110/80, SpO2 80% has been resting well, kept taking O2 off and holding in his hand or pushing up on forehead. O2 was removed at this time."
R11's Health Note written by E8, LPN, dated 12/29/16 at 5:20 AM, documents, "At 5:00AM, vital signs were temp 97.8, pulse 88, resp 20, SpO2 70%, BP 112/80, HOB remains elevated at 30 degrees, non-compliant with O2, no resp distress notes, no noted LE (lower extremity) edema PPP." The physician and/or emergency personnel were not notified. There were no other

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{W 331}	Continued From page 30 nursing notes written on 12/29/16. Vital Signs Data View for R11, dated 12/29/16 at 7:00 PM documents O2 saturation of 82%, Pulse 92, Respirations 14 and BP 114/63. Vital Signs Data View for R11, dated 12/30/16 at 9:00 PM, documents Pulse 92, BP 136/68. No other vital signs or assessments documented. R11's Health Status Note written by E11, LPN, dated 12/31/16 at 9:28 PM documents, "Bilateral wheezing noted upon auscultation." No Oxygen saturation level is documented. R11's Health Note written by E8, LPN, dated 12/31/16 at 10:46 PM documents, "At 11:00 PM, noted to have very quick, even respirations at 40, unable to obtain an SpO2 (oxygen saturation level), pulse 92, unable to hear a B/P (Blood Pressure. HOB (Head of Bed) is elevated and is resting well. Will monitor closely." R11's Health Note written by E8, LPN, dated 1/1/17 at 12:26 AM documents, "12:30 AM, continues to rest well with HOB elevated. Breathing remains rapid at 44 but even, eyes are slightly open and glazed looking. Unable to obtain SpO2, will not register on machine. Pulse at the carotid is 92. Mouth care given, due to dryness from mouth breathing." E6 (LPN) completed the General Event Report (dated 1/1/17 at 6:15 AM) documents, "Staff reported that resident was breathing funny. Writer went into his room to find him breathing fast and shallow, his (oxygen) was 65 and he was unresponsive. (Primary Care Physician) was notified and resident sent to (local hospital)	{W 331}		

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emergency room." The form documents that Z1 (Physician) was notified at 6:20 AM.

R11's Health Note written by E6, LPN, dated 1/1/17 at 10:18 AM documents, "Staff reported that resident was breathing funny. Writer went into his room to find him breathing fast and shallow, his O2 (sat) was 65 and he was unresponsive. PCP (Primary Care Physician) notified and resident sent to (local hospital) Emergency Department. Administrator notified, GER (General Event Report) made, on 24 report log."

R11's Health Note written by E6, LPN dated 1/1/17 at 11:19 AM, documents, "Resident intubated and admitted to ICU (intensive care unit).

R11's Health Note written by E6 dated 1/4/17 at 1:37 PM, documents, "His nurse reports that he has pneumonia, is intubated and unresponsive."

Nurses Schedule (dated 1/1/17- 1/14/17) documents that E6 and E7 worked 6:00 AM-12:00 PM on 1/1/17.

On 1/4/17 at 4:35 PM, E2, DON (Director of Nursing) stated; "Vital signs are document on the T-Log and/or vital signs data view." E2 was asked what a nurse should do if unable to obtain SpO2. E2 responded, "Try to warm resident up, try other areas of the body, assess quickly if symptoms of distress." E2 was asked if the facility had parameters to identify when a doctor should be notified regarding O2 saturation levels and respirations. E2 responded, "Nothing in writing but normal is 12-20 respirations and below 90% for O2 sat." E2 was asked what the nurses

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should do if they were unable to obtain a Blood Pressure. E2 responded, "Notify the physician." E2 stated, "If a resident is in distress, the nurse should call 911 then notify the physician. There is no need to get permission from the doctor to send out."

