

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145259</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/23/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN PARK STRATHMOOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5668 STRATHMOOR DRIVE ROCKFORD, IL 61107</b>	
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F 000	INITIAL COMMENTS  Annual Licensure and Certification  Complaints: 0812258/IL35145 = F250 & F309 0812433/IL35347 = F157 & F309 0812443/IL35360 = F157 & F309  No extended survey was conducted.  VALIDATION SURVEY FOR SUBPART U: ALZHIEMER UNIT The facility is in substantial compliance with SUBPART U: Alzheimer Unit, 77 Illinois Administrative Code, Section 300.7000 for this survey	F 000		
F 157 SS=E	483.10(b)(11) NOTIFICATION OF CHANGES  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		6/19/08

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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F 157	<p>Continued From page 1</p> <p>or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify family of R16 and R20's change in condition in a timely manner. The facility failed to notify a physician of unplanned weight loss for R17 and R18. The facility failed to notify the physician and/or family of a change in resident's condition for R3 and R16.</p> <p>This applies to 6 of 24 residents sampled. (R3, R9, R16, R17, R18, R20)</p> <p>The examples include:</p> <ol style="list-style-type: none"> <li>1. The May 2008 Physician Order Sheets (POSs) show R16 is 57 year old male with diagnosis of Dementia, GERD, Glaucoma, Depression, Neurogenic Bladder, Constipation, Dysphagia, Pneumonia, and Huntington Chorea.</li> </ol> <p>R16's nursing note dated 05/06/2008 at 9:00 PM, states, "resident had lg [large] emesis of clear to brown tinted mucus. Requires frequent suctioning and has very sensitive gag reflex. TF [tube feeding] shut off in order to give his stomach time to settle down." Nursing notes</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>continue on 05/07/2008 at 4:00 AM, "TF remains off as res continued to have gagging emesis." Then, at 6:00 AM, "Resident had a huge emesis... unable to tolerate any tube feeding or meds [medications ordered by physician] this shift." On 05/07/2008 at 1:15 PM, over sixteen hours after tube feeding stopped, nursing notes document, "Talked to wife re: cond. [condition of resident] She will come out to see pt." Nursing note dated 05/07/2008 at 10:00 PM documents, "...order received to transfer to St. Anthony ER [Emergency Room] for evaluation." Nursing note dated 05/08/2008 at 6:00 AM states, "OSF called and informed (facility) resident was admitted to hospital." The Transfer sheet dated 05/12/2008 shows the primary diagnosis included aspiration pneumonia.</p> <p>On 5/20/2008 at 11:50 AM R16's wife stated I am not notified timely when there is a condition change. Two weeks ago on a Tuesday R16 was doing good during the day. Then, that night R16 became ill. I was not notified of his condition until 1:11 PM the next day. It was a Wednesday.</p> <p>On 05/22/2008 at 10:30 AM E2, Director of nursing stated, "I put a note in the front of R16's chart to notify R16 wife of all changes in condition."</p> <p>2. R20 is a 64 year old male resident with diagnoses of Dementia, Diabetes Mellitus, Coronary Artery Disease, Peripheral Vascular Disease, Right above the knee amputation, Left below the knee amputation and Chronic Obstructive Pulmonary Disease.</p> <p>On 2/15/08, the Nurses Note entered at 2030 PM, for R20 shows the "resident was having altered mental status, talking incoherently &amp;</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>running his electric chair into the wall. Resident was sweating profusely." The blood sugar obtained at that time registered "Lo" on the machine per the nursing note. The manufacturers booklet for the accu-check machine states the machine will read "Lo" if the result is lower than 20mg/dL. After several treatment interventions, the nurses note states E4 (Certified Nurse Practitioner - CNP) was notified.</p> <p>The Facility Policy and Procedure for "Hypoglycemia" lists specific symptoms that need reported immediately (example: perspiring, sweating excessively, personality changes, partially unconscious {stupor}, etc). Under section B. Procedure: number 12 states: "Should any of these conditions exist, report the diabetic resident's condition to the physician IMMEDIATELY." Neither the physician or the family were made aware of this change in the residents condition.</p> <p>On 3/11/08 at 1300 PM, a nursing note documents R20's blood sugar was 454 mg/dL and the nurse notified E4. R20's Physician Order Sheets (POS) dated 2/08, 3/08, 4/08 and 5/08 all contain an order for sliding scale insulin based on accu-check results. The order states if the blood sugar is "&gt;400 CALL MD". Neither the physician or the family were made aware of this change in the residents condition.</p> <p>On 3/27/08 at 1400 PM, the nursing note for R20 states "Resident ran increased B/S (blood sugar) today. S/S (signs and symptoms) given to R4 (CNP). . ." Neither the physician or the family were made aware of this change in the residents condition.</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>On 4/28/08 at 0140 AM, the nursing note documents "resident (R20) lethargic, skin diaphoretic and cool . . . CNP notified of low blood sugar . . ." Neither the physician or the family were made aware of this change in the residents condition.