STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 11/09/2017

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GLENSHIRE NURSING & REHAB CTRE	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaint Investigation 1796300/IL97715- 300.690 c 1796303/IL97712- 300.690 c 1796309/IL97711- 300.690 c 1796330/IL97740 - No Findings 1796487/IL97923 - No Findings	S 000		
S9999	Final Observations Statement of Licensure Violations: Licensure 1 of 2 300.610a) 300.1010h) 300.1210b)d)3) 300.3240a) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interview and record review the facility failed to assess, monitor and document vital signs and any changes in physical condition of ventilator and tracheotomy dependent residents during uncomfortable facility environmental temperatures. This failure applies to 2 of 8 residents (R1, R2) reviewed for change in condition. In addition the facility failed to monitor vulnerable residents for immediate medical service, after staff noticed an uncomfortable environmental condition. This failure applies to two residents of eight residents (R1 and R2) reviewed for change in condition. As a result, R1 and R2 being found unresponsive, and arrived to the emergency room with temperatures of 107.7 and 108 degrees Fahrenheit and ultimately dying. Findings Include: R1's face sheet diagnoses include chronic respiratory failure, tracheostomy, anoxic brain damage, acute embolism and thrombosis, gastrostomy, hypertension, and atrial fibrillation. R1's face sheet documents that R1 was a 61 year old who was admitted to the facility on 11/17/15.	S9999		

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R1's orders note dated 10/20/17 documents that R1 was on contact isolation for clostridium difficile. R1's nurse's note dated 10/21/17 at 4:06 pm documents R1 appeared to have anasarca (swelling throughout entire body), +1 pitting edema in bilateral arms, lung sounds bilaterally clear, urine amber color with sediment in urinary catheter noted, remains on total parental nutrition150 ml/hr x 16 hours, talked to in-house Nurse Practitioner about R1, new orders given.

R1's progress/nursing notes do not includes what Physician orders and interventions were initiated after R1's change in condition.

On 11/2/17 at 12:45 E22 Registered Nurse (RN) stated that she took care of R1 on 10/21/17 and the Nurse Practitioner ordered labs after being informed of R1's change in condition. R1 stated that R1's condition as documented above was a change in condition for R1. The facility could not provide laboratory orders for R1 on 10/21/17. R1's Physician Order Sheet (POS) was reviewed with no new orders dated 10/21/17 noted.

R1's nurses note dated 10/22/17 at 5:10 am documents R1 noted unresponsive to verbal and tactile stimuli, Cardiopulmonary Resuscitation (CPR) immediately administered, code blue called, 911 phoned, Emergency medical services arrived, transferred to hospital, family made aware, message left with on call Nurse Practitioner, awaiting call back.

R1's POS includes an order dated 9/19/17 for vital signs every shift.

R1's electronic medication administration record (eMAR) documents 10/21/17 on the day shift the following: blood pressure - 142/84 mmHg,

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Continued From page 4 temperature - 98.4 degrees Fahrenheit, pulse - 84 beats per minute, and respirations - 18 breaths per minute. R1's eMAR documents 10/21/17 on the evening shift the following; blood pressure - 142/84 mmHg, temperature 98.4 degrees Fahrenheit, pulse - 84 beats per minute, respirations 20 breaths per minute. R1's eMAR does not include vital signs for 10/21/17 night shift. R1's Fire Department Paramedic report documents in the narrative that R1 was unresponsive and not breathing, CPR was being performed by staff. The Fire Department continued CPR and transported R1 to the hospital. R1's Fire Department report provided by the hospital documents under skin: hot and mottled. R1's hospital record dated 10/22/17 documents R1 was pronounced dead at 5:55 am. R1's hospital records documents R1 remained pulseless and unresponsive upon arrival to the hospital. R1's hospital records dated 10/22/17 at 5:30 am documents a rectal temperature of 107.7 degrees Fahrenheit, and 0 for the pulse, blood pressure, respirations and oxygen saturations. R1's hospital documents under integument that R1 was very warm (febrile). R1's hospital records documents R1 blood glucose level at 460 milligrams/deciliter. R2's face sheet documents that R2 was a 44 year old admitted to the facility on 10/18/17. R2's face sheet diagnoses include acute and chronic respiratory failure, persistent vegetative state, encephalopathy, heart failure, tracheostomy, dysphagia, atherosclerotic heart disease, functional quadriplegia, and respirator ventilator	S9999		

