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Z 000	COMMENTS COMPLAINT INVESTIGATION SURVEY # 1888305 / IL00108252	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1230d)1)2) 350.3240a) 350.3240c) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect	Z9999	Attachment A Statement of Licensure Violations	

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

These requirements were not met as evidenced by:

Based on record review and interview, the facility failed to:

(1) Follow facility policies and procedures to prevent neglect on change in individual's condition, and charting and documentation for 1 of 1 individual in the sample who had a change in health condition (that required medical intervention) that resulted in death (R1)
(2) Implement policies on investigating death, training agency nurses, and physician services affecting 1 of 1 individual in the sample who had a change in health condition that resulted in death (R1) and ensure that a thorough investigation was conducted.

Findings include:

Facility policy on Change in Client's Condition (undated) requires, "1. All significant changes in the client's condition shall be noted on the client's chart. The nurse noting the change shall notify the attending physician. 2. The nurse noting any significant changes in the client's condition shall notify the client's responsible party and / or legal representative. 3. A client whose condition worsens or becomes critical shall be placed

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under frequent observation. Vital signs shall be recorded as needed. Nursing personnel shall keep the client as comfortable as possible and give reassurance and comfort to the family. 4. If the attending physician, alternate, or Medical Director cannot be contacted, then the client will be transferred to the nearest emergency room."
"Purpose: To take appropriate steps when there is a change in client's condition.
Policy: 4. If the attending physician, alternate, or Medical Director cannot be contacted, then the client will be transferred to the nearest emergency room."

The facility's (undated) Emergency Transport Service documents the following: :
"Call 911 for: Changes in Level of Consciousness"

The facility's Notification of Change in Resident Status policy (not dated) reads the following:
"Policy: 1. when a significant change in a resident's condition has been observed, emergency care will be rendered immediately and the physician, family member and/or guardian will be notified.

The facility's Emergency Transport Service policy (not dated) reads the following: :
"Call 911 for: Changes in Level of Consciousness"

The facility's Charting and Documentation policy (not dated) reads the following:
"Policy Statement: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.
Policy Interpretation: 1. All observations, medications administered, services performed,

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etc., must be documented in the resident's clinical records. 3. All incidents, accidents, or changes in the resident's condition must be recorded.

On 1/2/19, at 1:20 p.m., E3 (Medical Records staff) confirmed that she did not receive any investigation for R1's (death) incident that happened on 12/22/18.

On 1/2/19, at 3:23 PM, E5 (Assistant Director of Nursing, ADON) confirmed that the nurses notes written by Z7 (Agency Nurse) and Z8 (Agency Nurse) should have documented their ongoing assessments and findings for R1 as they conducted their ongoing assessments with information on whether symptoms were improving or not improving. E5 stated the following: "When an individual has a change in condition, the nurse needs to describe the individual's change in condition when the nurse notifies the physician. If an individual is lethargic, the nurse should take the individual's vital signs and monitor the individual for 30 minutes, to see if there is another change in the individual's condition. The nurse should then perform a head to toe assessment when reassessing the individual and provide the physician with an update regarding the individual's healthcare condition. The nurses should document their assessment findings in the nurses' notes, have ongoing communication with the physician regarding their assessment findings, and follow the physician's orders. Nurses should tell the physicians if the individual's condition has improved, stayed the same or has gotten worse."

On 1/2/19 at 3:48 PM, E5 stated, "If E5 provided care to an individual with persistent lethargy for three to five hours, E5 would call the physician and tell the physician that E5 was sending the

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individual to a local hospital's emergency room for an evaluation."

On 1/2/19, at 4:23 p.m., Z2 (Nurse Practitioner) stated that she was the primary care physician for R1 since he was admitted to the facility. According to Z2, R1 had a diagnosis of adrenal insufficiency, diabetes insipidus, renal insufficiency, history of a stroke, history of seizures, and history of right leg deep vein thrombosis. Over the last year, R1 had multiple hospitalizations secondary to his healthcare conditions. Z2 added that R1 had multiple hospitalizations secondary to his healthcare conditions during the past year.

