STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145906	A. BUILDING _____ B. WING _____	C 10/12/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY NURSING & REHAB CTR	800 DIVISION STREET DIXON, IL 61021

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F 312	Continued From page 9 bathing. Physician order sheet dated 9/1/05 lists R1 diagnosis as left cerebral vascular accident, dementia, agitation and dysphagia. On 10/3/05 at 9:45 AM, E1 (Director of Nurses - DON) states, "All residents receive a shower twice a week and their hair is washed at the same time unless the resident has their hair done at the beauty shop. We schedule residents twice a week, that way if they refuse, they will at least get a bath once a week". On 10/3/05 at 12:40 PM, E5 (Certified Nursing Assistant - CNA) states, "Baths and showers are documented on the bath record and signed off by the nurse each day. Hair shampoos are done with the bath unless the resident gets their hair done by the beauty shop". Bath records documented R1 as receiving only a bath on 7/13/05, 8/9/05, 8/17/05, and 8/31/05. Records document that a bath and hair wash were completed on 9/4/05, 9/14/05 and 9/18/05. On 10/3/05 at 3:15 PM, E1 (DON) states, "There are no bath records for R1 for the month of June ". On 10/3/05 at 10:20 AM, E4 (Licensed Practical Nurse-LPN) states, "R1's scalp was very dry with white crusting. It looked like cradle cap, like what kids get".	F 312		
F9999	FINAL OBSERVATIONS 300.1210 (a) 300.1210. (b) (3) 300.1220 (b) (2)	F9999		

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F9999	Continued From page 10 300.120((b) (3) 300.3240 (a) The facility must 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 assessment and plan of care. 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. 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. The DON shall supervise and oversee the nursing services of the facility, including: Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be	F9999		

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reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

Based on interview and record review the facility failed to assess, monitor, obtain vital signs and identify a need for treatment after being informed by a relative that R1's forehead veins were distended, her breathing was labored and she was in pain. R1 was hospitalized with congestive heart failure and possible myocardial infarction. This failure resulted in R1 not receiving immediate treatment.
This applies to 1 of 3 residents in the sample (R1).

The findings include:

R1's physician's order sheet for September 2005 documents R1's diagnoses as Left Cerebral Vascular Accident, Dementia, Agitation and Dysphagia.

On 9/25/05 at 2:25 PM, the nurse's notes for R1 document that Z1 called for a nurse to check R1. Z1 was concerned that R1's forehead veins were distended, her breathing was labored and that she was in pain.

On 10/3/05, E1 (Director of Nurses -DON) provided a written statement from E9 (Licensed Practical Nurse -LPN) regarding R1 on 9/25/05. " At approximately 2:25 PM, Z1 was in hallway yelling for the nurse. I went in the room with 2

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certified nursing assistants. Z1 was upset about R1's bulging forehead veins and because R1 was muttering et flailing her right arm. Z1 said that last time R1 had a stroke the veins looked the same. Z1 said that R1 looked like she was in a lot of pain. I told her that I didn't think it was pain so much as that we had just turned her et (and) changed her pad. She gets agitated when cares are done to her. Z1 asked if the doctor could come today and we told her that doctor was (out of town)but would be here tomorrow. Z1's blood pressure was not high like it was before and she had no other signs and symptoms of a stroke that I could see. Z1 wrote a note to the doctor and I taped it to front of chart. I told Z1 that R1 had a shower today and sat at nurses circle for awhile. R1 also sat quietly through a Bible reading. R1 was only agitated during the shower et (and) during cares. She slept quietly the rest of the time."

On 10/12/05 at 2:10 PM, E9 (LPN) confirmed that she wrote the statement provided by E1. E9 stated, "I did not take R1's blood pressure at that time (when Z1 called her to the room). I used the morning recording to determine her blood pressure was not high. I didn't really see anything that warranted immediate action. I started a transfer record, but the paramedics left with R1 before I could get it done."

On 10/3/05 at 10:50 AM E1 (DON) states, "The nurse assessed R1 and thought she didn't look any different than she had. The nurse did not refuse to call the doctor, Z1 asked if the doctor would be here today, and the nurse told her the doctor would be here the next day. Z1 appeared satisfied and she wrote a note for the doctor and

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we taped it on the chart. Z1 didn't say anything more, she left. The next thing we knew the paramedics were at the back door to take R1 to the hospital."

Nurse's notes prior to R1 leaving the facility did not contain a resident assessment.

On 9/25/05 at 3:17 PM, the ambulance transfer record for R1 documents, "Skin color as cyanotic, skin temp cool, lung sounds diminished, blood pressure 154/90, Pulse 100 beats per minute with an irregular rhythm, respirations 60 breaths per minute, patient was slightly gasping for air. Oxygen saturation was at 84% on room air. Resident made several sounds that indicated she was in pain. Nursing home staff informed us (transfer team) the patient has been in this current state for some time, ... and they did not feel she needed to be transported".
The narrative note on the ambulance transfer record documents, "911 dispatch center was contacted by the relative of the patient and not by the nursing staff or doctors at the nursing home. Upon arrival at the nursing home, the patient's relative and another patient were the only two people in the room other than the patient. The relative stated that the patient's level of consciousness had been decreasing since yesterday, the patient's forehead veins were distended and the patient was complaining of back pain. The relative stated she called 911 because the nursing staff would not do anything for the patient. Patient was very cyanotic when we entered the room and the patient's upper body was in a fetal position. Patient made several sounds that indicated she was in pain."

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F9999	Continued From page 14 On 10/6/05 at 2:10 PM, Z4 (ER physician) stated he treated R1 in the hospital emergency room on 9/25/05 for "congestive heart failure and myocardial infarction". R1's emergency physician record dated 9/25/05 documents R1's assessment as "respiratory distress, wheezing, rales/rhonchi and diminished breath sounds in the left lung. Cough with sputum". R1's hospital admission history and physical report dated 9/26/05 documents an admission diagnosis of congestive heart failure with possible myocardial infarction. On 10/4/05 at 8:55 AM, Z3 (physician) stated, "R 1 was admitted to the hospital with congestive heart failure and pulmonary edema. The heart enzyme troponin was significantly elevated. I can't say it was a complete myocardial infarction, but probably had some heart damage. R1 was treated for a myocardial infarction, but the blood thinner was not given. R1 definitely had congestive heart failure. R1 appears to be in pain."	F9999		