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S9999	Continued From page 5 dependent. R2's POS includes an order dated 10/18/17 for vital signs every shift and an order dated 10/19/17 Do Not Attempt Resuscitation (DNR). The facility could not provide R2's DNR paperwork. R2's eMAR vital signs for 10/21/17 day, evening and night shift documents blood pressure - 136/78 mmHg, temperature - 98.4, pulse - 88 beats per minute, respirations - 18 breaths per minute and oxygen saturation 94% on day and evening and 96% on night shift. R2's progress/nursing notes do not include documentation for 10/20/17 or 10/21/17. R2's progress/nursing notes do not include documentation of R2's condition on 10/22/17 prior to or during time of unresponsiveness. R2's progress/notes do not include documentation of any interventions during uncomfortable facility environmental temperatures. R2's Fire Department Paramedic report dated 10/22/17 at 8:12 am documents that R2 was not breathing and CPR was in progress. R2's Fire Department Paramedic report dated 10/22/17 at 8:13 am documents R2 had no blood pressure, pulse, or respirations. R2's paramedic report documents R2's skin was diaphoretic (moisture), hot and cyanotic (blue). R2's hospital records dated 10/22/17 documents R2 arrived with blood glucose of 27 mg/dl, temperature of 108 degrees Fahrenheit and no blood pressure, pulse, respirations or oxygen saturations. R2's hospital records documents R2 appears cachectic with a sickly appearance. R2's hospital records documents that EMS came to desk, notified nurse that it was extremely hot in R2's room. On 10/24/17 at 1:20 pm R3 stated that her room	S9999		

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was too hot on Saturday 10/21/17 and Sunday 10/22/17. R3 stated that she complained to the staff and was told that the heat was not on. R3 stated that hot air continued to blow out of the heating vent so she placed a blanket over the vent to block the heat. R3's blanket was observed covering the heating vent. R3 stated that the Certified Nursing Assistant (CNA) opened her window and turned on the portable fan but the room remained too hot. R3 stated that her hair was soaked with perspiration on 10/21/17 because it was so hot in her room.
On 10/24/17 at 1:25 pm R4 stated that the room was extremely hot on 10/21/17 and 10/22/17. R4 stated that the CNA turned her fan on but the room was still too hot.

On 10/24/17 at 2:32 pm E9 CNA stated that he worked Saturday 10/21/17 and Sunday 10/22/17. E9 stated that the facility was too hot. E9 stated that anyone who could speak complained about the heat. E9 stated that on Saturday 10/21/17 the staff opened windows and on Sunday 10/22/17 Maintenance brought fans to the 3rd floor.

On 10/25/17 at 7:55 am E10 CNA stated that the facility was hot on 10/22/17. E10 stated that on 10/22/17 she was pulled from her assignment to take temperatures throughout the building. E10 stated that Maintenance opened windows and put fans out.

On 10/25/17 at 8:10 am R6 stated that his room temperature was too hot over the past weekend.

On 10/25/17 at 10:02 am Z3 (Police Officer) stated that he was at the facility three times on 10/22/17. Z3 stated that he did not enter any resident rooms but noticed that the temperature in the hall was hot.

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S9999	Continued From page 7 On 10/25/17 at 2:56 pm E7 Licensed Practical Nurse (LPN) stated that on Saturday 10/21/17 during 3:00 pm - 11:00 pm the 3rd floor of the facility was extremely hot. E7 stated that she called E5 (Maintenance Worker) on 10/21/17 at 4:00 pm to inform him that the facility was too hot. E7 stated that E5 stated that it was nothing that he can do about the heat. E7 stated that she worked 10/21/17 - 10/22/17 during the night shift and the facility remained extremely hot. E7 stated that most of the residents on the 3rd floor are ventilator dependent and non-verbal. E7 stated that she was not assigned to care for R1 and R2 on 10/21/71 - 10/22/17. E7 stated that she provided ice for residents who could have ice, flushed gastrostomy tubes, provided cold compresses to residents and opened the room windows. The facility could not provide documentation of above interventions. On 10/26/17 at 10:52 am E2 Director of Nursing (DON) stated that she was notified of the issues in the building on 10/22/17 when she called the facility to check on the staffing for the day. E2 stated that she did not receive any calls from staff on 10/21/17. E2 stated that in emergencies the staff should notify the DON and the Administrator. E2 stated that when the temperature in the facility is assessed to be too warm the nurses should keep residents well hydrated, provide fans, open windows, monitor vital signs and document the findings. On 10/26/17 at 10:24 am during a 2nd interview, E5 (Maintenance Worker) stated that a Nurse (not sure of name) called him on Saturday 10/21/17 around 4:00 pm to report that the facility was too hot. E5 stated that he told the Nurse to open some windows, turn on the fans and call E6	S9999		

