STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. BUILDING _____ B. WING _____	C 01/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTRE	**2330 WEST GALENA BOULEVARD AURORA, IL 60506**

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F 000	INITIAL COMMENTS Complaint #0875658/IL38893 Licensure findings Complaint #0875746/IL38985 No Deficiency No extended survey was conducted. COUNTRYSIDE CARE CENTER OF AURORA is in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities for this survey	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1220b)2) 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 to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services	F9999		

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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F9999	Continued From page 1 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. 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 failed to develop and implement specific interventions to prevent a confused resident from decannulating her Tracheostomy Collar (TC), R1 and to have a system and operate the system to monitor residents when weaning from Continuous Positive Air Pressure (CPAP) to TL. R1 on 6/27/08 between 10:30 p.m. and 11:00 p.m. decannulated TC when left unsupervised and she became unresponsive. R1 expired in the hospital on 7/1/08 due to Respiratory Failure. The facility was aware of R1's history of decannulating her TC and pulling on tubing. This is for one of five residents in the sample, R1. Findings include: On 1/5/09 a review of R1's Nurses Notes reviewed. It was noted on 6/27/08 at 11:05 p.m.	F9999		

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F9999	Continued From page 2 that E5, the Respiratory Therapist (RT) found R1 in an unresponsive state. A further review of R1's Nurses Notes noted she pulled off TC and she went into acute respiratory distress with Oxygen Saturation (O2 SAT) level of 82%. R1 also attempted to pull on the CPAP tubing and TC on 4/14, 5/13, 5/25, 5/27, 5/30 and 5/31 for which she either received antianxiety medication and / or restraint therapy. On 5/31 when R1 pulled on CPAP tubing her O2 SAT dropped to 72% and she had to be connected back on to the Ventilator. R1 received restraint therapy (left wrist restraint) from 5/30/08 to 6/20/08. When R1's restraints therapy was discontinued on 6/20/08 the facility did not resolve if the problem goal was achieved or developed any alternative interventions as to how the staff was to monitor R1 in the absence of restraint. It was documented in R1's Nurses Notes on 6/26/08 at 7:55 a.m. and 6/27/08 7:40 a.m. R1 attempted to pull on the Gastrostomy Tube (GT). On 6/27/08 at 10:00 p.m. evening Nurse (E3) documented that she noted R1 was pulling on the tubings. Knowing the history of R1's behavior of pulling on tubings the facility did not initiate any interventions, such as giving medications and or providing a restraint, to monitor or prevent R1's behavior of pulling the tubings on 6/27/08. On 1/5/09 E3 stated R1 has the tendency of pulling on tubings especially when there was no one with her when she wakes up from her naps. R1 had the tendency to pull on the tubes especially when was waking up from sleep. There was no assessment to show why R1 demonstrated such behaviors of anxiety,	F9999		

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F9999	Continued From page 3	F9999		

confusion, restlessness that made her to pull the tubes. The care plan interventions for anxiety, mood and behavior are general, not specific to R1's behaviors. Examples of such interventions are: (1) administer medications as ordered, discuss behaviors, fear and anxiety, reality orientation, inform resident of behavior expectations, monitor resident for safety hazards. The care plan did not describe R1's behavior related to pulling tubes, confusion or restlessness. The criteria for administration of antianxiety medication was not determined. The facility identified R1 to be confused and disoriented from her dementia and it is unclear how the staff will ensure R1 could be oriented to reality and follow the content of discussion of her behaviors and process not to pull on the tubes.

On 1/7/09 E4, the night Nurse stated on 6/27/08 R1 was on TC with a continuous Pulse oximetry with an alarm to measure O2 SAT, but she did not hear the Pulse oximetry alarm sound. E4 became aware of R1's decannulation of TC only when E5 yelled for help from R1's room. At this time R1 was unresponsive, TC, Pulse oximetry and G-Tube all were on the floor. E4 and E5 started Cardio Pulmonary Resuscitation (CPR) on R1 and she was sent to the Hospital. E4 stated that they do not have a specific tool that shows the details of staff assigned to monitor and document resident vital information such as blood pressure, pulse, respiration and O2 SAT. The RT is responsible to check on the status of Ventilators, CPAP and TCs and she is responsible for nursing care.

On 1/8/08 E5, the RT who found R1 on 6/27/08 unresponsive was interviewed. E5 stated, she does her rounds on all the residents on Ventilator

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F9999	Continued From page 4 Unit every two hours. The last time she did rounds was at 9:00 p.m. and that is why she went to check on R1 at 11:05 p.m. E5 also stated it would not be possible for her to round sooner than two hours because there were about 10 residents on the Ventilator Unit and it takes about 20 to 30 minutes per resident. On 6/27/08 upon entering the room as soon as E5 found R1 unresponsive, she yelled for help, covered R1's Tracheostomy with a towel; E4 and E5 did the CPR and sent R1 to Hospital. E5 could not explain if she or any one heard Pulse oximetry alarm sound. E5 continued to say she might be busy in other Ventilator resident room. Neither there was any documentation nor the RT and / or the Nurse knew how or when R1's TC was decannulated. R1 room was the very first room from the Nurses station, the distance from the room to the Nurses Station is about 25 feet. On 1/5/09 it was noted from the interview with the facility Administrator (E1) on 1/5/09 that R1's family (Z2) wanted to stay with R1 during the night of 6/27/08, but E1 had asked Z2 to leave and R1 will be taken care. Z2 thinks the incident of R1's TC decannulation on 6/27/08 would not have occurred if she was allowed to stay with R1 that night. On 1/5/09 surveyor asked E1 the following questions: (1) How often the staff (Nurse or RT) check residents when they were in the process of weaning from CPAP to TC. The answer was there is no specific set system to check the residents; the Nurses, RT, Activity and House Keeping departments do their routine. (2) Was there a check sheet utilized showing who and what time the residents were checked	F9999		

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F9999	Continued From page 5 and documented. The answer was there is no check sheet to show the details of who and when the residents were checked and documented. E1 added that the facility does not operate the Ventilator Unit any longer. When the Unit was in operation, the facility rented the equipment from an Agency who provided the equipment and Policy and Procedures for its operation. The facility adopted the Agency Policy and Procedures and made minor changes with the Pulmonologist (Z1) consultation for the residents weaning from Ventilator and followed his recommendations. On 1/7/09 Z1, the Pulmonologist was interviewed. Z1 stated the facility may have the policy to do Arterial Blood Gases (ABG)during the process of weaning residents from the CPAP to TC, but he does not generally order ABGs for the residents on trial weaning from CPAP to TC. Z1 mentioned he depends and manages the residents during the weaning trials with a continuous Pulse oximetry to measure O2 SAT levels and if the O2 SAT levels are less than 90% the residents are placed back on Ventilators. Z1 stated the Pulse oximetry if connected supposed to alarm sound loud and clear when either it was disconnected or when the O2 SAT levels were lower than 90%. Z1 could not explain how the staff could not hear the Pulse oximetry alarm sound if the Pulse oximetry was removed from R1's body contact. Z1 also stated that residents like R1 needs to be monitored constantly or restrained to make sure she does not pull the tubes, but the facility is concerned that they may get citations if restraints are used.	F9999		

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