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GALESBURG TERRACE	1145 FRANK STREET GALESBURG, IL 61401

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F 465	Continued From page 31 11 AM to 11:50 PM on 8/2/10, black mold is present on the walls under peeling wallpaper around air conditioner units located under windows in resident rooms # D5, D7, D8, D9, D10, E1 and E3. Twelve residents (R51, R78, R43, R44, R45, R53, R71, R28, R66, R68, R76 and R77) lived in those rooms, according to the facility room roster presented by the facility on 8/2/10. Also on the tour, water present on the floor at the west end of the small storage plumbing crawls behind the wall of the Men's Common Shower Room. Black mold present on the drywall in this area behind the shower room for approximately six feet in length and two and one half feet above the floor. E28 stated at 11:30 AM that this leakage was from a wall-mounted toilet in the shower room on the other side of the wall. E28 stated that this toilet has leaked repeatedly, and that it apparently started doing it again last week while E28 was off work on medical leave. E28 also stated that the mold under the windows in the rooms mentioned above is most likely due to rainwater leakage through windows on areas of the building which had no rain gutters on the eaves in the past.	F 465		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1230c) 300.3240a) Section 300.1010 Medical Care Policies	F9999		

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F9999	Continued From page 32 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. Section 300.1230 Staffing c) It is the responsibility of each facility to determine the staffing needed to meet the needs of its residents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met, as evidenced by	F9999		

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F9999	Continued From page 33 the following: Based on observation, interview and record review, the facility failed to provide appropriate respiratory care for 4 of 9 residents reviewed for tracheostomy and/or ventilator care in a sample of 11 residents. (R59, R75, R80, R72) The facility nurse failed to connect oxygen therapy to the ventilator unit for R59. The facility nurses added additional aerosol tubing to R75's ventilator unit allowing a build up of carbon dioxide. The facility moved R72 off the respiratory care/ventilator unit to an intermediate care bed and failed to provide R72 with necessary monitoring and suctioning. R72's airway became obstructed and his oxygen saturation dropped. The facility's nursing and respiratory staff failed to perform ventilator checks and respiratory monitoring on two nights for 10 residents, 5 of 9 residents sampled for respiratory care on the selected sample of 11 (R59, R4, R18, R72, R80) and 5 residents on the supplemental sample. (R17, R62, R31, R11, R60) R80 was found hypoxic, in respiratory distress, with her tracheostomy tube out, and required insertion of a new tracheostomy tube, and transfer to the emergency room for initial evaluation and treatment before admission to the intensive care unit. Findings include: The facility has a respiratory care unit which on 07/28/10 had 12 ventilator dependent residents and 5 residents requiring tracheostomy care, per interview with E6 (Registered Nurse) at 4:40 p.m. on 07/28/10. In addition to the respiratory care unit, there is 1 resident (R72) requiring tracheostomy care and respiratory monitoring	F9999		

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F9999	Continued From page 34 residing on an intermediate care unit. 1. Hospital Discharge Order form dated 07/08/10 states that R75 was being sent back to the facility from a hospitalization from 07/05/10 - 07/08/10. This form states that R75 has been hospitalized with diagnoses of Carbon Dioxide Narcosis, pneumonia, congestive heart failure, diabetes, dementia, seizures, chronic obstructive pulmonary disease, and sleep apnea. This form instructs that R75 is to use the trach collar during the day and a ventilator with BIPAP (Bilevel Positive Airway Pressure) at night. On 08/02/10 at 10:30 a.m., R75 stated he had a tracheostomy tube with oxygen via tracheostomy mask. R75 stated that on the night he returned from the hospital there was a piece of tubing like his ventilator tubing and the nurse did not know what to do with it. R75 said that the head nurse came and did not know what to do with it either. R75 said "I told them where I thought it should go, but the next morning (E24-Respiratory Therapist) explained that that piece should never have been attached and I was lucky to be alive." On 07/28/10 at 4:40 p.m., E6 (Registered Nurse) stated that on 07/08/10 she came to work at 6:00 p.m. and worked until 6:00 a.m. (07/09/10). E6 said that R75 had returned from the hospital that day and that there was an extra piece of tubing in R75's room that R75 wanted connected to his ventilator. E6 said the extra piece of tubing was unfamiliar to her and she (E6) didn't know what it was. E6 said that she got E2 (Director of Nurses) to accompany her to R75's room. E6 said that she and E2 connected the extra piece of tubing to R75's ventilator tubing. E6 said that she found out later that they (E6 and E2) should not have	F9999		