On 1/4/17 at 5:15 PM, E6, LPN, stated; "On 1/1/17, I came in to work, clocked in and got my keys. E9, DSP (Direct Support Person) reported (R11) was breathing funny. I grabbed the pulse oximeter and SpO2 level was 65%. I went and grabbed oxygen and tubing and called the PCP (Primary Care Physician) and asked if she wanted (R11) sent out. The PCP responded yes. Ambulance was called." E6 stated she could not recall getting a report from the night shift nurse as the nurse was still passing medications then everything happened so quickly.

On 1/5/17 at 9:45 AM, E4, LPN, stated; with current staffing levels, it is "Very difficult to get all required work done."

On 1/5/17 at 11:40 AM, E10, DSP (Direct Support Person) stated he had worked the night of 12/31/16. E10 stated; "E8, LPN reported (R11) was not doing well and to make a point of checking in on him. Breathing was labored. (I) wasn't sure if he was going to make it through the night.

On 1/5/17 at 12:15 PM, E7, LPN stated; "I was working the morning of 1/1/17. The overnight nurse reported (R11) had not done well overnight, was glassy eyed and lemon glycerin swabs were used to keep mouth moist. The day nurse (E6) went down and got vitals then made decision to send (R11) out. I helped get paperwork ready.

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{W 331}	Continued From page 33 (E6) called (Local non-emergency ambulance)." On 1/5/17 at 12:30 PM, E8, LPN stated; "Basically, I was monitoring (R11) as he had been in and out of the emergency room over the last 24 to 48 hours and they were not doing anything. They kept sending him back. Was trying to make (R11) as comfortable as possible. Monitor to get oxygen level up. I could not hear (R11's) Blood pressure. Did mouth care. I did not call the doctor." E8 confirmed she was aware R11 was a full code. E8 stated on the night of 12/31/16, "I was checking (R11) every 30 minutes and had DSP (direct support person) checking him often, telling them to let me know if anything changes. I honestly did not think (R11) was going to live." E8 stated she would normally notify the doctor if an O2 sat dropped below 80%. E8 stated normal respirations are 18-20. E8 confirmed she did not contact the DON (Director of Nursing) or the administrator. E8 was asked about staffing levels at night. E8 stated, "Work with 2 nurses until about 9 PM then I am by myself for the whole building. Another nurse stays to help with the 8 PM medication pass then leaves. E8 stated, "There is not enough time to get all the work done." E8 stated she has complained about lack of nursing staff to the DON. On 1/5/17 at 12:55 PM, Z2 Office Manager for local ambulance service stated, a non-emergency call came in at 6:45 AM on 1/1/17 to transport (R11) from the facility to a local hospital. On 1/5/17 at 1:00 PM, Z1, Physician, stated, "I was on call over the New Year's holiday. The facility did not notify me of R11's condition	{W 331}		

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following the Emergency Room visit on 12/28/16. If I had gotten a call related to low O2 sat levels or the inability to obtain a Blood pressure, I would have given the order to send R11 back to the emergency room. R11 is a full code." Z1 stated she would expect to be notified if O2 sat levels were below 90% or Respirations were above 30. Z1 stated, "Someone should have called 911. Someone should have been notified." Z1 was asked if the delay in treatment for R11 could have contributed to the current condition including intubation. Z1 responded, "Yes. Most definitely."

2) Physician's Orders (dated 1/1/17-1/31/17) identifies R12 as a 60 year old individual who functions at the Moderate level of Intellectual Disabilities with additional diagnoses of Congestive Heart Failure, Sleep Apnea, Cardiac Enlargement and Asthma.

Local walk in medical care clinic consultation report (dated 12/26/16) documents R12 was seen for complaints of chest congestion. The clinic diagnosed R12 with Pneumonia and prescribed Amoxicillin by mouth and a ProAir Inhaler.