</p> <p>On 5/5/08 at 4:50 PM, the nurses note documents a hypoglycemic episode not responding to interventions on R20. The nurse called CNP and resident required transported to the hospital for evaluation and treatment. This nursing note shows R20's daughter was notified of this hypoglycemic episode and the daughter requested return phone calls on R20's condition. The physician was not made aware of this change in the residents condition.</p> <p>On 5/15/08 at 0615 AM, the nurses notes document a hypoglycemic episode for R20. The note shows an accu-check of 20 mg/dL at 05:00 AM. The resident was "drenched from head to toe". Repeat accu-checks documented were 27 mg/dL, 38 mg/dL and 89 mg/dL. The nurses note shows that when R20's accu-check was at 201 mg/dL, the CNP was "left a message . . .on voicemail." Neither the physician or family were made aware of this change in the residents condition.</p> <p>The Facility Policy and Procedure for Physician Notification of resident's condition or status change states the following; B. PROCEDURE: 1. The nurse will notify the resident's attending physician when: b. there is a significant change in the resident's physical, mental or</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>psychosocial status;</p> <p>f. deemed necessary or appropriate in the best interest of the resident;</p> <p>2. . .the nurse. . .will notify the resident's next-of-kin or responsible party . . .</p> <p>b. there is a significant change in the resident's physical, mental or psychosocial status;</p> <p>3. . . notification will be made within twenty-four (24) hours of a change . . .</p> <p>The facility uses Medstar Laboratories Inc. to obtain and report ordered laboratory diagnostics/values. Medstar's Normal Range for random blood sugars are 65-110 mg/dL.</p> <p>In a healthy person, autonomic (physical) symptoms of hypoglycemia (low blood sugar) begin when blood sugars reach 60 mg/dL. Impairment of brain function is manifested when blood sugars reach 50 mg/dL. Low levels can eventually lead to neuroglycopenia (interference with the brains metabolism producing confusion, agitation, coma, or brain damage.) (Source: Cecil's Textbook of Medicine, 21st Edition, Copyright 2000, Chapter 243.)</p> <p>During an interview on 5/22/08 at 10:00 AM, E4 stated R20 is a brittle diabetic and she has some problems with his "up and down sugars".</p> <p>3. R9's Medication Administration Record (MAR) identifies diagnoses to include: Chronic Obstructive Pulmonary Disease, Arthritis, Hypertension, Coronary Artery Disease.</p> <p>R9's nurses' notes document: "2/27/2008 1820, heard a bang in the bathroom and saw blood on the floor. Resident ambulating</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>independently, has a laceration 1.5cm on right side of her head with bleeding. Order received from E4 (Nurse Practitioner) to send to hospital. 4/12/2008 10:15, Fell in dining room doorway. States sick all over. E4 was made aware. 5/12/2008 1400, Ambulating, tripped over another resident's feet. Red area on cheek, slightly swollen. Hematoma over left eye brow. Ambulate to room. Notified POA, notified E4. 5/13/2008 Right eye purple and swollen. 5/13/2008 1800, Right eye still swollen and 'markedly' discolored. Complaints of pain. 5/15/2008 1800, Right eye still discolored, still restless, wandering about the dining room." For 5/16, 5/17, 5/18/2008 no nursing notes were documented.</p> <p>"5/19/2008, 0800, Resident asleep soundly. Lethargic. Responsive opening eyes et nodding. No medication given allowing resident to sleep. 1100, Resident non responsive unable to speak, open eyes despite many attempts to arouse her. 11:15 Noted shaking with hands drawn in toward body et closed. Temp 100.9, B/P 199/98, pulse 100, respirations 18, labored. Notified E4.</p> <p>Z3 (R9's POA) stated on 5/23/2008 at 9am, "I was not called, and no message was left when R9 fell and sustained the head injuries on 5/12/2008. I was not aware of her injuries until 5/19/2008 when she was sent to the hospital with diagnosis of Intercranial Hemorrhage. The nurse told me that since I live out-of-town, R9's locally residing family was called, not me, her POA on 5/12/2008."</p> <p>4. R3's MAR identifies diagnoses to include: Pneumonia, Thrombocytopenia, Dementia,</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>Arthritis.</p> <p>R3's nurses' notes document, "3/7/2008, 1500, Resident had shower. Today noted in past week dropping things most noted coffee. Noted today to let right arm hang, not using much and has bruising to right elbow and arm. Resident did state he had weakness. Talked to E4. E4 states this is part of his disease process and wanted to talk to son. 2100, Noted resident with right sided weakness. Weak hand grip, unsteady gait, Drops water glasses from right hand noted. E4 has been notified.</p> <p>Both R9 and R3 reside on the Alzheimer Unit. On 5/22/2008 at 8:45am E3 (Alzheimer Unit Director, Licensed Practical Nurse) stated, "We don't call the resident's physician when there is a change of condition, we call E4."</p> <p>5. R18 is a 45 year old resident whose diagnoses include Seizures, Quadriplegia, Gastric Esophageal Reflux Disease, Allergic Rhinitis, Closed Head Injury, and Severe Organic Brain Syndrome, according to the May 08 Physician Order Sheet (POS). The resident's Minimum Data Set of 5/8/08 shows that the resident receives his nutrition via tube feeding only. Monthly weight sheets show that the resident weighed 165.9 in 12/07. The resident has had a steady weight decline every month. On 5/22/08 the resident's weight is 154.3. According to the 2008 weight sheet, the</p>	F 157			