Facility did not have reproducible documentation to indicate that an investigation was conducted regarding the events that occurred prior to R1's death on 12/22/18; thus failing to determine if staff provided timely care upon discovery of change in health condition on 12/21/18, at 7:30 p.m.

Nursing notes from 7:30 p.m. (12/21/18) to 1:00 a.m. (12/22/18) reveal that Nursing staff (Z7 and Z8) did not did not conduct consistent assessment and monitoring when they failed to document consistent and comprehensive notes on R1's health condition from 7:30 p.m. to 1:00 a.m. Nursing staff did not include in their documentation whether R1 was deteriorating or improving in his health condition of lethargy (which started at 7:30 p.m.) Nursing notes from 7:30 p.m. (12/21/18) did not send R1 to the Emergency Room (ER) as R1's symptoms were getting worse. Z7 and Z8 (Agency Nurses) discovered R1 as being lethargic at 7:30 p.m.; R1 continued with no change in symptoms of lethargy at 10 p.m. and 10:30 p.m. with added

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symptoms of vomiting twice, and at 11:00 p.m. with added symptoms of drainage coming out of his nose. Nursing staff did not call the ER as required by facility policy on Change in Client's Condition, which states that if the Physician cannot be reached, individual should be sent to the ER. On 1/2/19, at 3:48 p.m., E5, Assistant Director of Nursing (ADON) and on 1/8/19, at 11:05 a.m., Z1 (Primary Physician) confirmed that nursing staff (Z7 and Z8) should have sent R1 to the ER based on stated symptoms of R1 in nursing notes. Nursing notes (from 7:30 p.m., 12/21/18 to 1:00 a.m. 12/22/18) did not have documentation on Guardian notification.

On 1/3/19, at 11:02 a.m. Z8 (Agency Nurse) and on 1/3/19, at 1:39 a.m., Z7 (Agency Nurse) confirmed that they did not call the Guardian as required by Change in Condition policy when R1 was having symptoms of lethargy, and vomiting later.

Record Review and interview reveal that Z8 and Z7 did not send R1 to ER (emergency room) after R1's change in health condition and when the on-call doctor did not call back on 12/21/18 and 12/22/18 as required by Facility Change in Condition policy.

1) a) On 1/3/19, at 9:39 a.m., Z7 (Agency Nurse) stated that Z8 (Agency Nurse) told her that R1 had been lethargic since 7:30 p.m on 12/21/18. Z7 stated that at 12:00 a.m. on 12/22/18, she thought about calling 911 because R1 was still lethargic and not responding as he usually does. Z7 stated she decided not to call and wait for Z3's (physician) call. Z7 stated staff (E18) told her R1 was unresponsive between 12:50 a.m. and 1:00 a.m. Z7 went to R1's room right away and R1 did not have a pulse and was not breathing. On

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1/3/19 at 9:45 AM, Z7 stated that "she should have called 911 and sent R1 to a local hospitals' emergency room, when Z7 came to the facility around 10:30 PM."

1) b) Facility policy (undated) on Charting and Documentation reads, "1. All observations... services performed must be documented in the resident's clinical records... All incidents... changes in the resident's condition must be recorded..."

R1's nurses notes reads, "12/21/18-7:30 p.m. - found R1 lethargic, no eye movement, no verbal response, no reaction to pain..." Nurses Notes on 12/21/18, at 8 p.m., 9 p.m., and 10 p.m. do not state if R1's health status of lethargy improved or worsened. The notes do not state whether R1 continued the symptoms of no eye movement, no verbal response, and no reaction to pain. Nurses Notes stated that on 12/21/18 at 10:30 p.m., R1 was "very lethargic". Nurses Notes at 11:00 p.m. did not contain any information on his lethargy status and whether his symptoms of "no eye movement, no verbal response, and no reaction to pain" got resolved. 12:00 a.m. Nurses Notes state"appears to be lethargic".

2) (a) General Incident Report Sheet (dated 12/22/18) reads, "date of incident: 12/22/18 time of incident: 1:00 a.m... R1 passed away at 1:05 a.m. DPH, family, OSG [Office of State Guardian] notified... Was First Aid Administered? No...
Fill-in vitals and indicate injury: [No vitals documented] patient passed away...
Care Rendered: Patient was placed on [Oxygen], fowler position to right side, no struggles noted...
Was Family / Guardian notified? Yes... Left message: No, Time of Notification: 1:15 a.m...

