

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

PRINTED: 10/02/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145555	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/29/2008
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 ST MARY DRIVE EDWARDSVILLE, IL 62025		
(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	F 000			
F 157 SS=D	<p>Complaint Investigation #0844383/IL37546</p> <p>An extended survey was not conducted.</p> <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>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).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative 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>	F 157			

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>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to notify the physician of an error in tube feeding administration for one of one residents reviewed receiving a tube feeding, R1.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on 1/30/07 with diagnoses, in part, of pulmonary insufficiency, respiratory arrest, tracheostomy, Downs syndrome and history of aspiration pneumonia. R1 had a physician order to receive continuous oxygen at six liters/minute via the tracheostomy and a gastrostomy tube feeding of Jevity 1.2 at 55 cc's per hour.</p> <p>According to the "Incident/Accident Report" dated 9/18/08 E5 (Licensed Practical Nurse) found R1 with his tube feeding running at 300 cc's per hour at approximately 12:00 AM. According to the nurses notes dated 9/18/08 E5 stopped the tube feeding. Residuals were checked and there were none noted. Oxygen saturation levels were 88%. There is no notation that the physician was contacted. At 2:00 AM the nurses notes stated that the tube feeding was restarted at 55 cc's per hour. At 4:00 AM the nurses notes states R1 was found with a large amount of yellow, liquid appearing emesis smelling fluid coming from trach, large amt diarrhea noted also. The tube feeding was again turned off. There is no notation that the physician was notified at that time. At 6:50 AM, according to the nurses notes, the hospice nurse was notified of the resident situation. At 7:00 AM the hospice nurse returned the call and told E5 to notify the physician. At 7:15 AM the physician was called but did not</p>	F 157			

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F 157	Continued From page 2 return the call until 8:25 AM. The nurses notes by E3 (Licensed Nurse) dated 9/18/08 noted that R1 was having thick cream colored emesis from nose, mouth et through trach, suctioned, -small amt emesis-only total. Oxygen saturation level was noted at 81%. The oxygen was turned up to 10 liters per minute and the oxygen saturation level was noted at 88%. At 8:25 AM the physician returned the call and ordered a chest x-ray, Reglan and hold other medications. In an interview with E5 on 9/29/08 by phone, she stated that she found the tube feeding at 300 cc's per hour at approximately midnight on 9/18/08. E5 confirmed that R1 vomited at approximately 4:30 AM on the 18th. E5 stated she did not call the physician until 6:00 AM on 9/18/08. In an interview with Z1 (Physician) on 9/29/08 by phone she stated that staff should have called her when the tube feeding rate error was discovered. Z1 stated that she did document that R1 had aspiration pneumonia on her 9/24/08 progress note, however, she stated it would be difficult with R1's history to determine if the tube feeding error caused the aspiration pneumonia as R1 had a history of excessive phlegm and vomiting.	F 157			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES 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	F 322			

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F 322	<p>Continued From page 3 possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide the correct tube feeding rate per the physician order for one of one residents reviewed receiving a tube feeding, R1.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on 1/30/07 with diagnoses, in part, of pulmonary insufficiency, respiratory arrest, tracheostomy, Downs syndrome and history of aspiration pneumonia. R1 is under hospice care. R1 has a physician order to receive continuous oxygen at six liters/minute via the tracheostomy and a gastrostomy tube feeding of Jevity 1.2 at 55 cc's per hour.</p> <p>According to the "Incident/Accident Report" dated 9/18/08 E5 found R1 with his tube feeding running at 300 cc's per hour at approximately 12:00 AM. According to the nurses notes dated 9/18/08 E5 stopped the tube feeding. Residuals were checked and there were none noted. Oxygen saturation levels were 88%. There is no notation that the physician was contacted. At 2:00 AM the nurses notes stated that the tube feeding was restarted at 55 cc's per hour. At 4:00 AM the nurses notes states R1 was found with a large amount of "yellow, liquid appearing emesis smelling fluid coming from trach, large amt diarrhea noted also". The tube feeding was again turned off. There is no notation that the physician was notified at that time. At 6:50 AM,</p>	F 322			

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F 322	<p>Continued From page 4</p> <p>according to the nurses notes, the hospice nurse was notified of the resident situation. At 7:00 AM the hospice nurse returned the call and told E5 to notify the physician. At 7:15 AM the physician was called but did not return the call until 8:25 AM.</p> <p>The nurses notes by E3 dated 9/18/08 noted that R1 was having thick cream colored emesis from nose, mouth et through trach, suctioned, -small amt emesis-only total. Oxygen saturation level was noted at 81%. The oxygen was turned up to 10 liters per minute and the oxygen saturation level was noted at 88%. At 8:25 AM the physician returned the call and ordered a chest x-ray, Reglan and hold other medications.</p> <p>In an interview with E4 on 9/29/08 by phone she stated that she had turned up the rate of the tube feeding pump to 300 cc's per hour at approximately 10:30 PM to bleed the line of tube feeding when she changed the tube feeding bottle. E4 confirmed that she forgot to turn the pump back to 55 cc's per hour. Attempts to restart the tube feeding were not successful as R1 was unable to tolerate the tube feeding. R1 is receiving comfort measures only with hospice.</p> <p>In an interview with E5 on 9/29/08 by phone, she stated that she found the tube feeding at 300 cc's per hour at approximately midnight on 9/18/08. E5 confirmed that R1 vomited at approximately 4:30 AM on the 18th. E5 stated she did not call the physician until 6:00 AM on 9/18/08.</p> <p>In an interview with Z1 on 9/29/08 by phone she stated that staff should have called her when the tube feeding rate error was discovered. Z1 stated that she did document that R1 had aspiration</p>	F 322			

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F 322	Continued From page 5 pneumonia on her 9/24/08 progress note, however, she stated it would be difficult with R1's history to determine if the tube feeding error caused the aspiration pneumonia as R1 had a history of excessive phlegm and vomiting.	F 322			