STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145713	A. BUILDING _____ B. WING _____	C 10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENCE MEADOWS NURSING & REHAB	**500 SOUTH WALNUT MOMENCE, IL 60954**

(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 Investigation of Complaint 1172914 - IL54579. F 322 cited. Investigation of Complaint 1172942 - IL54612. No deficiencies cited.	F 000		
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to: - Manage a resident (R1) with gastrostomy tube (GT) to prevent complications from dislodgement of GT. - Develop and implement GT care and interventions individualized and specific to R1's functional status. - Have effective policy and procedure for the management of GT. As a result: R1's GT came out three times (8/21/1, 9/03/11 and 9/19/11). On 9/19/11 the facility sent R1 to Hospital for elevation in temperature 102.2 degrees Farenheit.	F 322		11/11/11

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

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F 322	Continued From page 1 On 9/20/11 R1 expired in the Hospital due to Septic Shock, Peritonitis and Fever. This is for one of three residents (R1) in the sample of 13 residents in the facility with GT. Findings include: R1's admission record indicated he had multiple diagnoses including Dementia with behaviors, Dysphagia, Contractures to hands Cerebral Vascular Accident (CVA). The following entries were made in R1's Nurses Notes: On 4/25/11 R1 had a new GT put in due to Failure to Thrive, Severe Anorexia, Dementia with behaviors and Status Post CVA. On 8/21/11 GT came out, E5, a Licensed Practical Nurse (LPN) sent R1 to Hospital for GT re-insertion per physician order. There was no documentation between 8/21/11 and 9/3/11 to reflect the patency of the GT. On 9/3/11 GT came out, E5, LPN re-inserted GT per physician's (Z1) order but, unable to hear air rush after she re-inserted the GT. E5 sent R1 to Hospital per Z1's order. Again there was no documentation to reflect the patency of R1's GT between 9/3/11 and 9/19/11. On 9/19/11 GT came out during care. E8, night shift LPN re-inserted a 16 FR urinary catheter and endorsed to the day shift nurse, but reported wrong residents's name. The facility discharged E8 for sleeping on the job and poor quality of	F 322		

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F 322	Continued From page 2	F 322		

work. E9 the day shift LPN found R1 had urinary catheter in place of GT when she went to administer medications. E9 then removed the urinary catheter and inserted a GT. At 10:30 pm R1 developed heavy breathing, no blood pressure felt, temperature 102.2 degrees Farenheit. The facility sent R1 to Hospital Emergency Room, admitted to Intensive Care Unit.

At the hospital R1's abdomen CT Scan noted the GT was positioned in extra gastric space. There was free air and fluid noted in his abdomen. On 9/20/11 at 6:55 am R1 expired due to septic shock, peritonitis and fever.

All three times when R1's GT came out, there was no documentation to indicate what time and why the GT tube came out, how long it took for its re-insertion, what time R1 went to the hospital, what time R1 returned to the facility or whether any one checked for its placement after R1 returned to the facility.

On 10/18/11 reviewed facility policy and procedure for GT insertion. The policy and procedure prior to 9/22/11 noted if a similar GT does not slide easily into the tract or can not be located a 16 FR urinary catheter may be used to maintain the sinus tract until a more permanent tube can be inserted. On 9/22/11 the facility revised the policy and procedure not to use urinary catheter. The policy and procedure also does not have guidelines: (1)When to replace or change GT; (2) How and when to examine GT; (3) Instances when a GT can be replaced within the facility and by whom; (4) When GT be replaced in another setting.