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(Maintenance Director). E5 stated that on Sunday 10/22/17 the windows on the 3rd floor were closed and he removed the chains from the windows to allow them to open fully. E5 stated that sometimes the wind will close the windows after they have been opened.

On 10/26/17 at 10:30 am E11 LPN stated that he worked Saturday 10/21/17 on the night shift. E11 stated that there were only two nurses for about forty ventilator and tracheostomy residents. E11 stated that the 3rd floor was extremely hot on Saturday night. E11 stated that E7 reported that she called Maintenance and he (E11) called E2 (DON) at 1:00 am but did not get an answer and did not leave a message. E11 stated that he opened all of the windows, flushed the gastrostomy tubes, and applied cool towels and sheets to residents head and under arms. E11 stated that he was not assigned to R1 and R2 but assisted with the code blue for both. E11 stated that he documented on R1's code but did not document on R2's code because he was off duty. E11 stated that R1 and R2 did not have a nurse assigned to them because of short staffing. E11 stated respiratory therapy suctioned the residents and the CNA's turned and repositioned. The facility could not provide documentation to support the above interventions.

On 10/26/17 at 12:30 pm E12 CNA stated that she worked on Saturday 10/21/17 and Sunday 10/22/17. E12 stated that the 3rd floor was so hot that she was perspiring. E12 stated that she opened windows and made sure her residents heating vents were in the off position but the facility remained hot.

On 10/26/17 at 1:15 pm E14 LPN stated that she worked on the 3rd floor of the facility on 10/21/17

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during the evening shift. E14 stated that the facility was so hot that she became ill from the heat. E14 stated that E7 LPN called maintenance to report the hot temperatures in the facility. E14 stated that she opened windows, turned on fans and took vitals. E14 stated that some residents appeared to be in distress but she was not familiar with the residents. E14 stated that R1 had a slight temperature of 99 degrees Fahrenheit. E14 stated that R1 did not look good when E7 and E14 went into the room to hang his total parental nutrition and intravenous fluids, so she took the blanket off of R1. E14 stated that R2 temperature was not high but he was warm to touch. E14 stated that the building was too hot.

On 10/26/17 at 3:05 pm Z4 (R5's family) stated that she visited the facility on 10/22/17 at 6:00 am and the facility was extremely hot. Z4 stated that R5, the staff and she were sweating because the facility was so hot.

On 10/29/17 at 1:40 pm Z5 Medical Examiner stated that the final report denoting whether heat was a factor in R1's death is not complete. Z5 stated that R1 started to decompose quickly which is common with high body temperatures.

On 10/30/17 at 12:05 pm E1 Administrator stated that she was notified about the concerns of the temperatures in the facility on Sunday 10/22/17 between 9:30 am - 10:00 am.

On 10/30/17 at 1:25 pm Z6 (Nurse Practitioner) stated that R1's diagnoses included chronic respiratory failure, anoxic brain injury (comatose), hypertension, infection and wounds. Z6 stated that it was natural for R1 to have an elevated temperature because of the infection and total

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parental nutrition. Z6 stated that ambient room temperature does not play a role in elevated body temperatures. Z6 stated that staff is expected to monitor vital signs, medicate as needed for elevated temperatures and notify Physician or NP for change of condition.

R1's October 2017 eMAR temperatures and vital summary do not include documentation of elevated temperatures.

On 10/30/17 at 1:50 pm Z7 (R2's Pulmonologist) stated that he cannot comment on R2's temperature. Z7 stated that R2 had the diagnoses of chronic tracheostomy, ventilator dependence, encephalopathy and he was non-verbal. Z7 stated that it is possible to be susceptible to high temperatures related to R2's condition. Z7 stated that if the room temperature is elevated staff must make ensure the resident temperature is not elevated, evaluate and treat if needed.

