STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. BUILDING _____ B. WING _____	C 07/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN REHAB & HLTH CARE CTR	**11 HAWTHORNE STREET SULLIVAN, IL 61951**

(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 000	INITIAL COMMENTS Complaint Investigation #0762858 (IL29627). A Partial Extended Survey was conducted.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		7/25/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the family of a significant change in condition for one (R3) of four residents sampled for resident rights. Findings include: R3's Physician's Orders dated 7/02/07 showed R3 is a twenty year old resident with diagnoses of Down's Syndrome, History of Pseudomonas Pneumonia with Respiratory Failure, History of Adult Respiratory Distress Syndrome (ARDS), and History pf Pulmonary Hypertension. Nurses notes demonstrated R3 had a serious respiratory distress event on "7/5/07 0300 (3AM) O2 (Oxygen) sat (saturation level) dropped to 28%...trach (tracheostomy tube) suctioned. Res fighting. (Ambulance) called. Paramedics here to help with res (resident). Res suctioned again. Neb (nebulizer) tx (treatment) given. Res (resident's) O2 sats (up to) 97%. Res became more calm, continuous oximetry cont. (continued)..." Z2, Paramedic, on 7/13/07 at approximately 10:30AM indicated the Rescue Squad was called out regarding R3, twice, in the early morning hours of 7/5/07. Z2 stated, "I went out on both calls. First time at about 3:45 AM to about 4:20 AM. We were on scene approximately 35 minutes. We got a call for respiratory arrest. We rushed down there code four (sirens and red lights activated). When we got there the nurse met us in the hall. She told us he (R3) was in respiratory distress. He quit breathing for awhile but she (the nurse) suctioned him and everything	F 157		

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F 157	Continued From page 2 was fine now..." Z6, father of R3 on 7/18/07 at approximately 10:50 AM indicated he was not notified of this event involving his son. Z6 stated, "The only call I received was about 7:40 (AM) after (R3) had died. I did not receive any calls at 3:00 AM, if I would have , I would have had him (R3) transported to the hospital immediately..." E6, Licensed Practical Nurse (LPN) on 7/12/07 at approximately 1:40 PM confirmed the family was not notified. E6 stated, "I didn't call the Physician or family because after we cleared the mucous plug, he (R3) was OK..."	F 157		
F 328 SS=J	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to use an available Continuous Pulse Oximetry Monitor to help oversee the respiratory status of R3, one of four residents sampled for Oxygen/Respiratory. R3 was a severely ill resident in need of continuous oxygen saturation monitoring. R3's respiratory	F 328		7/25/07

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F 328	Continued From page 3 status became critically compromised and as a result of the failure to use the monitor facility staff were unaware of a potential life and death situation. Consequently R3 suffered respiratory arrest and died. Findings include the following: This failure resulted in an Immediate Jeopardy situation. While the immediacy was removed on 7/13/07, the facility remains out of compliance at a severity level 2. The facility is monitoring the effectivenes of a new policy regarding new equipment training. The facility is also in the process of staff retraining. R3's Physician's Orders dated 7/02/07 showed R3 is a twenty year old resident with diagnoses of Down's Syndrome, History of Pseudomonas Pneumonia with Respiratory Failure, History of Adult Respiratory Distress Syndrome (ARDS), and History pf Pulmonary Hypertension. Nursing Admission Assessment dated 7/2/07 at (3:30 PM) indicated R3 was admitted to the facility alert to self and others. The assessment demonstrated R3 was admitted with a tracheostomy and showed R3 had diagnoses of "Acute Respiratory Failure and Down's Syndrome." Nurses notes dated 7/4/07 10PM - 6AM shift showed R3's tracheostomy required suctioning. Nurses notes dated 7/4/07 6AM - 2 PM shift, and 7/4/07 at 6:30 PM also indicated it was necessary to suction R3's tracheostomy tube. E1, Administrator on 7/13/07 at approximately 10:00 AM indicated the family had requested the	F 328		