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F9999	Continued From page 35 connected the extra piece of tubing, but received no explanation. On 07/29/10 at 10:22, E2, Director of Nursing stated that (on 07/08/10) R75 came back from a hospitalization and had an extra tubing with a little plastic jar that she (E2) had never seen before. E2 said this tubing was the same size as R75's ventilator tubing and that R75 said that the hospital told him he needed that (the tubing) for moisture. E2 said she asked R75 to wait for E24 (Respirator Therapist) to come in the next day, but he (R75) insisted. E2 said about what R75 said that "it made sense to me - but I'm not a Respiratory Therapist." E2 said that the tubing fit into the ventilator tubing so she (E2) and E6 attached it to R75's ventilator tubing at about 10:00 p.m. E2 said the next morning (07/09/10) when she arrived at work she saw E24 (Respiratory Therapist) who told her that he (E24) saw R75's set up (ventilator) and that he (R75) could have died. E2 said that E24 explained that by adding to R75's ventilator tubing, this created dead air space in the closed system and that R75 was rebreathing his own carbon dioxide all night. E2 said that she and E6 should have called the on-call Respiratory Therapist or R75's pulmonologist. E2 said that R75's pulmonologist was not notified of this incident. On 08/02/10 at 8:30 a.m., E24 (Respiratory Therapist) said that on the morning of 07/09/10 he went in to take R75 off the ventilator and a long piece of aerosol tubing was hooked in with his ventilator circuit. E24 said that this created 400 - 500 cc (cubic centimeters) of extra dead space, so that R75 was rebreathing his exhaled air. E24 said that one reason R75 is on the	F9999		

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ventilator at night is to blow off the carbon dioxide. E24 said that R75 was a little lethargic that morning. E24 said that E2 and E6 should have known that it was wrong to add the tubing, and should have called him (E24). E24 said that the potential for rebreathing exhaled air on the closed ventilator circuit could result in increased carbon dioxide and throw off the pH (measure of the acidity or basicity of a solution) which could result in coma.

The Respiratory Care Competency Assessment form states that the facility hired E2, Director of Nursing on 11/01/2004. This form documents that E2 completed the competency requirements regarding respiratory, tracheostomy and ventilator care on 12/15/04. E2 stated that E6 was rehired on 06/21/10. The Respiratory Care Competency Assessment forms state that the facility originally hired E6 on 03/30/07 and E6 completed competency regarding tracheostomy care, suctioning, and ventilator care on 04/04/07. The surveyor requested (to E2 on 07/30/10) any additional training, updating, or inservice records regarding respiratory care and/or ventilator care for E2 or E6 since their initial training, and none were provided.

Nurses notes dated 07/08/10 at 6:30 p.m., state that R75 returned from the hospital, but do not include any documentation regarding R75's tracheostomy, respiratory status or ventilator. Review of R75's clinical record includes no documentation regarding the connection of extra tubing to R75's ventilator. On 08/05/10 at 10:00 a.m., E2 (Director of Nurses) verified that there was no documentation in R75's clinical record regarding the error made with his ventilation tubing on 07/08/10. E2 stated she would make a

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late entry in R75's nurses notes. E2 stated that neither R75's pulmonologist nor physician was notified regarding the error. E2 stated that no incident report was written, that she (E2) "didn't look at it as an incident - I suppose I should have." E2 stated she did an investigation, but "didn't' write anything up."