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Was Administrator notified? Yes Time of Notification: 2:00 a.m...
Should Investigation report be completed? [left blank]"

Nursing Notification Form (dated 12/21/18) [included in the Incident Report for R1's packet] reads, "R1, Date of Notification: 12/21/18, Time of Notification: 7:30 p.m., Description of issue you would like the nurse to address: R1 is too weak. He is not responding. His eyes are staring and he is going to one side. Informed Nurse. He has large loose bowel movements. He is still too weak and not responding.
Name of Reporting staff: E16 (Habilitation Aide)."

Nurses Notes (written by Z8, Agency Nurse) from R1's file reads the following:
"12/21/18 7:30 p.m. - found resident lethargic, no eye movement, no verbal response, no reaction to pain...
8 p.m... Blood pressure (BP) 100/70, Temperature (T) 36.7, Pulse (P) 72...
9 p.m... BP 100/60, T 36.4, P 74...
10 p.m.... BP 110/70, T 36.4, P 76... vomiting... endorsed to next NOD (Nurse on Duty)"

R1's Nurses Notes (written by Z7, Agency Nurse) reads the following:
"12/21/18, 10:30 p.m. - patient was placed in high fowlers position [60-90 degrees sitting] and oxygen was administered. Patient was breathing, pulse oxygen read 95%. Staff was monitoring the patient. He was responsive but very lethargic... BP 110/70, T 36.4, P 76... Patient had some vomit present so staff was instructed to keep a close eye on patient...
12/21/18, 11:00 p.m... patient still in high fowlers position, some drainage noted coming out of his nose... Oxygen 96%, P 77, T 36.4, BP 100/65

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12/22/18, 12:00 a.m... Oxygen 96%, P 72, T 36.4, BP 100/65... patient responded to touch, but appears to be lethargic. Doctor on call was notified of patient status but still no orders have been given to sent patient out for an evaluation..." 12/22/18, 1:00 a.m. staff informed me that R1 is not responsive, pulse check no pulse, patient not breathing... patient has no vitals... 12/22/18, 1:30 a.m. patient was pronounced dead, doctor gave orders to proceed with official time of death as 1:00 a.m. 12/22/18. Patient's guardian was called..."

2) b) R1's Nurses Notes (for dates 12/21/18 and 12/22/18) show that Z7 and Z8 were the Agency nurses who took care of R1 from 7:30 p.m. (12/21/18) to 1:00 a.m. (12/22/18 when R1 died).

On 1/3/19 at 9:39 AM, Z7 (Licensed Practical Nurse/Agency Nurse) stated the following: "Z7 is an agency nurse that has been working at the facility for about 1 ½ years. Z7 worked at the facility on the night shift, on 12/21/18. Z7 was assigned to all of the residents on the 2nd and 3rd floors (129 residents). Z7 was the only nurse in the facility on the night shift. Z7 received verbal report from Z8 (Registered Nurse/Agency Nurse) around 10:35 PM. Z8 told Z7, that R1 had been lethargic since around 7:15 PM-7:30 PM. R1 remained lethargic. Z7 and Z8 rubbed R1's sternum [pain stimulus] and R1 jerked from the sternal rub. R1 had a towel with a small amount of white, yellowish secretions, underneath his mouth. The secretions resembled the formula from R1's GT feeding. R1 coughed and struggled like he wanted to vomit as R1 slightly opened his eyes. Z8 told Z7 that Z3 (On Call Physician/Resident Physician) would be calling the facility, in response to Z8's call at 10:10 PM. Z7 went to the 3rd floor around 10:40 PM and