On 10/30/17 at 1:38 pm E15 (Activity Director/Manager on Duty) stated that on Saturday 10/21/17 no one informed her of temperatures being too hot. E15 stated that she was in the building on Saturday 10/21/17 during the morning shift and the temperatures were comfortable to her. E15 stated that on Sunday 10/22/17 during the morning shift the facility did appear to be hot. E15 stated that she asked E5 about the heat and he stated that he turned the heat off.

On 11/1/17 at 10:04 am E16 LPN stated that she worked on 10/22/17 during the day shift. E16 stated that she was not assigned to the 3rd floor where there was a concern. E16 stated that the facility was warm on 10/22/17. E16 stated that

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she received a call from the emergency room to inform of resident elevated temperatures. E16 stated that she spoke with maintenance, who stated the heat was turned off. E16 stated that she told staff to keep residents cool, check to make sure all residents were well hydrated, and take vital signs of all the residents. E16 stated that once she received the call from the emergency room she reported to the manager on duty who called the Director of Nursing.

On 11/1/17 at 10:47 am E17 LPN stated that he worked at the facility on 10/21/17 and 10/22/17 from 7:00 am - 11:00 pm. E17 stated that the facility temperatures were very hot and uncomfortable. E17 stated that he noticed that the facility temperatures were too warm on 10/21/17 during the day shift. E17 stated that maintenance was aware of the high facility temperatures but there was no solution. E17 stated that the DON is new and no one had contact information for her so there were no means to contact, report and communicate with the DON. E17 stated that he provided ice packs and Tylenol to his residents. E17 stated that he is not aware of the weather emergency policy.

On 11/2/17 at 12:45 pm E22 RN stated that the facility on 10/'21/17 during the day shift was warm. E22 stated that a family member (cannot recall who) and staff complained about the warm temperature. E22 stated that most of the residents on the 3rd floor are non-verbal and could not express if the warm temperatures were uncomfortable.

The facility could not provide documentation of the interventions or assessments for residents when the uncomfortable facility temperatures were identified on 10/21/17.

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S9999	Continued From page 12 The facility's weather emergency dated 4/07 documents that the facility will maintain a safe and comfortable temperature level; if temperature is above the comfort zone, extra fluids will be administered; if an area is above or below comfort zone due to equipment failure, residents will be removed from the area while repairs are made and staff follow emergency procedures as needed. (A) (2 of 2) 300.690 c) Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the	S9999		

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GLENSHIRE NURSING & REHAB CTRE	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S9999	Continued From page 13 occurrence. This requirement is not met as evidence by: Based on interview and record review the facility failed to notify the state department of two resident deaths (R1 and R2) by telephone. Findings Include: R1's face sheet diagnoses include chronic respiratory failure, tracheostomy, anoxic brain damage, acute embolism and thrombosis, gastrostomy, hypertension, and atrial fibrillation. R1's face sheet documents that R1 was a 61 year old who was admitted to the facility on 11/17/15. R1's nurses note dated 10/22/17 at 5:10 am documents R1 noted unresponsive to verbal and tactile stimuli, Cardiopulmonary Resuscitation (CPR) immediately administered, code blue called, 911 phoned, Emergency medical services arrived, transferred to hospital, family made aware, message left with on call Nurse Practitioner, awaiting call back. R1's Fire Department Paramedic report documents in the narrative that R1 was unresponsive and not breathing, CPR was being performed by staff. The Fire Department continued CPR and transported R1 to the hospital. R1's Fire Department report provided by the hospital documents under skin: hot and mottled. R1's hospital record dated 10/22/17 documents R1 was pronounced dead at 5:55 am. R1's hospital records documents R1 remained pulseless and unresponsive upon arrival to the hospital. R1's hospital records dated 10/22/17 at 5:30 am documents a rectal temperature of 107.7 degrees Fahrenheit, and 0 for the pulse, blood pressure, respirations and oxygen saturations.	S9999		