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F 157	Continued From page 8 physician was notified on 4/23/08 of the resident's weight loss. On 5/22/08 at 12:30 PM E2 (Director of Nursing) agreed that, according to the chart and weight record, the physician was notified only 1 time of the resident's continued weight loss.  6. R17 is a 69 year old resident whose diagnoses include Cerebral Palsy and Esophageal Reflux Disease, according to a 1/28/08 office visit. R18's 2008 Monthly Weight sheet shows that the resident has had a slow, continuous weight loss. In January 2008 the resident weighed 185.5 and in May 2008 the resident's weight is 175.6. The facility could not provide evidence that the physician had been notified of the weight loss.  The current Minimum Data Sets(MDS) for each of the above residents, R17 (MDS of 4/25/08) & R18 (MDS of 5/8/08) show that neither resident was on a planned weight loss program.	F 157			
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a resident got to her Oncology appointments, surgical referral appointment. The facility failed to ensure that a resident's Abdominal and Pelvic CT scans were done per physician orders.	F 250		6/19/08	

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F 250	<p>Continued From page 9 This is for 1 (R1) of 24 residents reviewed.</p> <p>The examples include:</p> <p>R1 is a 61 year old resident whose diagnoses include, Diabetes Mellitus, Hypertension, Depression, and Seizure Disorder, according to her 5/2008 Physician Order Sheet. A History and Physical of 9/27/07 shows that the resident has Ovarian Cancer with increasing ascites.</p> <p>On 5/13/08 at 4:00 PM, Z1 said that R1 was supposed to have an evaluation and possible surgical Debulking (at a university clinic/hospital). A hospital communication by Z4 dated 5/23/08, concludes by saying, "If surgical debulking is not completed (this should have been completed at the latest in early March) the disease will progress and her prognosis will be unfavorable." R1 was to have an appointment for an Abdominal and Pelvic CT scan on 2/20/08. R1 was also to attend 3 local Oncology appointments (4/17/08, 4/21/08, &amp; 4/24/08). The facility did not assist her to get to any of these evaluations/appointments. Z1 said that the facility told her there was no transportation available that could transport the resident to any of her appointments.</p> <p>Record Review (Clinic Visit note of 2/7/08) shows that R1 was supposed to have a CT scan scheduled around 2/20/08 and was to return to the office on 2/28/08 at 10:15 AM for evaluation of the CT scans. Nursing Notes of 2/7/08 at 3:45 PM shows that the nurse was aware of the physician orders. The Nursing Notes states, "New orders received...need to schedule CT of the Abdomen and Pelvis on or around 2/20/08 and return to the clinic on 2/28/08 for a follow-up</p>	F 250			

