STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 08/04/2006

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AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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
F 517	Continued From page 48 heating/cooling units are running at full capacity. 4. Temperatures will be taken every 2 hours until the heat emergency has been resolved. 5. Effective 8/2/06 contracts have been obtained from local hospitals and a school to provide shelter in the event that the facility has to be evacuated. Contracts with several transportation venders has been established. These contract also include wheel chair vans and ambulances.	F 517		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.1010a) 300.1210a) 300.1210b)2) 300.1210b)3) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as	F9999		

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F9999	Continued From page 49 evidenced by written, signed and dated minutes of such a 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 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. b)2) All treatments and procedures shall be administered as ordered by the physician. b)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. Section 300.3220 Medical and Personal Care Program	F9999		

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F9999	Continued From page 50 f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following: Based on observation, record review, and interview the facility neglected to : a.) Accurately assess a resident for signs and symptoms of Urinary Tract Infection, and respiratory status, which resulted in a resident requiring emergency hospitalization for the treatment of Urosepsis and another resident requiring emergency hospitalization for Urinary Tract Infection, and Constipation. b.) Ensure that staff were knowledgeable and guidelines for care/ maintenance and emergency procedures for a Central Access Port for a resident receiving renal dialysis. c.) Ensure that agency staff nurses were knowledgeable on identifying residents who wish to have CPR full; and may require emergency Cardio Pulmonary Resuscitation. d.) Ensure that residents with indwelling urinary catheters were monitored and maintained to avoid complications of infection. e.) Ensure that residents had fresh drinking water available, and that residents were monitored for fluid consumption.	F9999		

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F9999	Continued From page 51 f.) Ensure that residents at heat related risk were identified and that the facility had an emergency evacuation plan. Findings include: 1. R1's July, 2006 Physician's Order Sheet documents that R1's diagnoses include Gastrointestinal Bleed and Clostridium Difficile. (C. Diff.) R1's assessment of 5/15/06 assessed R1 as having a short term memory problem and moderately impaired cognitive skills for daily decision making. R1 was assessed with moderately impaired vision, requiring limited assistance of one person for eating/drinking, incontinent of bowel, and as having an indwelling urinary catheter. Nursing Notes dated 7/21/06 at 1:00 AM document that R1 was found unresponsive, and diaphoretic. The emergency response 911 was called and R1 was transported to the hospital emergency room. The nursing notes document that R1 had a "change in condition," no other symptoms/ assessment information is recorded. The hospital Emergency Department Report dated 7/21/06 documents that R1 had a temperature of 102.5, a pulse of 112, respirations of 69 per minute, and a blood pressure of 118/69. The same report states, "the patient had worrisome symptoms of sepsis and significant turbid urine in her old Foley catheter that was indwelling, so that was replaced." The diagnoses listed include Urosepsis, and Hypokalemia.	F9999		

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F9999	Continued From page 52 The hospital record entitled Clinical History and Physical dated 7/21/06 documents that "On arrival to the emergency department, the patient was found to be very agitated, non-agonal with respirations in the mid 30's and septic secondary to urosepsis." This record states that R1's indwelling urinary catheter was not well maintained. A Hospital report dated 6/21/06 entitled Consultant's Report documents that R1 was hospitalized with diagnoses to include: Urinary Tract Infection, and Dehydration. Hospital report entitled Discharge Summary dated 6/21/06 shows that R1's diagnoses also included severe fecal impaction. On 7/27/06 at 9:00 AM, Z3 (M.D.) was interviewed. Z3 said that R1 came into the emergency room in " terrible shape." Z3 said "I was upset with the information I was given, I was told by the nursing home nurse that Z3 was found unresponsive, had agonal breathing, and they thought she had a stroke. Agonal breathing would be around 5-10 respirations a minute. When R1 arrived in the emergency room her respirations were 45 per minute, she was clearly septic, the nursing assessment skills are questionable. All we did was hydrate her and give her antibiotics, she is fine now, she is lucky. R1 is very lucky, there is no way they just found her that way at 1:00 in the morning. My nurses reported terrible hygiene and catheter maintenance." On 8/1/06 at 5:00 PM. E7(Director of Nursing) said " It was reported to me by a Certified Nursing Assistant that they could not find the nurse on the night shift and so the Certified	F9999		