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S9999	Continued From page 14 R1's hospital documents under integument that R1 was very warm (febrile). R2's face sheet documents that R2 was a 44 year old admitted to the facility on 10/18/17. R2's face sheet diagnoses include acute and chronic respiratory failure, persistent vegetative state, encephalopathy, heart failure, tracheostomy, dysphagia, atherosclerotic heart disease, functional quadriplegia, and respirator ventilator dependent. R2's Fire Department Paramedic report dated 10/22/17 at 8:12 am documents that R2 was not breathing and CPR was in progress. R2's Fire Department Paramedic report dated 10/22/17 at 8:13 am documents R2 had no blood pressure, pulse, or respirations. R2's paramedic report documents R2's skin was diaphoretic (moisture), hot and cyanotic (blue). R2's hospital records dated 10/22/17 documents R2 arrived with blood glucose of 27 mg/dl, temperature of 108 degrees Fahrenheit and no blood pressure, pulse, respirations or oxygen saturations. R2's hospital records documents that EMS came to desk, notified nurse that it was extremely hot in R2's room. On 10/24/17 at 12:50 pm E1 Administrator stated that she faxed the report of R1 and R2's death to the State agency and did not speak to anyone directly. On 10/25/17 at 10:02 am Z3 (Police Officer) stated that he was at the facility three times on 10/22/17 regarding a resident's call. Z3 stated that he did not enter any resident rooms but noticed that the temperature in the hall was hot. On 10/25/17 at 11:43 am E5 (Maintenance	S9999		

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Worker) stated that on Saturday 10/21/17 the facility heat was off during the day and he turned the heat back on before leaving on Saturday 10/21/17 around 3:30 pm. E5 stated that on 10/22/17 during the morning shift when he arrived to the facility he was informed by a Nurse and a Certified Nursing Assistant/CNA (not sure of the name) that the facility was too warm. E5 stated that he turned the facility boiler off, opened windows, put fans in the hallways and opened the stairwell doors along with the roof top door to allow cool air to circulate through the facility. E5 stated that he called E6 (Maintenance Director) between 7:00 am - 7:30 am on 10/22/17 to inform him about the facility temperatures being too warm. On 10/26/17 at 10:24 am during a 2nd interview, E5 (Maintenance Worker) stated that a Nurse (not sure of name) called him on Saturday 10/21/17 around 4:00 pm to report that the facility was too hot. E5 stated that he told the Nurse to open some windows, turn on the fans and call E6 (Maintenance Director). E5 stated that he did not call E6 because he told the nurse to call E6.

On 10/25/17 at 2:56 pm E7 Licensed Practical Nurse (LPN) stated that on Saturday 10/21/17 during 3:00 pm - 11:00 pm the 3rd floor of the facility was extremely hot. E7 stated that she called E5 (Maintenance Worker) on 10/21/17 at 4:00 pm to inform him that the facility was too hot. E7 stated that E5 stated that it was nothing that he can do about the heat. E7 stated that she worked 10/21/17 - 10/22/17 during the night shift and the facility remained extremely hot. E7 stated that most of the residents on the 3rd floor are ventilator dependent and non-verbal. E7 stated that she was not assigned to care for R1 and R2 on 10/21/71 - 10/22/17. E7 stated she provided ice for residents who could have ice, flushed gastrostomy tubes, provided cold

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compresses to residents and opened the room windows. The facility could not provide documented evidence of above interventions upon surveyor's request.

On 10/26/17 at 10:52 am E2 Director of Nursing (DON) stated that she was notified of the issues in the building on 10/22/17 when she called the facility to check on the staffing for the day. E2 stated that she did not receive any calls from staff on 10/21/17. E2 stated that in emergencies the staff should notify the DON and the Administrator. E2 stated that when the temperature in the facility is assessed to be too warm the nurses should keep residents well hydrated, provide fans, open windows, monitor vital signs and document the findings.