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F 328	Continued From page 4 continuous monitoring of R3's oxygen saturation levels. E1 stated, "...the family requested the continuous pulse oximetry because of (R3's) compromised respiratory status..." Nurses notes demonstrated R3 had a serious respiratory distress event on "7/5/07 0300 (3AM) , O2 (Oxygen) sat (saturation level) dropped to 28%...trach (tracheostomy tube) suctioned. Res fighting. (Ambulance) called. Paramedics here to help with res (resident). Res suctioned again. Neb (nebulizer) tx (treatment) given. Res (resident's) O2 sats (up to) 97%. Res became more calm, continuous oximetry cont. (continued)..." Z2, Paramedic, on 7/13/07 at approximately 10:30AM indicated the Rescue Squad was called out regarding R3, twice, in the early morning hours of 7/5/07. Z2 stated, "I went out on both calls. First time at about 3:45 AM to about 4:20 AM. We were on scene approximately 35 minutes. We got a call for respiratory arrest. We rushed down there code four (sirens and red lights activated). When we got there the nurse met us in the hall. She told us he (R3) was in respiratory distress. He quit breathing for awhile but she (the nurse) suctioned him and everything was fine now. We went into the room. (R3) was sitting on the end of the bed Indian style. He seemed to be fine. O2 Sat was in the low 90's...We said to her (the nurse) 'are you comfortable with refusing (refusing to have R3 transported to the hospital)...you are going to have to watch him because he could get another mucous plug...' The second time we went down (we got to the facility) was about 7:02 (AM). When they (the facility) called they said they have a full arrest and CPR (cardiopulmonary	F 328		

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F 328	Continued From page 5 resuscitation) was in progress. We got into the room (R3's room) - an employee was bagging (supplying artificial respirations with a manual respiratory resucitation device) and a nurse was doing CPR. He (R3) looked like he had been down (without circulation) for awhile. The skin (R3's) was cool to the touch - his legs were stiff. There was obvious pooling (blood pooling) to his hips and back. (The) nurse stated the arrest was not witnessed...If no one would have told us "down time" (the amount of time R3 was without oxygen or circulation) we would have called Med (Medical) Control to discontinue resuscitation efforts. Because based on our assessment he (R3) had been gone too long. He was very cold. We never got a heart beat. He (R3) was asystole (without a heartbeat based on electrical tracing) from the moment we applied the monitor...We removed the inner cannula (the tracheostomy inner cannula) and it was full of green/yellow mucous..." E4, Certified Nurses Assistant (CNA) on 7/13/07 at approximately 3:15 PM indicated the Continuous Pulse Oximetry Monitor had been shut off. E4 stated, "I work day shift. At about 7:00 AM (on 7/5/07) me and (E5) were going to get (R3) up. I knocked but he did not answer - we could usually hear him. I went over to him and pushed him and said his name and he was not moving. There was no alarm going off (the pulse oximetry monitor alarm). I hollered at (E5) and told her we needed the nurse and needed her now. Then (E5) went out and hollered at the nurses. The alarm was shut off when I went in there. I looked at the machine and saw the machine was shut off...I turned the machine back on and it worked. I turned it back on when the nurse started to do CPR. The nurses would have	F 328		

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F 328	Continued From page 6 known the alarm was not sounding when they came into the room. I did not touch that machine before the nurses came into the room. There were no residents in the vicinity of the room..." E5, CNA, on 7/13/07 at approximately 4:00 PM confirmed the account of E4. E5 stated, "I had come to work at 6:00 AM on 7/5/07. (E4) and I went into get (R3) up at between 6:45 AM and 7:00 AM. When we went into the room, I went into the bathroom to wash my hands. (E4) went over to (R3) at about the same time I came out of the bathroom. (E4) said to me 'I need a nurse'. I looked at (R3) and he was real pale...This was not his normal color. While in the room I did not hear the pulse ox alarm sounding.There were no reisdents around that I saw.." A read out was provided and identified on 7/14/07 at approximately 8:00 AM by Z3, Respiratory Therapist. The read out was identified as a record of the activity of the Pulse Oximetry Monitor used on R3. In addition Z3 confirmed the read out came from the same machine that was returned from the facility. This record demonstrated the machine was shut off at 5:51 AM; approximately one hour before R3 was found non-responsive. Z3 confirmed during this interview the internal record showed the machine was shut off at the power switch. Z3 stated the machine had a backup battery and if the electrical power to the machine were interrupted, the machine would continue to monitor. Observation of the machine and confirmation by interview with Z3, confirmed there were no error messages on the readout. The last oxygen saturation reading recorded by the machine at 5:51 AM was observed to be 83% and the heart rate was 128 beats per minute. Both of these	F 328		

