STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 10/13/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEPORT REHAB & HEALTH CARE CENTER	**900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 14 STATE VIOLATIONS FOR: Complaint #0514007/IL19038 Complaint #0514433/IL19492 300.1010h) 300.1210a) 300.1210b)3) 300.1220b) 300.1220b)6) 300.1220b)8) 300.3240a) Facility staff 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. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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. General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: Objective observations	F9999		

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F9999	Continued From page 15 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: b)6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. b)8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility training programs. This person may conduct these programs personally or see that they are carried out. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met based on interview and record review which revealed that the facility staff failed, on 9/18/05, to: [1] assess and monitor the respiratory status of R1, who was congested, immediately upon noticing a gurgling sound in the throat when first observed at 6:00AM; [2] provide ongoing, higher level care when Certified Nursing Assistants reported a change in R1's condition;	F9999		

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F9999	Continued From page 16 [3] notify the physician of changes in R1's status when it was brought to the attention of E4 by E5 and again by E6 later in the morning. [4] provide ongoing assessment of R1's status until 11:00 AM, when R1 was found unresponsive with a low blood pressure and low Oxygen Saturation levels (O2 Sats). These failures contributed to a delay in R1 receiving treatment for 5 1/2 hours. R1 was admitted to the hospital on 9/18/05 with the diagnoses of Right Side Pneumonia, Hypoxemia with Respiratory Failure, Dehydration with Hypotension/Acidosis and Urinary Tract Infection. The findings include: R1's nurses' notes from 9/8/05 through 9/18/05 were reviewed. On 9/17/05 at 4:00PM, nurses' notes showed the following documentation: "(R1) coughing. Has large amount of clear phlegm in back of throat. (R1) unable to cough phlegm out. Suctioned phlegm out." On 9/17/05 at 7:00PM nurses notes showed the following documentation: "(R1) coughed up large amount of clear phlegm". R1's nurses' notes on 9/18/05 at 11:30AM showed the following: "Wet voice early in shift. Continue to monitor." On 9/27/05 at 2:05 PM, E4 (Licensed Practical Nurse) was interviewed. E4 stated her first contact with R1 on 9/18/05 was at 6:00AM. E4 described R1 as having a "wet voice" which E4 described as resembling "gurgling." E4 stated R 1 was not receiving oxygen at that time. E4 stated, "I did not think I should suction (R1) at that time." A review of R1's nurse notes for 9/18/ 905 showed no documentation of vital signs,	F9999		

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F9999	Continued From page 17	F9999		

pulse oximetry, breath sounds or assessing the gurgling in R1's throat when E4 first saw R1.

On 10/11/05 at 10:55AM, E10 (Registered Nurse) was interviewed. E10 stated, "I first saw (R1) at about 7:30AM on 9/18/05. (R1) had a moist voice. It sounded like she needed to cough; like she had fluid in her throat, like phlegm, like you want to cough it up. I told (E4), who was (R1's) primary nurse; it was time to get the stethoscope. I did not listen to (R1's) chest and I did not do vitals. I knew (E4) was aware of (R1's) moist voice. I did not see (R1) again until I was called to (R1's) room when she was found unresponsive . We did not have a functioning pulse oximetry (pulse ox) monitor on the floor (Medicare floor) so one of the CNAs (Certified Nursing Assistants) had to go to first floor to get one."

On 9/27/05 at 3:00PM, E5 (Certified Nursing Assistant - CNA) stated, "(R1) wasn't eating (breakfast on 9/18/05) and was gurgling like her throat was full of phlegm. R1 just let the food and fluids roll out of her mouth. I told (E4) around 8: 30 or 8:45AM that (R1) was not looking good and had a gurgle in her throat. It was like she was full of phlegm, was not coughing and did not clear her throat. The nurse (E4) told me to monitor her . I placed (R1) in the recliner and put her in front of the nurses station. She tried to get out of the recliner; she was very restless so we moved her to the wheel chair with a soft padded restraint. About 11:00AM, I noticed (R1) was leaning to the right side and her eyes were rolling."

On 9/28/05 at 7:55AM, E6 (CNA) was interviewed. E6 stated, "Before I went to lunch (

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F9999	Continued From page 18	F9999		

on 9/18/05) at 10:00 or 10:30 AM, I noticed (R1) in front of the nurses station, R1 was slumped to the right side and had a purplish blue color. I thought maybe we should start her oxygen because she had been getting oxygen off and on in the past. (E4) told me she was more concerned about R1's gurgling in her throat at this time. I questioned E4 about checking the O2 Sats (oxygen saturation level) and when I saw (R 1's) color, I tried to find the O2 Sat thing (monitor) but I couldn't find it. I thought we might have to start oxygen. Around 11:00AM, when I came back from lunch, I went to push (R1) into lunch and I noticed she was leaning more and her color was worse. I hollered for the nurse to come right away. E10 (Registered Nurse) responded because E4 was passing medications down the hall. E10 told us to put E4 in bed right away."

On 9/27/05 at 2:05 PM, E4 stated, "When the CNAs came to get me at 11:30AM, (R1) was leaning to the right, not tracking with her eyes and not responding. We put her to bed and did vital signs. She was not responding and not doing well."

On 9/28/05 at 8:50AM, E2 (Director of Nurses) stated there was no documentation that R1 had been assessed and monitored or that any vital signs or pulse oximetry readings (O2 Sats) had been taken prior to 11:30AM.

The Patient Transfer Form for 9/18/05 showed R 1's vital signs on transfer to the hospital were: Blood Pressure - 78/52, Pulse - 112, irregular and Respirations - 34 with O2 Sats at 75% on 4 L (liters) of oxygen. Nurses' notes show R1 was transferred to the hospital at 12:10 PM.

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F9999	Continued From page 19 On 9/26/05 at 3:05PM, Z1 stated, "(R1) was very sick on admission to the Emergency Room (ER). We didn't think she would leave the ER alive." Z3 was interviewed on 9/28/05 at 8:07PM. Z3's description of R1 in the Emergency Room was " cachetic, moderate dyspnea, lethargic and periods of apnea." The nurse should have begun her assessment at 6:00AM when she first noticed (R1) had a gurgling sound. She should have listened to the lungs for wheezes and/or rattles, and done a pulse ox (O2 Sats). She should have contacted the primary physician. The staff would have had 5 hours to assess, notify the attending (physician) and transfer (R1). This would have resulted in less suffering for (R1). (A)	F9999		