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came back to the 2nd floor around 12:00 AM on 12/22/18. Z7 had to provide nursing care for the individuals on the 2nd and 3rd floors. E18 (Shift Supervisor) told Z7 that R1 remained lethargic. Z7 called Z3 again around 12:00AM on 12/22/18. Z7 called Z3 several times (doesn't recall number of times or exact times Z7 called the on call physician). Z3 never returned Z7's calls. Z7 asked the staff at the on call physician's answering service why the on call physician wasn't calling Z7 back. The staff said there was a mix up with the system and the on call physician may not have received Z7's phone messages. Z7 contemplated calling 911 and sending R1 to a local hospital's emergency room, because R1 was lethargic and wasn't responding like he normally would. Z7 didn't call 911 and send R1 to a local hospital's emergency room, because Z7 was waiting for Z3 to call Z7 back to give Z7 instructions about what to do for R1 and to get permission to send R1 out to a local hospital's emergency room. Z7 was unsure of what to do regarding sending R1 out to a local hospital's emergency room. Around 12:50 AM - 1:00 AM, on 12/22/18, when Z7 was on the 3rd floor, E18 called Z7 and told Z7 that R1 was not breathing. Z7 went to R1's room right away and R1 did not have a pulse and was not breathing. Z7 didn't have any training at the facility regarding what interventions to implement when a resident has a change in condition. Z7 guesses the standard of practice should be to call 911 for a resident that has a change in condition that doesn't get any better and when the on call physician doesn't call back. The only training Z7 had at the facility was regarding administering medications."

On 1/3/19 at 9:45 AM, Z7 stated that "she should have called 911 and sent R1 to a local hospitals' emergency room, when Z7 came to the facility

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around 10:30 PM."

On 1/3/19 at 11:02 AM, Z8 (Registered Nurse/Agency Nurse) stated that he started working at the facility in December 2018. Z8 stated the following: "Z8 is an agency nurse that has been working at the facility since December 2018. Z8 worked at the facility on the evening shift on 12/21/18. Z8 was assigned to R1 on 12/21/18. Around 7:30 PM, E16 (Habilitation Aide) told Z8 that R1 was in the shower room and wasn't responsive. Z8 went to the shower room to assess R1. Z8 rubbed R1's sternum [breastbone] to elicit a pain response. Initially, R1 wasn't responsive to pain. After 30 seconds, R1 opened his eyes and slightly moved his arms. About 15 minutes later, Z8 did a full assessment on R1, when R1 was back in bed. R1's eyes were open and after a subsequent sternal rub, R1 moved his arms. Around 7:45 PM, Z8 called the on call physician via an answering service to report R1's symptoms. Z3 (On Call Physician/Resident Physician) called Z8 right back and Z8 reported R1's symptoms. Z3 told Z8 to hold R1's next doses of medications and gastrostomy tube (GT) feedings until Z3 spoke to Z1 (Medical Physician). When Z3 called Z8 back (around 5 minutes later), Z3 told Z8 that Z3 had spoken to Z1 and gave Z8 an order to continue R1's medications and GT feedings, monitor R1's vital signs [blood pressure, pulse, respirations, temperature], and monitor R1 for changes in his healthcare condition. Before 8:00 PM, when Z8 gave R1 his scheduled medications and GT feedings, R1's eyes were still open and R1 responded to pinching of his arms [pain stimulus]. R1's healthcare condition remained the same. Around 10:00 PM, R1 vomited twice, with large amounts of stomach contents both times. The secretions noted when R1 vomited resembled the

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formula from R1's GT feeding. Z8 gave Z7 (Licensed Practical Nurse/Agency Nurse) a detailed verbal report of R1's healthcare condition at R1's bedside. R1 was stable according to R1's vital signs at that time. About 10:10 PM, Z8 called Z3 (On Call Physician/Resident Physician) again."

On 1/3/19, at 11:46 a.m., E1 (Administrator) stated, "Z7 (Licensed Practical Nurse/Agency Nurse) called E1 after 1:00 AM, on 12/22/18, (does not recall exact time) and reported R1's death. E1 asked Z7 what happened to R1. Z7 told E1 that when R1 was checked at 1:00 AM, R1 was unresponsive and R1 had died." When asked if E1 and Z7 have a conversation regarding the status of R1's healthcare condition, before R1 died, E1 replied, "No". E1 confirmed that R1's death incident on 12/22/18 was not investigated. E1 stated that he reviewed the nurses notes of Z7 (Agency Nurse) and Z8 (Agency Nurse) and added, " I did not see anything done incorrectly so I didn't see the need to conduct a formal investigation."