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F9999	Continued From page 53 Nursing Assistant had to call 911 for R1." R1 was observed in the hospital on 7/27/08 at 10:10 AM. R1 said " I feel much better." 2. On 7/28/06 at 9:30 AM Z5 (Agency LPN) was observed passing medications on the first floor. Z5 was asked by the surveyor if she had been oriented to the facility's emergency policies and procedures. Z5 stated that she had not received any orientation from the facility. The surveyor asked Z5 if she knew what the green dot by the resident's name meant and Z5 stated, "I do not know what the green dot means." The facility policy and procedure on Resident Code Status states that a green dot means that the resident wishes to receive Cardiopulmonary Resuscitation in the event that they are in cardiac/respiratory arrest. On 7:30 at 9:30pm, Z6 was asked by the surveyor if she had been oriented to the facility's emergency policy and procedures prior to the start of her shift and she replied "No". Z6 was asked by the surveyor if she knew what the green dots (indicates full code) meant and Z6 replied "No." Z6 was observed working on the second floor. During an interview conducted on 7/28/06 at 5:30 PM, E1(Administrator) and E2 (Acting Director of Nursing) were asked for schedules to include agency nurses. The facility was unable to provide working schedules including agency staff. On 7/28/06 E2 (Acting Director of Nursing) said, "We orient our own nurses. I assumed the night nurse oriented her before her shift started."	F9999		

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F9999	Continued From page 54 There is no evidence that the facility oriented E8 and E9 prior to the start of their shifts. The facility was unable to provide a policy and procedure showing who is responsible for the orientation of agency staff on identification of residents who require Cardiopulmonary Resuscitation . E8 worked on 7/28/06 on the day shift without knowing which residents are a full code. E9 worked on 7/30/06 on the evening shift (3-11) without knowing which residents were a full code. 3. R9's July 27, 2006 Physicians Order Sheet documented R9's diagnoses to include Renal Failure, and Urinary Retention. The same Physician's Order Sheet documented that R9 goes to dialysis on Wednesday and Friday. R9's Nursing Admission Note dated 7/28/06 at 4:30 PM documents that R9 has a central catheter. There were no Physician orders for the care and monitoring of R9's Central Catheter to include dressing changes, monitoring for infection, and emergency procedures in the event of dislodgement. R9's record had no guidelines for his immediate nursing care needs, including monitoring for potential risks/complications of a central line catheter, and emergency procedures in case of catheter dislodgement. This was confirmed with E2 (Acting DON) on 7/28/06 at 4:00pm. On 7/28/06 at 12:45 PM, E6 (LPN) Licensed Practical Nurse was interviewed. E6 was assigned to R9's care and was asked what care is being provided for R9's Central Venous Catheter? E6 said "we just monitor it." E6 was asked to specify what type of monitoring was required for R9's central line, and E6 said "we	F9999		

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F9999	Continued From page 55 listen for bruit." On 7/21/06 at 1:00 PM., E2 (DON) said that the facility should have obtained care orders for R9's Central Venous Catheter "before he came in the door." E2 confirmed that Central Access Devices do not require monitoring by listening for bruit. 4. R10 has diagnoses of Neurodegenerative Disorder, Cerebral Palsy, Insulin Dependent Diabetes, Spastic Bladder, Depression, Constipation, Hypertension and Mental Retardation per Physician's Orders for July 2006. On 7/30/06 at 7:00 PM during a facility tour with E7, R10 was observed in her room lying in her bed positioned on her right side. When the surveyor entered the room it was observed that her call light was wrapped around the lower rung of the side rail out of reach of the resident. R10 was noted to have approximately 250 to 300 cc of dark brown emesis on the front of her gown and all the way down her right leg. R10's abdomen was distended and firm. E7(Director of Nursing) informed the surveyor that her abdomen was firm. E7 immediately went to the second floor nursing station to inform the nurse. R10 had no way to call staff for assistance. R10 told the surveyor that she hd felt nauseated all day. Z6 (agency nurse) did not come down and assess R10 until 7:10 PM 10 minutes after she had been informed of R10's condition. E7 was asked by the surveyor when R10 would have been checked on by staff and E7 replied "I do not know. It could have been several hours." E7 verified that R10 can use a call light when it is	F9999		