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F 328	Continued From page 7 readings were abnormal and the read out indicated the alarm would have been sounding when the machine was turned off. Interview with Z4, (Electrical Engineer for the pulse oximetry machine manufacturer) , on 7/17/07 at approximately 10:45 AM indicated the model of pulse oximetry monitor used on R3 was made for home as well as facility monitoring and was very durable. Z4 stated the body was cast aluminum and the monitor had rubber bumper pads that would protect the external controls as well as the internal parts from falls or other trauma. Z4 stated it would be very unlikely for the machine to malfunction or turn off even if it fell from the height of a bed to the floor. Moreover, Z4 stated the machine would show an error message on the readout if it malfunctioned. The immediate jeopardy was determined to have began on 7/5/07 at 5:51 AM when facility staff turned the power off on the Pulse Ox Monitor. The failure to use the warning device resulted in facility staff not being aware of R3's respiratory difficulties and ultimately in the death of R3. The Administrator was notified of the Immediate Jeopardy on 7/13/07 at approximately 12:40 PM. It was confirmed through interview and record review the facility took the following actions to remove the immediate jeopardy: 1. An all staff inservice was conducted on 7/10/07 by independent educator (Z5) that addressed "no one but licensed staff could operate any equipment that involves monitoring of a resident." 2. An all staff inservice was conducted on 7/10/07	F 328		

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F 328	Continued From page 8 by independent educator (Z5) that addressed "no staff will operate any equipment unless they have received proper training." 3. A facility policy was written and instituted on 7/13/07 by the Director of Clinical Operations that stated no equipment would be used in the facility unless all staff were trained in it's proper use.	F 328		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.3240a) 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	F9999		

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F9999	Continued From page 9 to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures: b) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to use an available Continuous Pulse Oximetry Monitor to help oversee the respiratory status of R3, one of four residents sampled for Oxygen/Respiratory. R3 was a severely ill resident in need of continuous oxygen saturation monitoring. R3's respiratory status became critically compromised and as a result of the failure to use the monitor facility staff were unaware of a potential life and death situation. Consequently R3 suffered respiratory arrest and died. Findings include the following: R3's Physician's Orders dated 7/02/07 showed	F9999		

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F9999	Continued From page 10 R3 is a twenty year old resident with diagnoses of Down's Syndrome, History of Pseudomonas Pneumonia with Respiratory Failure, History of Adult Respiratory Distress Syndrome (ARDS), and History pf Pulmonary Hypertension. Nursing Admission Assessment dated 7/2/07 at 3:30 PM indicated R3 was admitted to the facility alert to self and others. The assessment demonstrated R3 was admitted with a tracheostomy and showed R3 had diagnoses of "Acute Respiratory Failure and Down's Syndrome." Nurses notes dated 7/4/07 10PM - 6AM shift showed R3's tracheostomy required suctioning. Nurses notes dated 7/4/07 6AM - 2 PM shift, and 7/4/07 at 6:30 PM also indicated it was necessary to suction R3's tracheostomy tube. E1, Administrator, on 7/13/07 at approximately 10:00 AM indicated the family had requested the continuous monitoring of R3's oxygen saturation levels. E1 stated, "...the family requested the continuous pulse oximetry because of (R3's) compromised respiratory status..." Nurses notes demonstrated R3 had a serious respiratory distress event on "7/5/07 0300 (3:00 AM) , O2 (Oxygen) sat (saturation level) dropped to 28%...trach (tracheostomy tube) suctioned. Res fighting. (Ambulance) called. Paramedics here to help with res (resident). Res suctioned again. Neb (nebulizer) tx (treatment) given. Res (resident's) O2 sats (up to) 97%. Res became more calm, continuous oximetry cont. (continued)..." Z2, Paramedic, on 7/13/07 at approximately	F9999		