T-Log /Electronic Nurses Notes (dated 11/4/16-1/2/17) documents the following for R12:
"12/22/16 at 8:37 PM- Home Visit"
"12/26/16 at 2:07 PM- Resident returned to facility, family had taken to (local clinic) this am and given orders for Amoxicillin -Pot Clavulante 875-125 mg BID (twice a day) for URI (upper Respiratory Infection) pneumonia, community acquired."
"12/26/16 at 9:28 PM- temp is 99.4 at 2100 hrs. is resting in bed (antibiotic) was started SpO2 (peripheral capillary oxygen saturation)= 91%, in no respiratory distress at this time, Lung sounds

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{W 331}	Continued From page 35 are (slightly) wheezy (especially) upper lobes." "12/27/16 at 1:45 AM- Had episode of loose, mushy yellowish-brown stool, attempted to get to bathroom and fell, hit mid forehead and left side of nose. Small goose egg to mid forehead. Radial pulse is 60, unable to detect B/P, respirations 16 and regular, no cyanosis noted. Very lethargic, PEÁRL (pupils equal and reactive to light), but verbally unresponsive, responsive slightly to physical stimuli. 911 was called at 0118, here at 0135." "12/27/16 - Spoke with nurse at (local hospital) ICU (Intensive Care Unit) resident diagnosis septic shock: continues bi-pap." The T-Log Notes,confirm nursing did not do an assessment of R12 when he returned to the facility from his home visit until approximately 7 hours later. A thorough pulmonary assessment inclusive of a of pulse, respirations and blood pressure was not done by nursing. ON 1/4/17 at 10:05 AM an interview was conducted with E2/ Director of Nursing. When asked what would be expected of nursing when an individual has a SpO2 of 91%, E2 stated, "Assess for cyanosis, take vitals and listen to lungs." E2 confirmed that vitals would be a full set inclusive of pulse, respirations and blood pressure. On 1/4/17 at 11:40 AM an interview was conducted with E11/ Licensed Practical Nurse. When asked if there was any other documentation of assessments or vitals, E11 stated, "No other vitals/ assessments outside of Nurse's Notes." Hot Chart Policy (revised 6/6/14) states; "Nurse	{W 331}		

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{W 331}	Continued From page 36 will continue charting on the resident's condition change until the resident is free of clinical abnormal or symptom free for three consecutive shifts." 3) Resident Room Assignments (dated 12/16/16) identifies that 95 individuals reside at the facility (R1- R95). 6:00 AM Medication Count by wings (provided to surveyor per fax on 1/9/17) identifies that 64 individuals receive medications at the 6:00 AM medications administration. The form also documents there are a total of 262 medications administered at 6:00 AM. Nurse's Schedule (dated 12/18/16- 1/28/17) documents that only one nurse worked from 11:00 PM- 6:00 AM on 12/18/16, 12/25/16, 12/27/16, 12/30/16, 12/31/16 and 1/1/17. The schedule also documents that there is only one nurse scheduled to work from 11:00 PM- 6:00 AM on 1/8/17, 1/14/17, 1/15/17, 1/17/17 and 1/28/17. Open Shift Needs (dated 12/31/16-1/17/17) is a sign up sheets for nurses to fill open shifts. This sign up sheet documents needs for the 12:00 PM- 6:30 PM and 6:00 PM- 11:00 PM . The form does not identify that the facility was trying to fill the dates identified as having only one nurse from 11:00 PM- 6:00 AM. In an interview with E1/ Administrator and E2/ Director of Nursing on 1/4/17, when asked about staffing regarding nurses, E1 stated , "Nurses work 12 hour shift. We have two shifts. First shift works 6:00 AM -6:30 PM. Second shift works 6:00 PM -6:30 AM. We have a third nurse on day who works with the outside Physicians, Dentist	{W 331}		

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and Medical Director who do visits to the facility." E2 stated the facility has 3 individuals with Gastrostomy Tubes, 1 individual with a colostomy, 3 individuals with suprapubic catheters and 1 individual with a urostomy. When asked about the medication administration, E1 stated that the 6:00 PM-6 :30 AM nurses are responsible for the 6:00 AM medication administration.

On 1/5/17 at 9:45 AM, E4, LPN, stated with current staffing levels, it is "Very difficult to get all required work done."