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F 250	<p>Continued From page 10 visit and CT results...". CT report shows that the test was not done until 3/5/08. The facility did not schedule a follow-up appointment to review the CT results.</p> <p>On 5/20/08 at 9:45 AM, E1 (Administrator) said that they called all of the area transport services for the resident's local and out of town appointments (surgical evaluation). E1 said that none of the services wanted to tie up their transportation units for residents receiving state funding. She said that their sister facility (same city) has a van, but they have difficulty being able to access it.</p> <p>On 5/21/08 at 2:45 PM, E2 (Director of Nursing) said, "I think we did all we could do to get the resident to her appointments". E2 said that they had not contacted the local Oncologist to see if he would come to the facility to see her. They also had not considered using staff to transport the resident to and from appointments. E2 said that in the past staff accompanied the resident to appointments when transferred by transport companies. The resident's 3/27/08 Minimum Data Set shows that the resident requires the limited assistance of 1 person when transferring from one surface to another.</p> <p>The 5/1/08 Progress Notes written by Z4 state, "Chemotherapy completed...however, the patient kept missing her appointments )she is mentally challenged and the institution did not make an appointment with (university clinic/hospital) for debulking surgery...with delay in surgery in spite of neo-adjuvant chemotherapy, this is the least the ascites may get...". On 5/23/08 at 11:30 AM Z4 said that the resident's abdominal ascites will not further improve without the surgery.</p>	F 250			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145259</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/23/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN PARK STRATHMOOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5668 STRATHMOOR DRIVE ROCKFORD, IL 61107</b>		
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F 250	<p>Continued From page 11</p> <p>Interview with Z2 on 5/21/08 at 10:00 AM, shows that the resident was seen at the local Oncology clinic on 2/7/08. The resident was to have a CT of the Abdomen and Pelvis at or around 2/20/08 and then to follow up in the office for the results of the scans of 2/28/08. Z2 said she called the facility on 2/26/08 to remind them that the CT needed to be done and that they should re-schedule the resident's appointment for 3 days after the test is done. Z2 said that on 4/17/08, R1 was scheduled to be seen at the local Oncology clinic. The resident did not show up for her appointment and the facility did not call to cancel the appointment. Z2 said that she called the facility and rescheduled the appointment for 4/21/08. Again the resident did not show up for the appointment and the facility did not call to cancel the appointment. Z2 then rescheduled the resident's appointment for 4/24/08. This time the facility called to cancel the appointment. Z2 said that the facility stated they could not find transportation to get the resident to and from her local and university clinic appointments. Z2 said that she spoke with the clinic Social Service department who contacted a local transport service. The service said that they would be willing to transport the resident within 100 miles (which would include the university clinic/hospital) if the following questions could be answered:</p> <ol style="list-style-type: none"> <li>1. Why is the patient going there?</li> <li>2. Can they be seen closer?</li> <li>3. Is there a medical need?</li> <li>4. Date and time of appointment.</li> </ol> <p>Z2 said that she contacted the facility and spoke with E5 (LPN) to relay this information. Z2 said that she was told, "We'll try, but no guarantees."</p> <p>Z2 said that the university clinic/hospital is the</p>	F 250			

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F 250	Continued From page 12 place that Z4 refers his patients to for this type of cancer, when requiring the debulking surgery (tumor reduction). She said that the standard of practice for this type of Ovarian Cancer is that the patient receives a round of chemotherapy, then the debulking surgery followed by another round of chemotherapy. Z2 said that the resident completed her first round of chemotherapy in 2/2008 and has not received any further treatment because of not getting to her scheduled appointments.  The facility's Appointment policy states, "...Assistance will be given to residents in need of arranging and scheduling appointments...". Step 2 of the procedures states that the facility will. "Arrange transportation as appropriate...". The facility's Transportation policy states, "The facility assists residents in arranging for transportation when such assistance is requested or needed".	F 250			
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		6/19/08	

