PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULT LDII	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		145713	B. Will	· · ·		10/1	8/2011
	ROVIDER OR SUPPLIER  CE MEADOWS NURS	ING & REHAB			REET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH WALNUT MOMENCE, IL 60954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ГS	F (	000			
	Investigation of Co F 322 cited.	mplaint 1172914 - IL54579.					
F 322 SS=G	No deficiencies cite	REATMENT/SERVICES -	F3	322			11/11/11
	resident, the facility who is fed by a nas receives the appror to prevent aspiratio vomiting, dehydration	orehensive assessment of a must ensure that a resident to-gastric or gastrostomy tube oriate treatment and services in pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers and to restore, if ating skills.					
	by: Based on record refailed to: - Manage a residen (GT) to prevent corof GT Develop and impleinterventions individunctional status Have effective polymanagement of GT As a result:	dualized and specific to R1's licy and procedure for the					
I ARORATOD	and 9/19/11). On 9/19/11 the faci elevation in temper Farenheit.	lity sent R1 to Hospital for ature 102.2 degrees	NATURE		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.

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDIN	G	(	C
	145713	B. WING	<del></del>		8/2011
NAME OF PROVIDER OR SUPPLIER  MOMENCE MEADOWS NURSING	G & REHAB	50	EEET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT IOMENCE, IL 60954		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Septic Shock, Periton This is for one of three sample of 13 resident Findings include: R1's admission record diagnoses including D Dysphagia, Contractu Vascular Accident (CV The following entries Notes: On 4/25/11 R1 had a Failure to Thrive, Seve behaviors and Status On 8/21/11 GT came Practical Nurse (LPN) re-insertion per physic There was no docume and 9/3/11 to reflect the On 9/3/11 GT came oper physician's (Z1) or ush after she re-insertion per physician's	er residents (R1) in the ts in the facility with GT.  d indicated he had multiple Dementia with behaviors, ures to hands Cerebral VA).  were made in R1's Nurses  new GT put in due to rere Anorexia, Dementia with Post CVA.  out, E5, a Licensed ) sent R1 to Hospital for GT cian order. entation between 8/21/11 he patency of the GT.  out, E5, LPN re-inserted GT order but, unable to hear air orted the GT. E5 sent R1 to	F 322			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145713	B. WIN	IG _			C <b>3/2011</b>
	PROVIDER OR SUPPLIER	ING & REHAB		5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT MOMENCE, IL 60954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322	work. E9 the day she catheter in place of administer medicati urinary catheter and R1 developed heaver felt, temperature 10 facility sent R1 to Hadmitted to Intensive At the hospital R1's GT was positioned was free air and flu 9/20/11 at 6:55 am shock, peritonitis are All three times where was no documentati why the GT tube care-insertion, what time R1 returnany one checked for returned to the facility one consistency of the procedure prior to 9 does not slide easil located a 16 FR uring maintain the sinus to tube can be inserted revised the policy a urinary catheter. The does not have guide change GT; (2) How (3) Instances when	off LPN found R1 had urinary GT when she went to cons. E9 then removed the dinserted a GT. At 10:30 pm y breathing, no blood pressure 12.2 degrees Farenheit. The ospital Emergency Room, re Care Unit.  abdomen CT Scan noted the in extra gastric space. There id noted in his abdomen. On R1 expired due to septic and fever.  In R1's GT came out, there tion to indicate what time and time out, how long it took for its me R1 went to the hospital, and to the facility or whether or its placement after R1 ity.  In R6 facility policy and it is placement after R1 ity.  In R6 facility policy and is placement after R1 ity.  In R7 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.  In R8 facility policy and is placement after R1 ity.	F3	322			

