STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. BUILDING _____ B. WING _____	C 01/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN PARK STRATHMOOR	**5668 STRATHMOOR DRIVE ROCKFORD, IL 61107**

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F 327	Continued From page 45 day usually. They don't have enough help. Most of the time I stay in my room for meals because it is easier for us both (resident and staff)." R10 stated that staff are not real good about putting her tray table where she can reach it. On 12/20/06 at 11:21, R11 stated, "We get water once in the morning and once in the evening around 2:30pm or 3:00pm. But they are short (staffed) so we haven't been getting any lately in the evening. On 12/20/06 at 11:35am, R12 stated, "Hey they will put R13's water on her table but then they don't put her table next to her bed. So she can't reach it. R13 can drink if they put it next to her, but let her tell you about it." On 12/20/06 at 11:27am, E1 (Administrator) was asked when water is delivered to residents? E1 stated, "It varies. The time varies. I don't know if there is a set time. They don't pass water on the night shift. They just replenish it." The facility's policy and procedure on passing water showed, "Fresh water will be passed as needed ...."	F 327		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b)3) 300.1220b)2) 300.1220b)3) 300.3240a)	F9999		

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F9999	Continued From page 46 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 300.1010 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 47 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) 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. 3) 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 reviewed and modified in keeping with the care needed as indicated by the resident's condition.	F9999		

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F9999	Continued From page 48 The plan shall be reviewed at least every three months. 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 record review and interview the facility neglected to recognize a change in R1's condition beginning on 12/11/06 through 12/16/06. R1 experienced loose stools, confusion, slurred speech, poor oral intake and shortness of breath, and developed new pressure sores. The facility neglected to notify the physician of these changes until family members called the nurse to inform him that R1 was having difficulty breathing. At 5:25 P.M. R1 had increased shortness of breath and later displayed mental statur changes. At 5:25pm E4 called the physician and orders were received to transfer R1 to a local emergency room where she expired later the same day due to Urosepsis, Acute Renal Failure, and an electrolyte imbalance secondary to dehydration. The facility failed to assess, develop and provide interventions to prevent unplanned weight loss for R1. R1 had a 20.2 pound (9.5%) unplanned weight loss from 2/06 to 3/9/06. R1 had a 13 pound weight loss from 4/06 to 5/06, and continued to decline 24 pounds between 6/7/06 and 12/6/06 (greater than 10% weight loss). As of 12/16/06 R1 had stage II pressure ulcers to her sacral area and necrotic tissue along right posterior thigh. R1's last stage IV pressure ulcer	F9999		

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F9999	Continued From page 49 was healed on 12/5/06. The facility failed to assure a R1's hydration needs were met, failed to have a plan to meet R1's hydration needs and failed to assure additional fluids were provided when R1 began having loose stools on 12/11/06. R1 expired in the emergency room on 12/16/06 due to complications from dehydration. This applies to 1 resident in the facility at risk for dehydration, weight loss and pressure sore development (R1). The examples include: 1. On 12/27/06 at 10:30am, Z3 stated, "I was there the Monday before R1 died (12/11/06). R1 was confused and slurring her words. I talked to the CNA who thought R1 had an infection. The CNA went and got the nurse. The nurse talked to R1 and squeezed her hands and said she didn't think R1 had a stroke. The nurse gave her some pain medicine and that was that. At 9:00pm I called them to check on R1. They said she was sleeping and that they would call the doctor and let him know what was going on." Z3 was asked if R1 had any diarrhea. Z3 stated, "Yes she had it when I was there." Z3 confirmed that the stool was not formed but loose. Z3 stated, "It was diarrhea." Z3 was asked if R1 was able to feed herself. Z3 stated, "R1 was having trouble holding a cup. I told them they needed to help her. They needed to set up her tray for her and get it close to her. I told them (facility staff) that too." R1's intake and output monitoring sheets for 12/1/06 through 12/16/06 showed no output was	F9999		

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F9999	Continued From page 50	F9999		

monitored. There was missing/incomplete documentation of fluid intake during the same time period.

On 12/21/06 at 4:00pm, E5 (CNA) was shown R1's Intake and Output (I&O) monitoring sheet. E5 stated, "This is the nurses sheet. We write on our sheets and report it to the nurse. The nurse will document the intake and output on these sheets." E5 was asked if the I&O monitoring sheets are the "final" sheets for documenting the residents intake and output. E5 stated, "Yes, I believe so." E5 stated that the CNA sheets are kept only for the month.

R1's nutrition assessment dated 9/26/06 showed, "Estimated daily nutrient needs...Fluid 2200ml - 2500ml."

R1's Intake & Output record from 12/5/06 through 12/16/06 showed incomplete documentation of R1's intake of fluids on 5 out of 12 days. R1's fluid intake ranged from 720ml to 2240ml. No urine output monitoring was recorded on this sheet.

R1's urine output on the CNA assignment sheets from 11/1/06 through 11/29/06 showed a range of output from 500ml to 1100ml per day.

The facility presented CNA assignment sheets to show output monitoring for R1 for 12/4/06, 12/6/06, 12/7/06, 12/8/06, 12/11/06, 12/13/06, 12/14/06and 12/15/06. The documented urine output for R1 recorded on these sheets ranged from 400ml to 700ml.