On 1/5/17 at 12:30 PM, E8 was asked about staffing levels at night. E8 stated, "Work with 2 nurses until about 9 PM then I am by myself for the whole building. Another nurse stays to help with the 8 PM medication pass then leaves." E8 stated, "There is not enough time to get all the work done." E8 stated she has complained about lack of might shift nursing staff to the Director of Nursing.

In an interview with E1 on 1/5/17 at 1:45 PM, when asked again about staffing of nursing, E1 stated two 12 hour shifts with 2 nurses on each shift. The nurse's schedule was reviewed with E1. E1 confirmed that there was only one nurse on duty from 11:00 PM on 12/31/16 to 6:00 AM on 1/1/17. When asked if only one nurse works from 11:00 PM - 6:00 AM, E1 stated, "Yes it happens." E1 confirmed that the schedule showed several dates where there was only one nurse scheduled to work. When asked who was responsible for scheduling the nurses, E2 stated, "The DON." E1 stated, "We have a problem with nursing schedule, we need nurses."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G039	A. BUILDING _____ B. WING _____	R 01/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROTHER JAMES COURT	**2508 ST. JAMES ROAD SPRINGFIELD, IL 62707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 38 E1 was notified that the IJ was removed on 1/23/17 at 5:00 PM. The facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan. The surveyor confirmed through Interview and review of facility plan the facility took the following actions to remove the IJ: 1. R11 no longer resides in the facility and R12 remains in the hospital with plans to transfer him to a long term care facility for rehabilitation. 2. Staff will monitor residents frequently during daily assistance with activities of daily living and report any changes to the nurse on duty. 3. The facility's policy on significant change in condition will be reviewed and revised by the Administrator and Director of Nursing to specifically address: >SpO2 >Assessing and documenting pulmonary status >Identifying and responding for medical emergencies >Following the DNR/Code Status >Monitoring and reporting abnormal vital signs 4. The Administrator and the Director of Nursing will inservice all licensed personnel on the significant change of condition policy. 5. The facility has reviewed staffing and hired three additional nurses, two specifically for the night shift.	{W 331}		
{W 440}	483.470(i)(1) EVACUATION DRILLS	{W 440}		2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{W 440}	Continued From page 39 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Repeat Based on record review and interview, the facility failed to complete quarterly fire drills for all shift for 89 of the individuals residing in the facility. Finding Includes: Review of the Facility Roster (Dated 1/3/17), There are 95 male individuals residing in the facility. 12 functioning in the mild range, 28 moderate, 25 severe and 30 in the profound range of Intellectual Disability and 9 individuals utilizes a wheelchair for mobility. Review of the fire drills, total evacuation were completed on the 1st on 7/20/16, 2nd shift on 6/29/16 and a 3rd shift on 7/26/16. There was no reproducible evidence that other drills were completed throughout the year. Interview with E3 (Maintenance Director) on 1/3/17 at 2:20 PM, E3 stated clients only participate in total evacuation drills. E3 confirms staff on the wings give the individuals verbal instruction on fire drills quarterly and no participation by the individuals.	{W 440}		
{W 441}	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	{W 441}		2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G039	A. BUILDING _____ B. WING _____	R 01/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROTHER JAMES COURT	**2508 ST. JAMES ROAD SPRINGFIELD, IL 62707**

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{W 441}	Continued From page 40 This STANDARD is not met as evidenced by: Repeat Based on record review and interview, the facility failed to complete disaster drills on all shifts for the 95 individuals (R1-R95) who resided in the facility. Finding Includes: Review of the Facility Roster (Dated 1/3/17), There are 95 male individuals residing in the facility. 12 functioning in the Mild range, 28 Moderate, 25 Severe and 30 in the Profound range of Intellectual Disability. 9 individuals utilizes a wheelchair for mobility. Interview with E1 (Administrator) on 1/3/17 E1 was unable to produce any reproducible evidence that the facility completed disaster drills on each shift. The last disaster drill completed by the facility occurred on 3/20/15.	{W 441}		