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F9999	Continued From page 11 10:30 AM indicated the Rescue Squad was called out regarding R3, twice, in the early morning hours of 7/5/07. Z2 stated, "I went out on both calls. First time at about 3:45 AM to about 4:20 AM. We were on scene approximately 35 minutes. We got a call for respiratory arrest. We rushed down there code four (sirens and red lights activated). When we got there the nurse met us in the hall. She told us he (R3) was in respiratory distress. He quit breathing for awhile but she (the nurse) suctioned him and everything was fine now. We went into the room. (R3) was sitting on the end of the bed Indian style. He seemed to be fine. O2 Sat was in the low 90's...We said to her (the nurse) 'are you comfortable with refusing (refusing to have R3 transported to the hospital)...you are going to have to watch him because he could get another mucous plug...' The second time we went down (we got to the facility) was about 7:02 (AM). When they (the facility) called they said they have a full arrest and CPR (cardiopulmonary resuscitation) was in progress. We got into the room (R3's room) - an employee was bagging (supplying artificial respirations with a manual respiratory resucitation device) and a nurse was doing CPR. He (R3) looked like he had been down (without circulation) for awhile. The skin (R3's) was cool to the touch - his legs were stiff. There was obvious pooling (blood pooling) to his hips and back. (The) nurse stated the arrest was not witnessed...If no one would have told us 'down time' (the amount of time R3 was without oxygen or circulation) we would have called Med (Medical) Control to discontinue resuscitation efforts because based on our assessment he (R3) had been gone too long. He was very cold. We never got a heart beat. He (R3) was asystole (without a heartbeat based on electrical tracing)	F9999		

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F9999	Continued From page 12 from the moment we applied the monitor...We removed the inner cannula (the tracheostomy inner cannula) and it was full of green/yellow mucous..." E4, Certified Nurses Assistant (CNA) on 7/13/07 at approximately 3:15 PM indicated the Continuous Pulse Oximetry Monitor had been shut off. E4 stated, "I work day shift. At about 7:00 AM (on 7/5/07) me and (E5) were going to get (R3) up. I knocked but he did not answer - we could usually hear him. I went over to him and pushed him and said his name and he was not moving. There was no alarm going off (the pulse oximetry monitor alarm). I hollered at (E5) and told her we needed the nurse and needed her now. Then (E5) went out and hollered at the nurses. The alarm was shut off when I went in there. I looked at the machine and saw the machine was shut off...I turned the machine back on and it worked. I turned it back on when the nurse started to do CPR. The nurses would have known the alarm was not sounding when they came into the room. I did not touch that machine before the nurses came into the room. There were no residents in the vicinity of the room..." E5, CNA, on 7/13/07 at approximately 4:00 PM confirmed the account of E4. E5 stated, "I had come to work at 6:00 AM on 7/5/07. (E4) and I went into get (R3) up at between 6:45 AM and 7:00 AM. When we went into the room, I went into the bathroom to wash my hands. (E4) went over to (R3) at about the same time I came out of the bathroom. (E4) said to me 'I need a nurse.' I looked at (R3) and he was real pale...This was not his normal color. While in the room I did not hear the pulse ox alarm sounding.There were no reisdents around that I saw..."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. BUILDING _____ B. WING _____	C 07/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 13 A read out was provided and identified on 7/14/07 at approximately 8:00 AM by Z3, Respiratory Therapist. The read out was identified as a record of the activity of the Pulse Oximetry Monitor used on R3. In addition Z3 confirmed the read out came from the same machine that was returned from the facility. This record demonstrated the machine was shut off at 5:51 AM; approximately one hour before R3 was found non-responsive. Z3 confirmed during this interview the internal record showed the machine was shut off at the power switch. Z3 stated the machine had a backup battery and if the electrical power to the machine were interrupted, the machine would continue to monitor. Observation of the machine and confirmation by interview with Z3, confirmed there were no error messages on the readout. The last oxygen saturation reading recorded by the machine at 5:51 AM was observed to be 83% and the heart rate was 128 beats per minute. Both of these readings were abnormal and the read out indicated the alarm would have been sounding when the machine was turned off. Interview with Z4, (Electrical Engineer for the pulse oximetry machine manufacturer), on 7/17/07 at approximately 10:45 AM, indicated the model of pulse oximetry monitor used on R3 was made for home as well as facility monitoring and was very durable. Z4 stated the body was cast aluminum and the monitor had rubber bumper pads that would protect the external controls as well as the internal parts from falls or other trauma. Z4 stated it would be very unlikely for the machine to malfunction or turn off even if it fell from the height of a bed to the floor. Moreover, Z4 stated the machine would show an error	F9999		

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F9999	Continued From page 14 message on the readout if it malfunctioned. (A)	F9999		