The facility's Intake and Output monitoring policy and procedure showed, "Intake and output will be

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F9999	Continued From page 51 recorded for all residents on.... Output recorded for residents with an indwelling catheter or suprapubic catheter." 2. R1's nurses notes dated 12/16/06 at 6:00am showed, "Complains of, "my bottom hurts." Has open areas on sacral area ...necrotic tissue visible along right posterior thigh even with diaper with no drainage noted. Having loose stools ... Indwelling urinary catheter draining cloudy dark yellow urine. Temperature 97.7, pulse 96, respiratory rate 28, pulse oximetry 95% on room air." R1 had no additional nurses notes or orders on the physician's order sheet (POS) to show that R1's doctor had been contacted with these changes in her condition. The facility's policy and procedure for a "Resident's Condition or Status/ Change In" showed, "Policy: The facility will promptly notify the resident, his or her attending physician and responsible party of any changes in the resident's condition and/or status.; Procedure: The nurse will notify the resident's attending physician when: b. There is significant change in the resident's physical, mental or psychosocial status.; g. Changes occur that affect the resident's current level of care." R1's skin treatment sheets showed the last pressure ulcer she had was on the right heel and was healed on 12/5/06. There were no new treatment sheets that showed the stage two pressure ulcers to R1's coccyx or the necrotic area to her right posterior thigh. 3. The vital sign sheet for R1 showed the following weights (in pounds) for 2006: 1/6/06 = 229.5; 2/6/06 = 230; 3/9/06 = 209.8; 4/12/06 =	F9999		

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F9999	Continued From page 52 214; 5/5/06 = 200.9; 6/7/06 = 200.5; 7/5/06 = 197.5; 8/8/06 = 195; 9/6/06 = 190; 10/5/06 = 190; 11/6/06 = 185.7 and 12/6/06 = 175.3. The nutrition progress notes dated 12/12/06 for R1 showed, "Weight significantly decreased.... Oral intake poor. Plan: Feed resident as needed, encourage resident to eat." R1's nurses notes dated 12/16/06 at 5:25pm showed, "Certified nursing assistant called this nurse as resident is having shortness of breath and difficulty swallowing her food. Vital signs taken, temperature 96.5, blood pressure 140/67, pulse 68, respiratory rate 28-30. Oxygen saturation 78% on room air. Cold hands noted. Resident alert but confused and obvious mental status changes seen." The ER physicians dictation dated 12/16/06 for R1 showed, "Chief complaint: Unresponsive. History of present illness: This ...female ...was brought in by the paramedics with a history over the last two to three days, she has been confused and tonight she got more short of breath and did not improve. Her blood pressure dropped and she was agonally breathing. She is bradycardic with a blood pressure of 60/40. Do not rescucsitate order .... Intravenous fluids were started. Blood work was obtained. She was no longer responding to painfull stimuli. Potassium came back at 8.1. Her BUN and creatinine were very elevated. She had a urinary tract infection so it appeared she was really dehydrated with hyperkalemia and possibly urosepsis." R1's complete metabolic panel, in the ER, on 12/16/06 at 6:45pm showed, "Serum Sodium 151 (normal range 136-145), Serum Potassium 8.1	F9999		

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F9999	Continued From page 53 (normal 3.5-5.1), Chloride 125 (98-107), Blood urea nitrogen (BUN) 148 (normal 7-18), Creatinine 6.4 (normal 0.6-1.3) and Albumin 2.9 (normal 3.4-4.8). " On 12/21/06 at 11:15am, Z1 (physician) stated, "When R1 came in the paramedics said she was in respiratory distress. That is what was told to them. R1 was a DNR when she came in. She was also unresponsive. R1 was septic. She had a urinary tract infection. R1's catheter had thick cloudy urine. R1 was dehydrated. The dehydration caused acute renal failure and an electrolyte imbalance. R1's elevated potassium caused an arrhythmia. R1's decreased level of consciousness (LOC) resulted from the electrolyte imbalance. Respiratory depression goes along with the decreased LOC." On 12/27/06 at 8:09am, Z2 stated, "I got there between 10:30 and 20 minutes to eleven on 12/16/06. There was a black pillow on R1's right side. The tray was on the right side of the bed and was lower than the bed. There was no way she could reach it. R1 had a resource drink and yogurt. It showed that it was delivered at 10:00. R1 said she was hungry. I fed her the yogurt and held the resource. R1 ate the yogurt in less than 5 minutes and took only 2-3 gulps to drink the resource. There was no way she could open the yogurt or the resource if she wanted to. I asked her what they would have done if she didn't eat it. R1 said they would have just taken it away. I don't understand. R1 ate fast when I fed her. It was like she was starving. I couldn't get the yogurt in fast enough. Whoever set the tray there new she could not reach it. R1 couldn't even pick up her phone. R1's skin was peeling off her hands, face arms and neck. She had bad	F9999		

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F9999	Continued From page 54 diarrhea. The nurse called my daughter in to help clean her up. R1 kept asking for drinks of water. Her lips were all dry too. She was terribly dry all over. At about 3:00 or 3:30pm she said she couldn't breathe real well. At 5:30pm I got a call saying they were taking her to the ER. I thought they could have monitored her a little closer when she said she couldn't breathe." On 12/27/06 at 9:30am, E6 (Licensed Practical Nurse - LPN) stated, "R1 did have very little urine output. R1 gets a midmorning snack. I think it was yogurt and juice. R1 asked me if I would help her with them. I opened them both. I gave her a couple of bites of yogurt and told her I would come back. I went on break around 10:30am. I know R1 had not been eating well. She needed a lot of encouragement. R1 had low urine output. Her urine was amber colored." On 12/27/06 at 9:30am E6 stated that R1 had a catheter, was on thickened liquids and was not drinking too well lately. E6 stated that R1 did not have thickened liquids at her bedside on 12/16/06." (A)	F9999		