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F9999	Continued From page 56 in reach. On 7/30/06 at 7:10 PM staff were observed cleaning R10 up and getting her ready for transport to the hospital. R10 had a large bolus of hard stool protruding from her rectum. R10 was sent to the hospital by ambulance for evaluation and treatment on 7/30/06 at 7:30 PM. R10's Bowel Record for July 2006 shows that R10 had 5 consecutive small bowel movements over a 5 day period beginning on 7/23/06 and ending on 7/27/06. There were no other documented bowel movements after 7/27/06. On 7/30/06 at 7:10 pm R10 had not had a significant bowel movement for 3 days. Medication Administration Records (MAR) for July 2006 document that R10 is to receive Benifiber 15cc mixed with water by mouth twice daily, Milk of Magnesia (MOM)30 cc by mouth every 3rd day if no BM (bowel movement). R10 had not received MOM since 7/9/06. The MAR further shows that R10 did not receive Benifiber 15cc at 5:00 PM on 7/26/06, 7/27/06 and 7/28/06. 5. R6's July, 2006 Physician Order Sheet documents that R6's diagnoses include Chronic Renal Insufficiency, Urinary Tract Infection, and Prostate Cancer. The document entitled Indwelling Catheter Assessment dated 1/19/06 assessed R6 as having a supra public indwelling catheter. The same assessment documents that R6 has prostate cancer and only one kidney. R6's July, 2006 Physician's Order Sheet documents an order "supra pubic site care."	F9999		

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F9999	Continued From page 57 R6's Nursing notes show an entry on 4/17/06 that R6's catheter is intact. There are no other entries until 6/12/06. On 6/12/06, 6/14/06, and 7/12/06 Nursing Notes documentation shows that R6's supra pubic catheter was replaced. No assessment documentation was found to show the reason why R6's supra pubic catheter was being replaced. A Nursing Note for 7/21/06 documents that the Certified Nursing Assistant found R6 with no urinary drainage bag attached to the supra pubic catheter. R6 was observed on 7/28/06 at 4:00 PM. R6 was lying in bed. A strong smell of urine was noted. E6 Licensed Practical Nurse (LPN) was asked if R6 had an indwelling urinary catheter. E6 had difficulty locating R6's catheter, and discovered a leg bag was secured above R6's right knee. The catheter drainage bag was observed upside down,. the tubing was kinked and urine was leaking onto R6's right pant leg. R6's care plan entitled Potential for Infection related to Supra Pubic Catheter documents that R6 has history of Urinary Tract Infections on 1/3/06, 2/13/06, and 3/17/06. The approaches include keep tubing free from kinks, keep drainage bag below the level of the bladder, and maintain a closed drainage system. 6. R2's July, 2006 Physician's Order Sheet documents that R2's diagnoses include Morbid Obesity and Diabetes Mellitus. R2's assessment (MDS) of 5/1/06 assessed R1 as being continent of bowel and having an	F9999		

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F9999	Continued From page 58 indwelling urinary catheter. The same assessment assessed R2 as having a urinary tract infection in the last 30 days. R2's Nursing Notes for 7/25/06 at 4:00 PM documents that R2 complained of discomfort from her catheter. On 7/28/06 at 9:30 AM R2 was observed in her bed. R2 was positioned on her back. The catheter tubing was underneath a pillow and under R2's right leg. The urine tubing was obstructed from the weight of R2's leg. Urine was noted to begin to drain after E2 (Acting Director of Nursing), removed R2's urinary drainage tubing from underneath R2's leg. R2's urine was found to be concentrated with white mucous clumps in the tubing. E2 said "R2 will not let us change the catheter." On 7/28/06 at 3:00 PM R2 was interviewed. R2 said she does not want the nurses here to change her catheter because one time they inserted it wrong. R2's Nursing Notes dated 6/13/06 documents that R6 was transferred to the hospital because her indwelling urinary catheter was blocked. 6/16/06 entry for 3:30 PM documents that R2's catheter was changed due to being pulled out. Review of R2's Nursing Notes dated 7/28/06 documents that R2 was started on Levaquin for Eschericia Coli in the urine. Review of R2's catheter care plan dated 7/14/06 found approaches for care to include monitoring urine each shift for amount, clarity, and color, monitor for patency, and keep tubing free of kinks.	F9999		