On 1/3/19, at 12:29 p.m., E5, Assistant Director of Nursing (ADON) stated that facility nurses train the agency nurses; however, the nurses do not have a written guideline to train the agency nurses. E5 added that the nurses do not document the training they provided to the nurses. E5 stated "The staff nurses provide training for agency nurses. E5 follows up with questions or concerns or anything E5 thinks the agency nurses need to know. There are no written guidelines that the nurses follow when training the agency nurses. The agency nurses usually work on the off shifts [evening and night shifts] and on the weekends. The agency nurses are provided with the on call physician's number

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in case they have to call the on call physician to report the individuals' medical issues. The agency nurses have no formal training regarding what interventions to implement when a client has a change in condition."

On 1/3/18 at 4:13 PM, E14 (Habilitation Aide) stated, "E14 worked on the night shift on 12/22/18. On 12/22/18, around 12:30 AM, when E14 checked R1, R1 was breathing and sleeping. At 1:00 AM, R1 was not breathing."

On 1/4/19 at 8:28 AM, E18 (Shift Supervisor) stated the following: "E18 worked on the night shift on 12/22/18. Z7 (Licensed Practical Nurse/Agency Nurse) was the night shift nurse. On 12/21/18 around 11:40 PM - 11:45 PM and on 12/22/18 at 12:30 AM, R1 was in bed and was breathing. Around 1:00 AM, when E18 and (E14 Habilitation Aide) went into R1's room, R1 was not breathing. E18 called Z7 (Licensed Practical Nurse/Agency Nurse), to come to R1's room. Z7 came to R1's room and checked R1. Z7 told E18 that R1 had passed away."

On 1/4/19 at 2:50 PM, Z8 (Registered Nurse/Agency Nurse) stated, "Since R1 remained conscious and responsive to pain, Z8 did not think of calling 911 and sending R1 to a local hospital's emergency room for an evaluation." Nurse's notes written by Z8 (Registered Nurse/Agency Nurse) dated 12/21/18 from 7:15 PM - 7:30 PM, reads the following: "R1 was found lethargic [state of deep unresponsiveness], with no eye movement, no verbal response, and no reaction to pain, during a shower. R1 woke up after a few seconds. Z8 then assessed R1's healthcare condition, when R1 was in bed. R1 had eye movement in response to pain stimulation but did not have a verbal response.

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Z8 reported his assessment findings for R1 to Z3 (On Call Physician/Resident Physician). Z3 told Z8 to hold R1's medications. Z3 called Z8 back and told Z8 to continue R1's medications and to monitor R1's vital signs." Z8's nurse's notes do not contain documentation regarding the times that Z8 spoke with Z3 regarding R1's healthcare condition.

Z8's (Registered Nurse/Agency Nurse) nurse's notes from 8:00 PM - 10:00 PM, indicate that R1 vomited and Z3 (On Call Physician/Resident Physician) was updated on R1's healthcare condition, but do not contain documentation describing the details of R1's healthcare condition from 8:00 PM - 10:00 PM. Nurse's notes written by Z7 (Licensed Practical Nurse/Agency Nurse), reads the following: "12/21/18, 10:30 PM - 11:00 PM - R1 had vomit present, was responsive, but very lethargic and some drainage was noted coming out of R1's nose.
12/22/18 at 12:00 AM, R1 was responsive to touch but appeared to be lethargic.
12/22/18 at 1:00 AM, the staff at the facility told Z7 that R1 was not responsive. R1 did not have a pulse and was not breathing."

Nurse notes on 12/21/18 and on 12/22/18 do not contain documentation describing the details of R1's healthcare condition from 12/21/18 at 10:30 PM - 12/22/18 at 1:00 AM.