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F 322	Continued From page 3 On 10/7/11 at 3:40 pm E5 stated on 8/21/11 there was a different physician. He always sends residents for re-inserting the GT when it comes out. On 9/13/11 it was different physician (Z1). He orders the nurses to re-insert the GT. On 9/13/11 when she re-inserted the GT for R1 she could not hear air rush. Z1 then ordered to send R1 to hospital. On 9/13/11 when R1 returned from the hospital, E5 stated did not hear air rush which was verified by another LPN. E5 then contacted the hospital again, but the hospital told E5 R1's GT was in place and E5 did a good job re-inserting the GT. There was no documentation to reflect the hospital staff phone interview, or E5 not being able to hear air flush when R1 returned from the Hospital. E5 stated she did not document or informed any of her supervisors. When the facility sent R1 to the hospital on 9/3/11, GT proper placement was not confirmed with gastrografin of stomach to ensure good infusion. The facility obtained this information from the hospital on 9/30/11 when the surveyor questioned E2. On 10/18/11 at 12:50 pm E9, LPN stated on 9/19/11 morning shift she got report from the night LPN (E8) stating she put in a 16 FR urinary catheter for R4 and she did not mention any thing to E9 about R1's GT. E9 when caring for R1, E9 found out R1 had a 16 FR urinary catheter and not R4. E9 then called R1's doctor (Z1) and re-inserted a GT per Z1's order. E9 did not find any notation in R1's chart indicating E8 notified Z1 of inserting a 16 FR urinary catheter. E9 continued to say on 9/19/11 at 11:00 am she checked R1's GT placement by pushing air, turned on tube feeing at 2:00 pm. E9 also stated	F 322		

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F 322	Continued From page 4 she understood from the evening nurse R1 developed a temperature of 102.2 degrees Farenheit, no blood pressure and had abdominal breathing. E9 stated she became aware when R1 went to the hospital the GT was not in place and R1 expired from septic shock. E9 concluded if she was to go back to the situation she would send R1 to hospital and not re-insert the GT her self. On 10/7/11 at 2:55 pm E4, a Certified Nurse Aide (CNA) stated she was involved with two incidents (8/21/11 and 9/3/11) with R1. E4 stated both times R1 was restless and had shakes in his arms. When the staff goes to him to change, he wiggles his hands. The tubing got wrapped around his fingers and hands. When turned over he held on to the tube and tube got out. E4 stated she has been CNA in the facility close to an year, but has been CNA for seven year. E4 also stated she only got three days of orientation when the facility hired her and does not remember what she had during that time. E4 also stated she should have been more care full with R1, knowing he has contractures and wiggles. The facility documented all the three incidents of dislodgement of R1's GT. All three occasions the GT came out when CNAs providing care. R1 had a care plan for the maintenance of nutritional approaches for GT which he had for significant weight loss, poor appetite and failure to thrive. This care plan was developed on 4/29/11 and revised on 8/9/11. The care plan interventions are the same for both care plans. The care plan do not address (1) when to replace or change GT; (2) how and when to examine GT;	F 322		

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F 322	Continued From page 5 (3) instances when a GT can be replaced within the facility and by whom; (4) when GT be replaced in another setting. The interventions also did not include approaches to deal with his contractures, and wiggling of his fingers and hands. When the facility sent R1 to the hospital on 8/21/11 the hospital discharge instructions noted under tips: 'be sure to kink the tubing before removing the cap or disconnecting a syringe to prevent back flow. If a balloon catheter type tube, check for level of tube placement every day. If the length of the tube seems less than normal, call care giver." These tips / instructions were not included in the GT plan of care for R1. On 9/30/11 E2, the Director of Nurses confirmed the care plan interventions are not specific and did not include tips from the 8/21/11 hospital discharge instructions. E2 was not aware there were tips noted in the discharge instructions. On 10/18/11 at 12:35 pm Z1 stated on 9/19/11 night he did not get a call from the nurse or inserting a 16 FR urinary catheter in place of R1's GT, he only came when the day shift nurse called him. Z1 stated when the nurses call him, he question them if they are proficient to re-insert the GT. If the nurse says they are proficient in re-inserting the GT, he would authorize them to re-insert, if not he sends resident to hospital for re-insertion. In case of R1, he authorized to re-insert GT when she stated she is proficient in re-inserting the GT and expected to be 100% correct. Z1 stated he could not explain why R1's GT was in extra gastric space, having peritonitis or going into Septic Shock and dying.	F 322		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 6 LICENSURE VIOLATIONS 300.610a) 300.610c)2) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 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 evidenced by written, signed and dated minutes of such a meeting. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).	F9999		