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F 278	<p>Continued From page 13</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents skin condition.</p> <p>This is for 1 of 24 residents reviewed. (R5)</p> <p>The example includes:</p> <p>R5 is a 42 year old male resident with diagnoses of Paraplegia, Ventilator Dependency, and Diabetes Mellitus. R5 has an indwelling urinary collection device related to diagnoses of Neurogenic Bladder and Urinary Retention. R5 is bedfast most of the time and obtains most of his nutrition by a feeding tube.</p> <p>On 5/20/08 at 12:00 PM, R5 stated he had two pressure areas on his bottom. R5 said he has had at least one since December 2007 but obtained a new open area since that time. On 5/20/08 at 12:30 PM, E4 (Certified Nurse Practitioner - CNP) stated R5 has had pressure ulcers for 5-6 months.</p>	F 278			

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F 278	Continued From page 14 R5's dressing change was observed on 5/20/08 at 12:40 PM. Current dressings were saturated with sero-sanguinous drainage and had soaked the linens beneath the resident. Upon removal of the soiled dressings, 3 open areas were observed. Two stage II pressure ulcers to the left buttock draining bright red blood and one stage III pressure area to the left buttock draining copious amounts of sero-sanguinous fluid. R5 also was observed to have a stage II area to the prepuce of his penis with moist sero-sanguinous drainage.  The 10/22/07 Nutritional assessment documents a stage I pressure area to left buttocks for R5. A Nutritional assessment dated 11/23/07 shows R5 as having a "raw" left buttocks. A wound care sheet dated 11/22/07 documents a stage II pressure ulcer to the left buttocks. Nursing Notes and wound care sheets continue to show to the present date with various pressure ulcer and wounds identified and treated. (Including a stage IV pressure ulcer to R5's left hip). R5's MDS's dated 12/16/07 (quarterly) and 3/7/08 (annual) both score pressure ulcers at "0" reflecting no ulcerations.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		6/19/08	

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F 279	Continued From page 15  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a care plan for a resident with a peripherally inserted central catheter (PICC).  This applies to 1 of 24 residents reviewed. (R11)  The example includes:  Nursing notes show R11 returned from the hospital on 05/14/2008 with a PICC and the RN is flushing it.  On 5/20/2008 at 10:00 AM, R11 had a PICC line in the left arm.  On 5/21/2008 E1, (Administrator) and E2, (Director of Nursing) confirmed that there was no care plan for the maintenance of R11's PICC until 05/21/2008.	F 279			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.	F 281		6/19/08	

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F 281	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure R27s Physician order sheets (POs) were consistent with the Medication Administration Records (MARs). The facility failed to respond to R20s Hypoglycemic episode consistent with professional standards by giving a non-alert resident food by mouth.</p> <p>This applies to 2 of 24 residents reviewed (R20, R27).</p> <p>The examples include:</p> <ol style="list-style-type: none"> <li>1. The May 2008 Physician Order Sheets (POs) show R27 is a 53 year old female with diagnosis of Obesity, Hypotension, Hypothyroidism, Anxiety, Depression, Chronic Obstructive Pulmonary Disease, and Pneumonia. The May 2008 POS lists Sertraline (Zoloft) 3 -100mg half-tabs (150mg) by mouth daily. The May 2008 Medication Administration Record (MAR) lists Sertraline (Zoloft) 2-100mg half-tabs (100mg). The February 2008 POS shows an order dated 2/12/2008 to increase Zoloft to 150mg which was cancelled (with no date). POS's from March 2008 to May 2008 show an incorrect dose of Zoloft to be administered to R27.</li> </ol> <p>On 5/21/2008 at 11:00 AM E6, (LPN, Clinical Support Supervisor) stated, "The nurses review the MARs and POs and carry over changes each month." At 12:30 E1, (Administrator) stated, "we have new POs for May and pharmacy reviewed the changes; usually the night shift</p>	F 281			