On 1/4/19 at 8:28 AM, E18 (Shift Supervisor) stated the following: "E18 worked on the night shift on 12/22/18. Z7 (Licensed Practical Nurse/Agency Nurse) was the night shift nurse. On 12/21/18 around 11:40 PM - 11:45 PM and on 12/22/18 at 12:30 AM, R1 was in bed and was breathing. Around 1:00 AM, when E18 and (E14 Habilitation Aide) went into R1's room, R1 was

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not breathing. E18 called Z7 (Licensed Practical Nurse/Agency Nurse), to come to R1's room. Z7 came to R1's room and checked R1. Z7 told E18 that R1 had passed away."

R1's face sheet indicates Z1 (Medical Physician) as R1's primary physician.

On 1/4/19 at 3:27 PM, Z1 (Medical Physician) stated the following: "Z1 heard of R1's death when Z1 returned to work from vacation (12/21/18-12/30/18) . During the off hours and on the weekends, the physicians share on call physician services with other family medicine physicians. Z3 (On Call Physician) is a resident [student] physician. It sounds like Z3 spoke to another physician on call, regarding R1's healthcare condition, on 12/21/18. R1 should have been sent to the emergency room for an evaluation for the symptoms identified by the nurses. The protocol is if the nurses think an individual should go to the emergency room, the nurses should send the individual to the emergency room. It is within the nurse's judgment to send individuals to the emergency room, without the physician calling back and giving permission. R1 should have had a physician's order to go to the emergency room."

Per file review the facility did not have any training records for Z8 and Z7 (Agency Nurses) regarding nursing care. The nursing education records that E5 (ADON) submitted on 1/7/19 at 10:22 AM, for Z7 (Agency Nurse / Licensed Practical Nurse), from April - November 2018, did not contain training regarding any nursing care.

On 1/7/19 at 10:22 AM, E5 (ADON) stated , "I do not have any nursing education records for Z8 (Registered Nurse/Agency Nurse). The nurses

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don't document the training they provide for the agency nurses."

On 1/7/19 at 12:50 PM, E5 (ADON) stated, "R1 should have been transferred to a local hospital's emergency room for the symptoms that were documented in the nurses' notes on 12/21/18 and 12/22/18 from 7:15 PM to 12:00 AM

Facility correspondence to Department of Public Health (DPH) (dated 12/22/18) reads, "Resident's name: R1... What happened: patient is deceased as of 1:15 a.m."

Nursing Notification Form (dated 12/21/18) reads, "R1, Room 223, Date of Notification: 12/21/18, Time of Notification: 7:30 p.m., Description of issue you would like the nurse to address: R1 is too weak. He is not responding. His eyes are staring and he is going to one side. Informed Nurse. He has large loose bowel movements. He is still too weak and not responding. Name of Reporting staff: E16 (Habilitation Aide)."

Nurses Notes (written by E9, Agency Nurse) reads the following:
"12/21/18 7:30 p.m. - found resident lethargic, no eye movement, no verbal response, no reaction to pain...
8 p.m... Blood pressure (BP) 100/70, Temperature (T) 36.7, Pulse (P) 72...
9 p.m... BP 100/60, T 36.4, P 74...
10 p.m.... BP 110/70, T 36.4, P 76... vomiting... endorsed to next NOD (Nurse on Duty)"

Facility Incident Report (dated 12/22/18) did not have documentation on an investigation on R1's death and failed to review the following:
Should the Nursing staff (Z7 and Z8) have sent R1 to the ER as his condition worsened with

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vomiting and drainage coming out of his nose? Or, should Nursing staff (Z8) have called 911 at the beginning of R1's symptoms of lethargy at 7:30 p.m.?
What was R1's health condition for the past 2 days prior to R1's symptoms of lethargy at 7:30 p.m., on 12/21/18?
Why didn't the on-call Physician return Z7 (Agency Nurse) and Z8 (Agency Nurse)'s phone calls during an emergency?
Why didn't Nursing staff (Z7 and Z8) provide comprehensive and consistent documentation on R1's health status?
Why didn't Nursing staff (Z7 and Z8) document when they called the on-call Physician several times?
Why didn't Nursing staff (Z7 and Z8) contact Guardian regarding change in condition of R1 starting at 7:30 p.m. (12/21/18)?