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F9999	Continued From page 7 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	F9999		

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F9999	Continued From page 8 seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on record review and interview the facility failed to: - Manage a resident (R1) with gastrostomy tube (GT) to prevent complications from dislodgement of GT. - Develop and implement GT care and interventions individualized and specific to R1's functional status. - Have effective policy and procedure for the management of GT. As a result: R1's GT came out three times (8/21/1, 9/3/11 and 9/19/11). On 9/19/11 the facility sent R1 to Hospital for elevation in temperature 102.2 degrees Farenheit. On 9/20/11 R1 expired in the Hospital due to Septic Shock, Peritonitis and Fever. This is for one of three residents (R1) in the sample of 13 residents in the facility with GT. Findings include: R1's admission record indicated he had multiple	F9999		

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F9999	Continued From page 9 diagnoses including Dementia with behaviors, Dysphagia, Contractures to hands Cerebral Vascular Accident (CVA). The following entries were made in R1's Nurses Notes: On 4/25/11 R1 had a new GT put in due to Failure to Thrive, Severe Anorexia, Dementia with behaviors and Status Post CVA. On 8/21/11 GT came out, E5, a Licensed Practical Nurse (LPN) sent R1 to Hospital for GT re-insertion per physician order. There was no documentation between 8/21/11 and 9/3/11 to reflect the patency of the GT. On 9/3/11 GT came out, E5, LPN re-inserted GT per physician's (Z1) order but, unable to hear air rush after she re-inserted the GT. E5 sent R1 to Hospital per Z1's order. Again there was no documentation to reflect the patency of R1's GT between 9/3/11 and 9/19/11. On 9/19/11 GT came out during care. E8, night shift LPN re-inserted a 16 FR urinary catheter and endorsed to the day shift nurse, but reported wrong residents's name. The facility discharged E8 for sleeping on the job and poor quality of work. E9 the day shift LPN found R1 had urinary catheter in place of GT when she went to administer medications. E9 then removed the urinary catheter and inserted a GT. At 10:30 pm R1 developed heavy breathing, no blood pressure felt, temperature 102.2 degrees Farenheit. The facility sent R1 to Hospital Emergency Room, admitted to Intensive Care Unit.	F9999		

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F9999	Continued From page 10	F9999		

At the hospital R1's abdomen CT Scan noted the GT was positioned in extra gastric space. There was free air and fluid noted in his abdomen. On 9/20/11 at 6:55 am R1 expired due to septic shock, peritonitis and fever.

All three times when R1's GT came out, there was no documentation to indicate what time and why the GT tube came out, how long it took for its re-insertion, what time R1 went to the hospital, what time R1 returned to the facility or whether any one checked for its placement after R1 returned to the facility.

On 10/18/11 reviewed facility policy and procedure for GT insertion. The policy and procedure prior to 9/22/11 noted if a similar GT does not slide easily into the tract or can not be located a 16 FR urinary catheter may be used to maintain the sinus tract until a more permanent tube can be inserted. On 9/22/11 the facility revised the policy and procedure not to use urinary catheter. The policy and procedure also does not have guidelines: (1)When to replace or change GT; (2) How and when to examine GT; (3) Instances when a GT can be replaced within the facility and by whom; (4) When GT be replaced in another setting.

On 10/7/11 at 3:40 pm E5 stated on 8/21/11 there was a different physician. He always sends residents for re-inserting the GT when it comes out. On 9/3/11 it was different physician (Z1). He orders the nurses to re-insert the GT. On 9/3/11 when she re-inserted the GT for R1 she could not hear air rush. Z1 then ordered to send R1 to hospital. On 9/3/11 when R1 returned from the hospital, E5 stated did not hear air rush which

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was verified by another LPN. E5 then contacted the hospital again, but the hospital told E5 R1's GT was in place and E5 did a good job re-inserting the GT. There was no documentation to reflect the hospital staff phone interview, or E5 not being able to hear air flush when R1 returned from the Hospital. E5 stated she did not document or informed any of her supervisors.