Facility ID: IL6006258

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145713	B. WIN	1G _			3/ <b>2011</b>	
	ROVIDER OR SUPPLIER	ING & REHAB		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT 10MENCE, IL 60954	10/10	3/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 322	On 10/7/11 at 3:40 was a different physresidents for re-insequence out. On 9/13/11 it worders the nurses to when she re-inserte hear air rush. Z1 the hospital. On 9/13/11 hospital, E5 stated was verified by anothe hospital again, I GT was in place an re-inserting the GT. to reflect the hospit not being able to he from the Hospital. Edocument or inform When the facility se 9/3/11, GT proper with gastrografin of infusion. The facility from the hospital or questioned E2.  On 10/18/11 at 12:59/19/11 morning she night LPN (E8) staticatheter for R4 and to E9 about R1's G found out R1 had a not R4. E9 then cal re-inserted a GT peany notation in R1's Z1 of inserting a 16 E9 continued to say checked R1's GT p	ge 3 pm E5 stated on 8/21/11 there sician. He always sends erting the GT when it comes as different physician (Z1). He ore-insert the GT. On 9/13/11 ed the GT for R1 she could not en ordered to send R1 to 1 when R1 returned from the did not hear air rush which ther LPN. E5 then contacted but the hospital told E5 R1's d E5 did a good job. There was no documentation al staff phone interview, or E5 ear air flush when R1 returned E5 stated she did not led any of her supervisors.  ent R1 to the hospital on placement was not confirmed stomach to ensure good of obtained this information in 9/30/11 when the surveyor  50 pm E9, LPN stated on lift she got report from the ling she put in a 16 FR urinary she did not mention any thing T. E9 when caring for R1, E9 to FR urinary catheter and led R1's doctor (Z1) and the r Z1's order. E9 did not find the chart indicating E8 notified FR urinary catheter. If on 9/19/11 at 11:00 am she lacement by pushing air, and at 2:00 pm. E9 also stated	Fí	322				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED	
		145713	B. WING			0 <b>10/18</b>	
	PROVIDER OR SUPPLIER	ING & REHAB		STREET ADDRESS, CITY, S' 500 SOUTH WALNUT MOMENCE, IL 60954	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPF EFICIENCY)	) BE	(X5) COMPLETION DATE
F 322	she understood from developed a temper Farenheit, no blood breathing. E9 state went to the hospital R1 expired from se she was to go back send R1 to hospital self.  On 10/7/11 at 2:55 (CNA) stated she we (8/21/11 and 9/3/11 times R1 was restle arms. When the stawiggles his hands, around his fingers as he held on to the turn she has been CNA but has been CNA but has been CNA she only got three of facility hired her and she had during that should have been right he has contractures.  The facility documed dislodgement of R1 GT came out when R1 had a care plan nutritional approach significant weight to thrive. This care 4/29/11 and revised interventions are the The care plan do not seed to the care plan do	rature of 102.2 degrees pressure and had abdominal d she became aware when R1 the GT was not in place and ptic shock. E9 concluded if to the situation she would and not re-insert the GT her  pm E4, a Certified Nurse Aide ras involved with two incidents ) with R1. E4 stated both ress and had shakes in his aff goes to him to change, he The tubing got wrapped and hands. When turned over be and tube got out. E4 stated in the facility close to an year, for seven year. E4 also stated days of orientation when the d does not remember what time. E4 also stated she nore care full with R1, knowing	F 3:	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145713	B. WIN				C <b>8/2011</b>
	ROVIDER OR SUPPLIER	ING & REHAB	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT IOMENCE, IL 60954		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 322	the facility and by wreplaced in another also did not include contractures, and whands.  When the facility se 8/21/11 the hospita under tips: 'be sure removing the cap oprevent back flow. I check for level of tulength of the tube scare giver." These included in the GT 9/30/11 E2, the Director care plan interventinot include tips from discharge instruction	ge 5 a GT can be replaced within thom; (4) when GT be setting. The interventions approaches to deal with his viggling of his fingers and and the setting of his fingers and and the setting of his fingers and and the setting of his fingers and a setting of his fingers and the setting of his fingers and the setting of his fingers and his fingers and his fingers are not specific and did not he setting of his financial was a setting of his financial was not aware there are discharge instructions.	F3	322			
F9999	night he did not get inserting a 16 FR u R1's GT, he only ca called him. Z1 state he question them if the GT. If the nurse re-inserting the GT, re-insert, if not he serinsert GT when serinserting the GT correct. Z1 stated he		F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	G	l (	c
		145713	B. WI	NG _			8/ <b>2011</b>
	ROVIDER OR SUPPLIER CE MEADOWS NURS	ING & REHAB		50	EET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT IOMENCE, IL 60954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa		F99	999			
	300.610a) 300.610c)2) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 300.3240a)	esident Care Policies					
	a) The facility shall procedures, govern the facility which she Resident Care Policileast the administrative medical advisor representatives of re	have written policies and sing all services provided by sall be formulated by a cy Committee consisting of at ator, the advisory physician or cy committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. The shall be followed in any and shall be reviewed at its committee, as evidenced by dated minutes of such a string provisions: ervices including physician cy services, personal care and estorative services, activity eutical services, dietary vices, clinical records, dental nostic service (including					