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F 281	<p>Continued From page 17 nurses review the POSs and MARs."</p> <p>The 06/06 facility policy and procedure titled Change in Directions for Existing Medication Orders, shows the following: Purpose: To provide a safe, efficient and cost effective system of handling DIRECTION changes to medication orders and communicating these changes to the dispensing pharmacy. Procedure: 2. Transcribe the changed order on the POS and the MAR.</p> <p>The non-dated facility policy and procedure titled Monthly Review of Physician's Order, shows the following: Policy: It is the policy of (the facility) to have the nurse on duty for each unit review and ensure physician's order form, medication administration record, and treatment records reflect the most current medication orders. Nurses are to compare the physician order form medication administration record and treatment record and ensure they are identical to each other. Any discrepancy should be reported to the director of nursing or designee and communicated to the pharmacy.</p> <p>2) R20 is a 64 year old male resident with diagnoses of Dementia, Diabetes Mellitus, Coronary Artery Disease, Peripheral Vascular Disease, Right above the knee amputation, Left below the knee amputation and Chronic Obstructive Pulmonary Disease.</p> <p>On 2/15/08, the nursing note from 2030 PM documents, "Resident was having altered mental status by talking incoherently &amp; running his electric chair into the wall. Resident was sweating profusely. Blood sugar obtained to low to register on accu-check . . . juice &amp; pudding was given until resident became coherent . . ."</p>	F 281			

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F 281	Continued From page 18 At 1:30 PM on 5/23/08, Z6 (physician) stated it is common sense that an incoherent individual should not be fed. Nurses should be even more aware of the importance of not feeding incoherent individuals because they are knowledgeable of possible consequences such as aspiration, choking and blockage of the airway.	F 281			
F 309 SS=D	483.25 QUALITY OF CARE  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, record review, the facility failed to monitor and obtain treatment for one resident sustaining a head injury (R9), and failed to administer as ordered, a pretreatment medication, prior to chemotherapy for one resident (R1). The failure for R9 resulted in a delay in treatment for R9. R9 was admitted to the hospital on 5/19/08 (7 days later) with an intracranial bleed and was in critical condition.  This is for two of 24 residents reviewed.  The examples include:  1. Review of R9's Medication Administration Record records diagnoses of : Arthritis, GERD, Hypertension, Coronary Artery Disease. R9's nurses' notes document:	F 309		6/19/08	

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F 309	<p>Continued From page 19</p> <p>"5/12/2008,1400, Resident ambulating, tripped over another residents feet. Red area on cheek, slightly swollen. Hematoma over right eye brow. Ambulated resident to room. Notified E4 (Nurse Practitioner) notified. Orders given PRN Tylenol for pain. Neuro checks began.</p> <p>5/13/2008 1800, Right eye still swollen and markedly discolored, C/O of pain. Vicodin given 4pm and 9:50pm. "</p> <p>On 5/23/2008 at 9am Z3 stated, "I was not notified of R9's fall and head injuries."</p> <p>R9's nurses' notes continue: "5/14/2008 0530, Right eye (area) swollen and discolored. 1400, continue to have purple bruising circling around right eye. 5/15/2008 1800, right eye still discolored, still restless, wandering about dining room."</p> <p>There is no monitoring of R9's condition noted again until 5/19/2008.</p> <p>R9's nurses notes document: "5/19/2008 0800, Resident asleep soundly, lethargic, responsive opening eyes et nodding. No meds given allowing resident to sleep. 1100, resident non responsive, unable to speak, open eyes despite many attempts to arouse her. 1115, Noted resident shaking with hands drawn in toward body et closed. Temp 100.9, B/P 199/98, pulse 100. Z3 stated she does not want R9 to be sent to the hospital. "</p> <p>On 5/23/2008 at 9am Z3 stated, "Since she was unaware of the injuries acquired on 5/12/2008, she had temporarily made the decision not to send R9 to the hospital, but after staff informed</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>her about R9's head trama occurring on 5/12/2008, the cause of her present condition, she gave the ok to be sent to the hospital."</p> <p>Hospital records dated 5/19/2008 4:17pm show, Admitting Diagnosis of Intercranial Bleed with Midline Shift. Condition, Critical. A Hospital Result Review Report dated 5/19/2008 shows, CT Scan of the head reveals an acute on chronic intracranial hemorrhage with layering of blood. There is shift of the left cerebellar hemisphere into the right side of the skull. Final impression: Acute on chronic intracranial hemorrhage, Herniation.</p> <p>A Result Review Report dated 5/19/2008 show findings of, Left-sided hemispheric subdural collection has increased in size now having an acute hemorrhagic component, layering along the dependant aspect. Impression, Significant increase in size of the left subdural collection now with acutely hemorrhagic component. Significant associated mass effect and contralateral midline shift. Increased size of the right lateral ventricle. Decrease size of the chronic appearing right subdural collection.</p> <p>A Result review Report dated 5/19/2008 shows Impression, Massive intracranial bleed with midline shift. Hypertension, History of chronic subdural hematoma.</p> <p>2. R1 is a 61 year old resident whose diagnoses include, Diabetes Mellitus, Hypertension, Depression, and Seizure Disorder, according to her 5/2008 Physician Order Sheet. A History and Physical of 9/27/07 shows that the resident has Ovarian Cancer with increasing ascites.</p>	F 309			

