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 06/18/2015

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

(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 Complaint Investigations: 1573191/ IL77945- F 309 was cited. 1573181/ IL77931 - no deficiency was cited.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the attending physician regarding R1 continued respiratory distress and the expulsion of the tracheostomy tube. The facility failed to utilize 911 to transport R 1 to the hospital. This failure resulted in R 1 having labored breathing for five hours (from 8:00 AM through 1:00 PM) and waiting for the ambulance for an hour (from the time the order was given at 12:00 PM through the ambulance arrival time at 1:00 PM). This applies to one (R 1) of two residents (R1 and R3) reviewed for tracheostomy care and treatment. The findings include: R1 nurse's notes dated 05-01-15 showed: approximately 8:00 AM, while administering medication through gastrostomy tube, labored breathing with use of abdominal muscles	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COUNTRYSIDE CARE CENTRE	**2330 WEST GALENA BOULEVARD AURORA, IL 60506**

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F 309	Continued From page 1 observed ... At around 10:00AM, the patient's daughter notified this nurse (E3) that labored breathing was continuing ...called for another nurse to assist ...labored breathing continued At 11:00 , this nurse checked in on patient, labored breathing continued ...asked another nurse for assistance with tracheostomy ... staff nurse (E2) loosened tracheostomy collar to check the stoma and the tracheostomy came out. Large gray greenish mucus plug at the end of the tracheostomy ...tracheostomy was placed back into resident by staff nurse immediately and a new inner cannula inserted ...labored breathing continued ... At 11:45 this nurse did a full set of vitals (first vital signs obtained) BP 102/73, temperature 99.4, pulse 86 and respiration 22 ...due to increased temperature and continued labored breathing call was place to the MD (Z 2). An order was received to send the patient to ER (after four hours) . An ambulance service was called (not 911). The ambulance arrived at 1:00PM. On 04-30-15, Z1 (ENT (Ear, Nose and Throat Surgeon) history and physical showed an indirect laryngoscopy revealed a large right laryngeal tumor causing very poor visualization of the glottis and he also has a 4.0 cm right cervical lymph node ... a tracheostomy was inserted. On 06-17-15 at 11:45 AM, via phone, E3 described, " We were trying to help the patient (R1) because he was having difficulty breathing. The other staff (E2) loosened R1's tracheostomy collar. The patient was in 45-degree angle and the nurse (E2) undid the Velcro to check the stoma. The tracheostomy popped out. At the end or tip of the tracheostomy, there was a large mucous plug. The patient (R1) was having difficulty of breathing. I went and asked E2	F 309		

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F 309	Continued From page 2 because he said he knows tracheostomies. After the tracheostomy came out, we put in a new inner cannula, cleaned up the tracheostomy and put it back. The patient still breathing heavily, using abdominal muscles to breath. " On 06-17 15 at 11:15 AM, E 2 (Nurse/LPN) explained, " E3 (RN in charge) came to the second floor where I was working. She physically came and got me. She said she was having difficulty maintaining R1's oxygen saturation. It was below 90%. She told me when I did check it (pulse ox), it was 88%. She suctioned him (R1). The patient coughed and the tracheostomy came out. It is not normal for the tracheostomy to come out but it could happen... " On 06-18-15 at 1:40 PM via phone interview, Z1 /ENT (ear, nose and throat) /surgeon, "When I saw him in hospital, the tracheostomy collar was really loose. They (nursing home staff) should recognize the problem. They should recognize if the patient is not ventilating and the patient looks uncomfortable.. This could have been managed a little better. Calling 911 was a more appropriate thing when a patient is having respiratory problem. On 06-18-15 at 2:00 PM, Z1 said, " This situation is deemed as an emergency. The patient is in distress. I learned about the tracheostomy coming out from the hospital. It was after the fact. I did not know they called the ambulance. I recommended 911 because the patient (R1) was in distress."	F 309		