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		145713	B. WI	NG _			C <b>8/2011</b>
	ROVIDER OR SUPPLIER	ING & REHAB	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT IOMENCE, IL 60954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	a) Comprehensive with the participation resident's guardian applicable, must de comprehensive car includes measurab meet the resident's and psychosocial in resident's comprehensive to practicable level of provide for discharge restrictive setting by needs. The assess the active participate resident's guardian applicable. b) The facility shall and services to attapracticable physical well-being of the reeach resident's complan. Adequate and care and personal cresident to meet the care needs of the reshall include, at an procedures: c) Each direct care be knowledgeable arespective resident d) Pursuant to subscare shall include, at an and the care shall include, at an area shall include, at an area shall include, at an and the care shall include, at an area shall include, at an area shall include, at an and the care shall include at a care shall include at a care shall include at an and the care shall include at a care shall at	Resident Care Plan. A facility, nof the resident and the or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which of attain or maintain the highest independent functioning, and ge planning to the least assed on the resident's care ment shall be developed with air or maintain the highest in accordance with a previous the resident care in properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative measures hinimum, the following egiving staff shall review and about his or her residents' care plan. Section (a), general nursing at a minimum, the following	F9	999			
	d) Pursuant to subs	section (a), general nursing at a minimum, the following					

Facility ID: IL6006258

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI JER/CLIA

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145713	B. WIN	IG _		10/18	C <b>3/2011</b>
	ROVIDER OR SUPPLIER	ING & REHAB	1	5	REET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH WALNUT MOMENCE, IL 60954	10/10	5/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	administered as ord Section 300.3240 A a) An owner, license agent of a facility sh resident.	oasis: d procedures shall be dered by the physician.	F99	999			
	failed to: - Manage a residen (GT) to prevent con of GT Develop and imple interventions individ functional status.	t (R1) with gastrostomy tube inplications from dislodgement ement GT care and lualized and specific to R1's icy and procedure for the					
	9/19/11). On 9/19/11 the facil elevation in temperarenheit.	hree times (8/21/1, 9/3/11 and lity sent R1 to Hospital for ature 102.2 degrees red in the Hospital due to onitis and Fever.					
		ree residents (R1) in the ents in the facility with GT.					
	Findings include:						
	R1's admission reco	ord indicated he had multiple					

Facility ID: IL6006258

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		145713	B. WIN	NG _			3/ <b>2011</b>
	PROVIDER OR SUPPLIER	ING & REHAB			REET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH WALNUT MOMENCE, IL 60954	10/10	3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	diagnoses including Dysphagia, Contract Vascular Accident ( The following entries Notes:  On 4/25/11 R1 had Failure to Thrive, State of the Practical Research of the Practical Nurse (LP) re-insertion per physician's (Z1) rush after she re-inserted per physician's (Z1) rush after she re-inserted per Z1's or Again there was no patency of R1's GT on 9/19/11 GT care shift LPN re-inserted and endorsed to the wrong residents's new felt, temperature 10 diagnostical research place of administer medication urinary catheter and R1 developed heavifelt, temperature 10 diagnostical research processes and the processes of the proc	Dementia with behaviors, ctures to hands Cerebral CVA).  Is were made in R1's Nurses  In a new GT put in due to evere Anorexia, Dementia with us Post CVA.  In a out, E5, a Licensed In a licensed In a cout, E5, LPN re-inserted GT In a cout, E5	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145713	B. WIN			10/18	3/ <b>2011</b>
	ROVIDER OR SUPPLIER	ING & REHAB	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT 10MENCE, IL 60954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	GT was positioned was free air and flu 9/20/11 at 6:55 am shock, peritonitis ar All three times whe was no documentate why the GT tube care-insertion, what time R1 returnany one checked for returned to the facility on 10/18/11 review procedure for GT in procedure prior to 9 does not slide easil located a 16 FR uri maintain the sinus of tube can be inserted to the policy aurinary catheter. The does not have guide change GT; (2) How (3) Instances when the facility and by we replaced in another. On 10/7/11 at 3:40 was a different physical residents for re-inserted when she re-inserted hear air rush. Z1 the hospital. On 9/3/11	abdomen CT Scan noted the in extra gastric space. There id noted in his abdomen. On R1 expired due to septic and fever.  en R1's GT came out, there tion to indicate what time and ame out, how long it took for its me R1 went to the hospital, and to the facility or whether or its placement after R1 ity.  ed facility policy and asertion. The policy and asertion. The policy and asertion. The policy and procedure may be used to tract until a more permanent and On 9/22/11 the facility and procedure not to use the policy and procedure also belines: (1)When to replace or we and when to examine GT; a GT can be replaced within whom; (4) When GT be	F99	9999			

AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145713	B. WIN	NG _			3/ <b>2011</b>
	ROVIDER OR SUPPLIER	ING & REHAB		5	REET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH WALNUT MOMENCE, IL 60954	10/10	3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	was verified by ano the hospital again, I GT was in place an re-inserting the GT. to reflect the hospit not being able to he from the Hospital. E document or inform When the facility se 9/3/11, GT proper with gastrografin of infusion. The facility from the hospital or questioned E2.  On 10/18/11 at 12:59/19/11 morning sh night LPN (E8) stat catheter for R4 and to E9 about R1's G found out R1 had a not R4. E9 then cal re-inserted a GT pe any notation in R1's Z1 of inserting a 16 E9 continued to say checked R1's GT p turned on tube feein she understood from developed a tempe Farenheit, no blood breathing. E9 stated went to the hospital R1 expired from se she was to go back	ther LPN. E5 then contacted but the hospital told E5 R1's d E5 did a good job There was no documentation al staff phone interview, or E5 ar air flush when R1 returned E5 stated she did not led any of her supervisors.  Int R1 to the hospital on placement was not confirmed stomach to ensure good obtained this information in 9/30/11 when the surveyor  50 pm E9, LPN stated on lift she got report from the ling she put in a 16 FR urinary she did not mention any thing T. E9 when caring for R1, E9 16 FR urinary catheter and led R1's doctor (Z1) and led R1's doctor (Z1) and led R1's order. E9 did not find schart indicating E8 notified FR urinary catheter.  To no 9/19/11 at 11:00 am she lacement by pushing air, and at 2:00 pm. E9 also stated in the evening nurse R1 rature of 102.2 degrees pressure and had abdominal dishe became aware when R1 the GT was not in place and ptic shock. E9 concluded if to the situation she would and not re-insert the GT her	F99	999			

A. BUILDING C  145713	
1 10/10/2	
NAME OF PROVIDER OR SUPPLIER  MOMENCE MEADOWS NURSING & REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  500 SOUTH WALNUT  MOMENCE, IL 60954	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145713	B. WING			C <b>10/18/2011</b>	
NAME OF PROVIDER OR SUPPLIER  MOMENCE MEADOWS NURSING & REHAB				50	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH WALNUT 10MENCE, IL 60954	10/10	5/2511
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	removing the cap of prevent back flow. If check for level of the length of the tube is care giver." These the included in the GT prevention of included tips from discharge instruction were tips noted in the GT prevention of the length of th	to kink the tubing before r disconnecting a syringe to f a balloon catheter type tube, be placement every day. If the eems less than normal, call ips / instructions were not plan of care for R1. On ector of Nurses confirmed the cons are not specific and did in the 8/21/11 hospital ins. E2 was not aware there in edischarge instructions.  B5 pm Z1 stated on 9/19/11 a call from the nurse or rinary catheter in place of time when the day shift nurse in when the nurses call him, they are proficient to re-insert says they are proficient in he would authorize them to ends resident to hospital for e of R1, he authorized to she stated she is proficient in and expected to be 100% e could not explain why R1's estric space, having peritonitis	F99	999			