On 1/7/19 at 1:12 PM, E16 (Habilitation Aide) stated the following: "She worked on the evening shift on 12/21/18 and was assigned to R1. E16 described the following: E16 prepared to give R1 a shower in the shower room around 7:30 PM, R1 was not his usual self. R1 did not respond when E16 called his name. R1 had a blank stare with no eye movement, as he leaned to one side. R1 usually shook his head and smiled when his name was called. E16 called Z8 (Registered Nurse/Agency Nurse) around 7:30 PM, to give a report regarding R1's healthcare condition. E16 told Z8 that R1 was not his usual self. Z8 told E16 to put R1 back in the bed. E16 put R1 back in the bed."

Nursing Notification Form dated 12/21/18, written by E16 (Habilitation Aide) at 7:30 PM, reads, "R1 was weak, had a blank stare, was not responding to E16, and leaned to one side. E16

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informed Z8 (Registered Nurse/Agency Nurse) of R1's condition."

On 1/7/19 at 2:40 PM, E17 (Habilitation Aide) stated the following: "E17 worked on the evening shift on 12/21/18. E16 (Habilitation Aide) and E17 took R1 to the shower room to give R1 a shower. When E16 and E17 called R1's name, R1 did not respond. R1 was not active. E16 and E17 told Z8 (Registered Nurse/Agency Nurse) that R1's condition had changed. When E16 and E17 put R1 back in bed, R1 continued to not respond to them."

On 1/7/19, at 2:55 p.m., E5 confirmed that the Agency Nurses (Z8 and Z7) who took care of R1 should have notified the guardian about R1's change in health condition on 12/21/18. E5 also stated that based on the symptoms documented in the nurses notes, the Nurse(s) should have sent R1 to the ER.

The nursing education records that E5 (ADON) submitted on 1/7/19 at 10:22 AM, for Z7 (Licensed Practical Nurse/Agency Nurse), from April - November 2018, did not contain training regarding any nursing care.

Z3 (On-call Physician / resident) did not call back in a timely manner to provide appropriate recommendation to determine whether R1 should have been sent out to the ER earlier upon discovery of change in condition (of being lethargic, no eye movement, and no reaction to pain) at 7:30 p.m. on 12/21/18.

On 1/8/19, at 11:05 a.m., Z1 (Primary Physician) confirmed that nursing staff (Z7 and Z8) should have sent R1 to the ER based on stated symptoms of R1's in the nursing notes. Z1 added

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that if the nurses think an individual should go to the emergency room, the nurses should send the individual to the emergency room. Z1 stated that it is within the nurse's judgement to send individuals to the emergency room, even if the Physician does not call back or give permission. Z1 stated the following: "An individual can have a medical condition that requires emergency medical treatment and the individual's vital signs remain within normal limits. The on call physicians may not receive messages right away. If a resident needs immediate care the nurse should initiate a transfer to the emergency room and not wait for a return call from the on call physician. If an individual is persistently lethargic, the expectation is for the individual to be sent to the emergency room."

On 1/8/19, at 1:00 p.m., E5, Assistant Director of Nursing (ADON) confirmed that the facility does not have a policy for conducting investigations on death incidents. E5 confirmed that an investigation was not conducted for R1's death that happened on 12/22/18.

On 1/8/19, at 2:00 p.m., E5 (ADON) confirmed that Z3 (on-call Physician) should have returned Z7's calls and do not know why Z7's calls were not returned. E5 stated that the facility does not have a policy for physician services.

On 1/9/19, at 2:00 p.m. E5 stated that the facility does not have a policy regarding education and training for facility nurses.

Facility Incident Report (dated 12/22/18) indicates R1 passed away at 1:05 AM. Incident Report does not have investigation on the following: R1's health condition for the 2 days prior to change in condition on 12/21/18, Physician call-back issues

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Z9999	Continued From page 19 on 12/21/18 and 12/22/18, and nursing staff documentation on R1's health status, guardian notification and notification of Physician on 12/21/18 and 12/22/18. R1's certificate of death indicates that R1's died at the facility on 12/22/18 at 1:05 AM, with cause of death as probable status epilepticus. (A)	Z9999		