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F9999	Continued From page 59 7. R5's July, 2006 Physician Order Sheet documents R5's diagnoses to include Diabetes Mellitus and Encephalopathy. The same Physician's Order Sheet does not contain an order for an indwelling urinary catheter. The document entitled Indwelling Catheter Assessment dated 7/19/06 shows that R5 has a # 16 French catheter with a 10 cc (cubic centimeters) bulb, indwelling urinary catheter. The remainder of the assessment form is incomplete. On 7/28/06 at 9:40 AM, R5 was observed in her bed. An indwelling urinary catheter was observed. R5's left leg was positioned on top of the urinary drainage tubing, obstructing the free flow of urine into the drainage bag. The urinary tubing was observed to have white clumps of mucous in it and the urine was dark yellow in color. E2 of Nursing was present and verified that R5 had a # 18 French catheter with a 30 cc bulb. R5's current care plan does not show that R5 has an indwelling urinary catheter. It does not describe the approaches for care and maintenance of an indwelling urinary catheter. 8. R3's July 2006 Physician's Order Sheet documents that R3's diagnoses include Alzheimer's Disease, and Urinary Tract Infection. R3's assessment dated 6/19/06 assessed R3 as incontinent of bowel and bladder, and as having an indwelling urinary catheter. The facility did not present a catheter assessment for R3.	F9999		

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F9999	Continued From page 60 R3 was observed in the back hall dining room of the second floor on 7/28/06 at 9:40 AM. R3's urinary drainage tubing was laying on the floor underneath her wheel chair. R3's urine was observed to be amber colored with sediment and white mucous clumps present in the drainage tubing. A Fax Transmittal document dated 7/17/06 shows that R3's physician was made aware that R3 had an elevated temperature on and off over the past weekend, and a request was made for a Urinalysis and a Culture and Sensitivity. A Urinalysis Report for R3, dated 7/19/06 documents many bacteria (negative= normal), white blood cells of 50-100 (0-5 comparison for normal), 5-10 red blood cells (0-5 comparison for normal), nitrate- positive (negative= normal) moderate amount of occult blood, (normal= negative) A Urine Culture and Sensitivity report dated 7/21/06 shows that R3 had greater than 100,000 colonies/ milliliter of Escherichia Coli and greater than 100,000 colonies/ milliliter of Proteus Mirabilis. E2 was interviewed on 7/28/06 at 4:30 PM regarding R3's lab results. E2 said that R3's physician is not going to treat because R3 will always have Escherichia Coli in her catheter and she has no fever. Review of R3's care plan dated 7/14/06 entitled Foley catheter documents the following approaches: assess for signs of symptoms of urinary tract infection such as fever, and	F9999		

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F9999	Continued From page 61	F9999		

concentrated urine. The care plan does not address ensuring that R3's catheter tubing is positioned to avoid contact with the floor.

9. R4 has diagnoses of Diabetes, Osteoarthritis, Hypertension, Dementia, Congestive Heart Failure, and Chronic Renal Failure per Physician's Orders for July 2006. The Physician's Orders further document that R4 is receiving Hydrochlorothiazide 25mg every day, and Lasix 80 mg twice daily (both are diuretics contributing to fluid loss).

During an interview conducted on 7/28/06 at 10:00 AM R4 was asked by the surveyor if she was getting enough to drink. R4 stated, "I do not know where my water is. I sure could have used some water last night." R4's oral and mucous membranes were observed to be dry and her lips were cracked.

R4's Comprehensive Plan of Care dated 4/19/06 shows that R4 is at risk for dehydration related to diuretic use.

10. On 7/28/06 during the entrance tour the following residents (R7, R8, R11, R13, R10, R6, R12, R14, R4, R15) did not have any, or had stale, water in their room. In the rooms where drinking cups were present they were noted to be dirty and in need of washing. Some rooms were observed to have no cups or straws. On the secured unit there was a 2 quart pitcher of ice water at the nurses station. There are 13 residents on the unit.

E3 Licensed Practical Nurse (LPN) on secured unit was interviewed on 7/28/06 at 9:30 AM. E6 said that water is not placed in resident rooms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 08/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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
F9999	Continued From page 62 because there is a resident that wanders on the unit. (A) 300.610a) 300.670j) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.670 Disaster Preparedness j) Each facility shall establish and implement policies and procedures in a written plan to provide for the health, safety, welfare and comfort of all residents when the heat index/apparent temperature (see Section 300.Table D), as established by the National Oceanic and Atmospheric Administration, inside the residents' living, dining, activities, or sleeping areas of the facility exceeds a heat index/apparent temperature of 80°F. These regulations are not met, as evidenced by the following:	F9999		