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F 309	Continued From page 21 The Physician progress note of 10/7/07, written by Z4 shows that the resident was to begin chemotherapy. The order states that the resident is to receive Decadron 20mg 12 hours and 6 hours prior to receiving the chemotherapy. Nursing Notes of 10/12/07 show that the resident was to begin chemotherapy treatments on October 16, 2007. E7 documented, "Decadron 20mg (needs) to be given 12 hours and 6 hours by mouth prior to chemotherapy...".  Clinic Progress Notes of 11/6/07, written by Z4 show that the resident was to receive her 2nd chemotherapy treatment. The chemotherapy could not be given because the facility had not given the resident the premedication of Decadron. The resident was rescheduled for her 2nd dose of chemotherapy on 11/12/07. On 5/21/08 at 10:00 AM Z2 said that the Decadron is given prior to the administration of Chemotherapy to prevent a hypersensitivity reaction to the treatment.  On 5/21/08 at 10:00 AM, E2 (Director of Nursing) said that the nurses were not sure if the Decadron was to be given before each chemotherapy treatment. E2 agreed that the nurses should have called the physician for an order clarification if they were not sure.	F 309			
F 325 SS=D	483.25(i)(1) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.	F 325		6/19/08	

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F 325	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that residents (R17 &amp; R18) maintained their weight. R17 &amp; R18 had unplanned weight losses between December 2007 -April 2008 and between January 2008 and May 2008 respectively. R17 is solely fed by a feeding tube.</p> <p>This is for 2 (R17 &amp; R18) of 24 residents reviewed.</p> <p>The examples include:</p> <ol style="list-style-type: none"> <li>R18 is a 45 year old resident whose diagnoses include Seizures, Quadriplegia, Gastric Esophageal Reflux Disease, Allergic Rhinitis, Closed Head Injury, and Severe Organic Brain Syndrome, according to the May 08 Physician Order Sheet (POS). The resident's Minimum Data Set (MDS) of 5/8/08 shows that the resident receives his nutrition via tube feeding and that he is not on a planned weight loss program. Monthly weight sheets show that the resident weighed 165.9 pounds in 12/07. The resident has had a steady weight decline every month. On 5/22/08 the resident's weight was 154.3 pounds. There were no interventions in place between December 2007 and 4/23/08.</li> </ol> <p>R18's Tube Feeding Care Plan of 3/19/08 sets a goal that the resident will maintain his current body weight within 3 pounds by 8/8/08. The resident has lost 5.5 pounds since the implementation of the 3/19/08 care plan. One of the interventions is that the resident's weight will be monitored.</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145259</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/23/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN PARK STRATHMOOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5668 STRATHMOOR DRIVE ROCKFORD, IL 61107</b>		
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F 325	<p>Continued From page 23</p> <p>The last time the resident was seen by the dietitian was on 4/23/08. On 5/22/08 at 1:50 PM E1 (Administrator) and E2 (Director of Nursing) said that the resident's weights may not be accurate because they were having problems with their scales in February and March, 2008. E1 said that the dietician is in the facility at least monthly.</p> <p>2. R17 is a 69 year old resident whose diagnoses include Cerebral Palsy and Esophageal Reflux Disease, according to the 1/28/08 office visit. Review of R18's 2008 Monthly Weight sheet shows that the resident has had a slow, continuous weight loss. In January 2008 the resident weighed 185.5 pounds. In May 2008 the resident's weight is 175.6 pounds. R17's MDS of 4/25/08 shows that the resident is not on a planned weight loss program. The MDS documents that the resident has had a significant weight loss of 5% or more in 30 days or 10% or more in the last 180 days. The resident is not receiving any dietary supplements. The last time the resident was seen by the Registered Dietician was on 1/23/08.</p>	F 325			