STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145697	A. BUILDING ______ B. WING ______	C 03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX COUNTY NURSING HOME	**800 NORTH MARKET STREET KNOXVILLE, IL 61448**

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F 322	Continued From page 5 3/5/08 Licensed nurses reported to Illinois Department of Professional and Financial Regulation via internet. Advised by the nurse aide registry, via email that our reporting to them on the alleged perpetrator nursing aide was sufficient. 2/26/2008 Monthly Quality Assurance Meeting: Incident discussed. All new nursing staff will be inserviced at time of new employee orientation. G-tube audit will be completed monthly by nurse educator and included as part of quality assurance program. Director of Nursing had requested new crash carts one for each neighborhood, review was made of various options, and three new crash carts were ordered on 2/27/2008.	F 322		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1220b)3) 300.3240a) 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 6	F9999		

to each resident to meet the total nursing and personal care needs of the resident.
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:
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. 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. (Section 2-107 of the Act)

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F9999	Continued From page 7 These regulations are not met, as evidenced by the following: Based on interviews, observation, and record reviews, the facility failed to keep the head of the bed elevated as indicated in the resident's care plan, and to immediately assess and treat 1 of 3 sampled residents with gastrostomy tubes. R1 vomited several times, aspirated, and died after being transferred to the hospital. Findings include: R1's Physician's Orders sheet, dated 2/16/08 to 3/15/08, stated R1 was a 48 year old with diagnoses including Delayed Gastric Emptying, Gastrostomy Tube, Respiratory Failure Secondary to Bilateral Lung Infiltrate, and History of Recurrent Pneumonia. R1's assessment dated 12/7/08 noted R1 to be total care for all activities of daily living including turning side to side in bed. During interview with E2 on 3/06/08 at 9:20 A.M., with E1 (Administrator) present, E2 (Director of Nursing) provided the following information: On 2/22/08 R1 was given a bolus feeding through his Gastrostomy tube (G-tube) at approximately 4:00 A.M. as scheduled. At 6:00 A.M. E4 (3rd shift Certified Nurse Aide) found R1 had vomited in bed. The head of the bed was almost flat. E4 cleaned R1 up but did not raise the head of the bed. E4 reported that R1 had vomited to E5 (3rd shift nurse) at 6:20 A.M. E5 told E4 that E5 was getting ready to leave and that E4 should tell E6 (1st shift nurse). E4 informed E6 of R1's condition but E6 did not go to R1's room to assess him. E4 and E5 left the facility at approximately 6:30 A.M. E7 (1st shift Certified	F9999		

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F9999	Continued From page 8 Nurse Aide) went to R1's room at 7:00 A.M. The head of R1's bed was almost flat and R1 had vomited again. E7 could hear R1 gurgling with fluid. E7 cleaned R1 and raised the head of his bed. E7 told E6 that R1 had vomited again and that he sounded gurgly. E6 again did not go to R1's room and assess him. E7 went to R1's room around 7:45 A.M. and found R1 had vomited the third time and continued to sound gurgly. E7 cleaned R1 and again informed E6 of R1's condition. E6 continued her medication pass and then went to R1's room at 8:15 A.M. When E6 went into R1's room, E6 found R1 to be in respiratory distress. E6 tested R1's oxygen saturation level. The oxygen saturation level was found to be at 66%. (Previous oxygen saturation levels documented in the nurses notes on 02/17/08 were recorded as being 93-94%.) E6 could hear that R1 had fluid in his lungs. E6 called the supervisor, gave R1 a breathing treatment, attempted to suction him, and started R1 on oxygen. Supervisory staff came to room and assisted with emergency care until R1 was sent to the hospital per ambulance at 9:30 A.M. Hospital personnel notified the facility at 12:15 P.M. that R1 had died at the hospital. Interviews conducted with E4 on 3/10/08 at 10:00 A.M., E5 on 3/6/08 at 1:40 P.M., E6 on 3/6/08 at 1:30 P.M., and E7 on 3/6/08 at 1:36 P.M. all provided information to support the above interview with E2. E6 (Licensed Practical Nurse) stated on 3/6/08 at 1:50 P.M. when asked why she waited so long to assess R1, "I don't know. I have no excuse. I'm usually right on top of things, I guess I just made a mistake."	F9999		

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F9999	Continued From page 9 Z1 (R1's Attending Physician) stated by telephone on 3/6/08 at 2:00 P.M. that R1's cause of death was respiratory failure due to aspiration. R1's most recent care plan dated 12/12/07 specified that R1 was to have the head of his bed elevated at all times to help prevent aspiration. "Patient Information / Nursing Home Transfer Form" documents R1 had been sent to the hospital in the past due to aspiration on 6/11/05. Observation of R1's bed on 03/06/08 at approximately 11:15 A.M. showed that the head of the bed had no malfunctions when it was raised and lowered. (A)	F9999		