When the facility sent R1 to the hospital on 9/3/11, GT proper placement was not confirmed with gastrografin of stomach to ensure good infusion. The facility obtained this information from the hospital on 9/30/11 when the surveyor questioned E2.

On 10/18/11 at 12:50 pm E9, LPN stated on 9/19/11 morning shift she got report from the night LPN (E8) stating she put in a 16 FR urinary catheter for R4 and she did not mention any thing to E9 about R1's GT. E9 when caring for R1, E9 found out R1 had a 16 FR urinary catheter and not R4. E9 then called R1's doctor (Z1) and re-inserted a GT per Z1's order. E9 did not find any notation in R1's chart indicating E8 notified Z1 of inserting a 16 FR urinary catheter.
E9 continued to say on 9/19/11 at 11:00 am she checked R1's GT placement by pushing air, turned on tube feeing at 2:00 pm. E9 also stated she understood from the evening nurse R1 developed a temperature of 102.2 degrees Farenheit, no blood pressure and had abdominal breathing. E9 stated she became aware when R1 went to the hospital the GT was not in place and R1 expired from septic shock. E9 concluded if she was to go back to the situation she would send R1 to hospital and not re-insert the GT her self.

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F9999	Continued From page 12 On 10/7/11 at 2:55 pm E4, a Certified Nurse Aide (CNA) stated she was involved with two incidents (8/21/11 and 9/3/11) with R1. E4 stated both times R1 was restless and had shakes in his arms. When the staff goes to him to change, he wiggles his hands. The tubing got wrapped around his fingers and hands. When turned over he held on to the tube and tube got out. E4 stated she has been CNA in the facility close to an year, but has been CNA for seven year. E4 also stated she only got three days of orientation when the facility hired her and does not remember what she had during that time. E4 also stated she should have been more care full with R1, knowing he has contractures and wiggles. The facility documented all the three incidents of dislodgement of R1's GT. All three occasions the GT came out when CNAs providing care. R1 had a care plan for the maintenance of nutritional approaches for GT which he had for significant weight loss, poor appetite and failure to thrive. This care plan was developed on 4/29/11 and revised on 8/9/11. The care plan interventions are the same for both care plans. The care plan do not address (1) when to replace or change GT; (2) how and when to examine GT; (3) instances when a GT can be replaced within the facility and by whom; (4) when GT be replaced in another setting. The interventions also did not include approaches to deal with his contractures, and wiggling of his fingers and hands. When the facility sent R1 to the hospital on 8/21/11 the hospital discharge instructions noted	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145713	A. BUILDING _____ B. WING _____	C 10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENCE MEADOWS NURSING & REHAB	**500 SOUTH WALNUT MOMENCE, IL 60954**

(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 13 under tips: 'be sure to kink the tubing before removing the cap or disconnecting a syringe to prevent back flow. If a balloon catheter type tube, check for level of tube placement every day. If the length of the tube seems less than normal, call care giver." These tips / instructions were not included in the GT plan of care for R1. On 9/30/11 E2, the Director of Nurses confirmed the care plan interventions are not specific and did not include tips from the 8/21/11 hospital discharge instructions. E2 was not aware there were tips noted in the discharge instructions. On 10/18/11 at 12:35 pm Z1 stated on 9/19/11 night he did not get a call from the nurse or inserting a 16 FR urinary catheter in place of R1's GT, he only came when the day shift nurse called him. Z1 stated when the nurses call him, he question them if they are proficient to re-insert the GT. If the nurse says they are proficient in re-inserting the GT, he would authorize them to re-insert, if not he sends resident to hospital for re-insertion. In case of R1, he authorized to re-insert GT when she stated she is proficient in re-inserting the GT and expected to be 100% correct. Z1 stated he could not explain why R1's GT was in extra gastric space, having peritonitis or going into Septic Shock and dying. (B)	F9999		