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F9999	Continued From page 63 Based on observation, interview and record review the facility failed to have a detailed written heat emergency plan in the event of a heat related emergency. Findings include: On 7/30/06 at 6:30 PM the building was uncomfortably warm throughout. There were no fans seen in hallways to promote air flow/movement. There was a fan at the nurses station on each floor. The kitchen doors were propped open to the inner dining room, allowing heat from the kitchen into the dining room and main 1st floor hallway. The average temperature on the first floor to include the heat index was above 80 degrees F. The average temperature on the second floor to include the heat index was 81 degrees F. On 7/28/06 a new circulating pump was replaced. E4 (facility maintenance) and Z7 (corporate maintenance) said that the system has not been functioning at full capacity for the past 2 weeks because of parts not being available. E4 verified that the facility did not have any equipment in the building to measure ambient room temperature and humidity. According to www. Weatherunderground.com for Rockford Illinois for July 28, 2006 the mean temperature was 82°F with a maximum temperature of 89°F. The average humidity level was 77% with a range of 63 to 94% humidity. On 7/30/06 at 8:30 PM E1(Administrator) and E7(Director of Nursing) were asked for a copy of the facility's heat emergency plan for heat	F9999		

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F9999	Continued From page 64 emergencies. At 12:00 AM when the survey team left the building no plan had been provided by administration. On 7/31/06 at 10:30 AM E1 and E7 were asked for a copy of the facility's heat emergency plan. E1 stated, "I would have to look through the policy and procedure manual because I am not sure what we have. I do not know what the previous administration had in place if anything." On 8/1/06 E1 said that they found the old administration's policy. The policy did not address heat emergencies and had a floor plan for another facility. E1 verified that the existing policy in the building would have been of no use on 7/30/06. On 8/1/06, the facility provided documentation showing that they identified 42 residents who are at risk in a heat related emergency. On 7/29/06 the facility provided the following temperatures: At 4PM the first floor dining room measured 82.1° F with 65% humidity, Room 116 was 80 °F with 65.8% humidity, The New Beginnings Activity Room was 81.2°F and 51.3% humidity, Hallway 284 was 82.1°F and 60% humidity. At 9 PM Room 116 was 80.6° F and 62.1% humidity, The 264 Hallway measured 81°F and 45% humidity, the 287 Hallway was 82.6°F and 51.8% humidity. At 10PM the 287 Hallway was 83°F and 51.8% humidity, the New Beginnings Activity Room was 83.4°F with 44% humidity and the New Beginnings Nurses station 84.2°F with 46% humidity. According to www. Weatherunderground.com for Rockford Illinois for July 29 showed a mean temperature of 81°F with a maximum of 92°F and an average humidity of 78% (range 56% to 100%).	F9999		

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F9999	Continued From page 65 Temperatures (measured with a hygrometer) provided by the facility for 7/30/06 between 10PM and 12AM show on the first floor: Room 103 was 78.9°Fahrenheit (F) and 64% humidity, Room 104 was 78.9° F with 64% humidity, Room 146 was 79.1° F and 65% humidity, Room 148 was 78.7° F and 68.5% humidity, Room 150 was 77.7° F and 65.5% humidity, Room 152 was 78.4° F and 66.5% humidity, Room 114 was 78° F and 69 % humidity, Room 116 was 77.5° F and 67.5% humidity, Room 140 was 81° F and 67.9% humidity, Room 138 was 81.5° F and 67.1% humidity, Room 172 was 80° F and 62.8% humidity. Temperatures (measured with a hygrometer) provided by the facility for 7/30/06 between 10PM and 12AM show on the second floor: Room 216 was 80.2° F and 50.5% humidity, Room 218 was 79.8° F and 50.7% humidity, Room 220 was 79.4° and 49.2% humidity, Room 260 was 81.1° F and 52.8% humidity, Room 268 was 80.9° F and 51.5% humidity, Room 287 was 81° F and 56.2% humidity, Room 288 was 81.3° F and 57.2% humidity, Room 250 was 80.7° F and 53.5% humidity, Room 252 was 81.2° F and 49.3% humidity. According to www. Weatherunderground.com for Rockford Illinois for July 30, 2006 the mean temperature was 82°F, the maximum temperature was 89°F and the average humidity was 79% with a range of 63% to 94%. On 7/31/ at 6PM according to the facility's hygrometer, the 226 Hallway was 82.5° F and 48.8% humidity, the 118 Hallway was 80.5° F and 68 .5% humidity. At 10PM the first floor	F9999		