On 10/26/17 at 10:30 am, E11, LPN stated that he worked Saturday 10/21/17 on the night shift. E11 stated that there were only two nurses for about forty ventilator and tracheostomy residents. E11 stated that the 3rd floor was extremely hot on Saturday night. E11 stated that E7, LPN reported that she called Maintenance and he (E11) called E2 (DON) at 1:00 am but did not get an answer and did not leave a message. E11 stated that he opened all of the windows, flushed the gastrostomy tubes, and applied cool towels and sheets to residents head and under arms. E11 stated that the facility remained hot despite opening windows. E11 stated that he was not assigned to R1 and R2 but assisted with the code blue for both. E11 stated that he documented on R1's code but did not document on R2's code because he was off duty. E11 stated that R1 and R2 did not have a nurse assigned to them because of short staffing. E11 stated respiratory therapy suctioned the residents and the CNA's turned and repositioned. The facility could not

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S9999	Continued From page 17 provide documentation to support the above interventions. On 10/26/17 at 12:30 pm E12 CNA stated that she worked on Saturday 10/21/17 and Sunday 10/22/17. E12 stated that the 3rd floor was so hot that she was perspiring. E12 stated that she opened windows and made sure her residents heating vents were in the off position but the facility remained hot. According to R1's face sheet, R1 was a 61 year old who was admitted to the facility on 11/17/15. R1 had diagnoses including: chronic respiratory failure, tracheostomy, anoxic brain damage, acute embolism and thrombosis, gastrostomy, hypertension, and atrial fibrillation. R1's orders note dated 10/20/17 documents that R1 was on contact isolation for clostridium difficile. R1's nurse's note dated 10/21/17 at 4:06 pm documents R1 appeared to have anasarca (swelling throughout entire body), +1 pitting edema in bilateral arms, lung sounds bilaterally clear, urine amber color with sediment in urinary catheter noted, remains on total parental nutrition 150 ml/hr x 16 hours, talked to in-house Nurse Practitioner about R1, new orders given. R1's progress/nursing notes do not includes what Physician orders and interventions were initiated after R1's change in condition. R1's nurses note dated 10/22/17 at 5:10 am documents R1 noted unresponsive to verbal and tactile stimuli, Cardiopulmonary Resuscitation (CPR) immediately administered, code blue called, 911 phoned, Emergency medical services arrived, transferred to hospital, family made aware, message left with on call Nurse Practitioner, awaiting call back.	S9999		

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R1's Physician Order Sheet (POS) dated 9/19/17 ordered vital signs to be every shift. No new orders for 10/21/17 were noted.

On 11/2/17 at 12:45 E22 Registered Nurse (RN) stated that she took care of R1 on 10/21/17 and the Nurse Practitioner ordered labs after being informed of R1's change in condition. E22 stated that R1's condition as documented in the notes was a change in condition for R1. During the survey the facility could not provide laboratory orders for R1 on 10/21/17.

R1's electronic medication administration record (eMAR) documents 10/21/17 on the day shift the following: blood pressure - 142/84 mmHg, temperature - 98.4 degrees Fahrenheit, pulse - 84 beats per minute, and respirations - 18 breaths per minute. R1's eMAR documents 10/21/17 on the evening shift the following; blood pressure - 142/84 mmHg, temperature 98.4 degrees Fahrenheit, pulse - 84 beats per minute, respirations 20 breaths per minute.
R1's eMAR does not include vital signs for 10/21/17 night shift.

R1's Fire Department Paramedic report documents in the narrative that R1 was unresponsive and not breathing, CPR was being performed by staff. The Fire Department continued CPR and transported R1 to the hospital. R1's Fire Department report provided by the hospital documents under skin: hot and mottled.

R1's hospital record dated 10/22/17 documents R1 was pronounced dead at 5:55 am. R1's hospital records documents R1 remained pulseless and unresponsive upon arrival to the

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hospital. R1's hospital records dated 10/22/17 at 5:30 am documents a rectal temperature of 107.7 degrees Fahrenheit, and 0 for the pulse, blood pressure, respirations and oxygen saturations. R1's hospital documents under integument that R1 was very warm (febrile). R1's hospital records documents R1 blood glucose level at 460 milligrams/deciliter.

According to R2's face sheet, R2 was a 44 year old admitted to the facility on 10/18/17. R2's face sheet diagnoses include acute and chronic respiratory failure, persistent vegetative state, encephalopathy, heart failure, tracheostomy, dysphagia, atherosclerotic heart disease, functional quadriplegia, and respirator ventilator dependent.

Fire Department Paramedic report dated 10/22/17 at 8:12 am documents that R2 was not breathing and CPR was in progress. R2's Fire Department Paramedic report dated 10/22/17 at 8:13 am documents R2 had no blood pressure, pulse, or respirations. R2's paramedic report documents R2's skin was diaphoretic (moisture), hot and cyanotic (blue).

R2's hospital records dated 10/22/17 documents R2 arrived with blood glucose of 27 mg/dl, temperature of 108 degrees Fahrenheit and no blood pressure, pulse, respirations or oxygen saturations. R2's hospital records documents R2 appears cachectic with a sickly appearance. R2's hospital records documents that EMS came to desk, notified nurse that it was extremely hot in R2's room (at the facility).

R2's POS includes an order dated 10/18/17 for vital signs every shift and an order dated 10/19/17

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S9999	Continued From page 20 Do Not Attempt Resuscitation (DNR). The facility could not provide R2's DNR paperwork that confirms this is the correct order. R2's eMAR vital signs for 10/21/17 day, evening and night shift documents blood pressure - 136/78 mmHg, temperature - 98.4, pulse - 88 beats per minute, respirations - 18 breaths per minute and oxygen saturation 94% on day and evening and 96% on night shift. R2's progress/nursing notes had no nursing documentation regarding R2's condition for 10/20/17 or 10/21/17. R2's progress/nursing notes did not include documentation of R2's condition on 10/22/17 prior to or during time of unresponsiveness. R2's progress/notes did not include documentation of any interventions during uncomfortable facility environmental temperatures. On 10/29/17 at 1:40 pm Z5, Medical Examiner stated that the final report denoting whether heat was a factor in R1's death is not complete. However, Z5 stated that R1 started to decompose quickly which is common with high body temperatures. On 10/30/17 at 1:25 pm Z6 (Nurse Practitioner) stated that R1's diagnoses included chronic respiratory failure, anoxic brain injury (comatose), hypertension, infection and wounds. Z6 stated that it was natural for R1 to have an elevated temperature because of the infection and total parental nutrition. Z6 stated that ambient room temperature does not play a role in elevated body temperatures. Z6 stated that staff is expected to monitor vital signs, medicate as needed for elevated temperatures and notify Physician or NP for change of condition.	S9999		

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S9999	Continued From page 21 R1's October 2017 eMAR temperatures and vital summary do not include documentation of elevated temperatures. On 10/30/17 at 1:50 pm Z7 (R2's Pulmonologist) stated that he cannot comment on R2's temperature. Z7 stated that R2 had the diagnoses of chronic tracheostomy, ventilator dependence, encephalopathy and he was non-verbal. Z7 stated that it is possible to be susceptible to high temperatures related to R2's condition. Z7 stated that if the room temperature is elevated staff must make ensure the resident temperature is not elevated, evaluate and treat if needed. On 11/1/17 at 10:04 am E16 LPN stated that she worked on 10/22/17 during the day shift. E16 stated that she was not assigned to the 3rd floor where there was a concern. E16 stated that the facility was warm on 10/22/17. E16 stated that she received a call from the emergency room to inform of resident elevated temperatures. E16 stated that she spoke with maintenance, who stated the heat was turned off. E16 stated that she told staff to keep residents cool, check to make sure all residents were well hydrated, and take vital signs of all the residents. E16 stated that once she received the call from the emergency room she reported to the manager on duty who called the Director of Nursing. On 11/1/17 at 10:47 am E17 LPN stated that he worked at the facility on 10/21/17 and 10/22/17 from 7:00 am - 11:00 pm. E17 stated that the facility temperatures were very hot and uncomfortable. E17 stated that he noticed that the facility temperatures were too warm on 10/21/17 during the day shift. E17 stated that maintenance was aware of the high facility	S9999		

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S9999	Continued From page 22 temperatures but there was no solution. E17 stated that the DON is new and no one had contact information for her so there were no means to contact, report and communicate with the DON. E17 stated that he provided ice packs and Tylenol to his residents. E17 stated that he is not aware of the weather emergency policy. On 11/2/17 at 12:45 pm E22 RN stated that the facility on 10/'21/17 during the day shift was warm. E22 stated that a family member (cannot recall who) and staff complained about the warm temperature. E22 stated that most of the residents on the 3rd floor are non-verbal and could not express if the warm temperatures were uncomfortable. The facility could not provide documentation of the interventions or assessments for residents physical conditions, when the nursing staff acknowledged uncomfortable facility temperatures on 10/21/17. (B)	S9999		