On 08/04/10 at 8:20 a.m., Z2 (Pulmonologist) verified that adding tubing to the ventilator circuit would increase the carbon dioxide. Z2 stated that they were lucky this time, but that they (E2 and E6) should have called the Respiratory Therapist if they had any questions. Z2 stated that this is not something to guess at, it is a concern. Ventilator and respiratory systems are serious and a mistake could cause death.

2. History and physical dated 07/19/10 states that R59 has diagnoses including a history of multiple fractures of the cervical spine, quadriplegia, chronic respiratory failure with tracheostomy and ventilator dependent, cerebral palsy, gastrostomy tube dependency, chronic obstructive pulmonary disease and seizure disorder. This form states that R59 is to use the ventilator at night with an FIO2 (fraction of inspired oxygen) of 50% and a tracheostomy hood with oxygen enrichment during the day at 50% oxygen.

On 07/29/10 at approximately 11:00 a.m., R59 was in a room marked "Isolation," up in a wheeled recliner. R59 had a tracheostomy present connected to a trach mask with oxygen, tube feeding formula infusing via a gastrostomy tube, and a supra pubic catheter. R59 receives intravenous antibiotics via Mediport.

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F9999	Continued From page 38 On 07/28/10 at 3:45 p.m., E37 (Respiratory Therapist) stated that earlier this month (July 2010 she could not state exactly which night)) E6 (Registered Nurse) was working the evening and night shifts as the respiratory nurse on the respiratory care/ventilator unit. On this night E6 failed to connect R59's oxygen to his ventilator when she transferred R59 from his trach mask to the ventilator. E37 stated that when E6 did the 1:00a.m. (07/09/10) ventilator check R59's pulse oxygen had dropped to 92%. E37 stated that R59's pulse oxygen levels are usually 97% - 98%. E37 said that E6 should have picked up on this drop and rechecked everything to determine the cause. E37 stated that R59's 5:00 a.m. (07/09/10) pulse oxygen saturation level was not done and R59 remained without oxygen until E24 (Respiratory Therapist) came in the next morning. On 07/28/10 at 4:40 p.m., E6 stated that she came in at 6:00 p.m. (07/08/10) and worked until 6:00 a.m. (07/09/10). E6 said that she put R59 on the ventilator around 9:00 p.m. E6 stated that she did not connect R59's oxygen to his ventilator, stating that she "overlooked it." E6 said that she checked R59's vent and pulse oxygen saturation every 4 hours and did not realize any problem. E6 said she did not know about R59 not receiving his oxygen until a later date when she worked. The Respiratory Therapy Flow sheet documents at 10:00 p.m. on 07/08/10 that R59 was on the ventilator is in CPAP (Continuous positive airway pressure) mode with oxygen at 5 liters and his pulse oxygen saturation at 92%. E6 documents on this form on 07/09/10 at 1:00 a.m. and 5:00 a.m. that R59 was receiving oxygen via his ventilator. There is no pulse oxygen level	F9999		

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F9999	Continued From page 39 documented at 5:00 a.m. On 08/02/10 at 8:30 a.m., E24 (Respiratory Therapist) stated that on 07/09/10, he arrived at the facility around 7:00 a.m. E24 said that when he initially checked R59, his (R59's) pulse oxygen was low at 92% which he (E24) thought was odd. E24 stated he then found R59's oxygen mask still connected to the oxygen tubing and not connected to his ventilator. E24 said that the oxygen was still set at 8 liters which is the rate used when R59 is on the tracheostomy mask. E24 said the oxygen flow rate should be set at 5 liters when R59 is on the ventilator. E24 said that R59 is a spontaneous breather and has his ventilator on CPAP mode. E24 said that R59 was not in respiratory distress, but that if this had happened to a resident on SIMV (Synchronized Intermittent Mandatory Ventilation) the outcome may have been worse and mistakes like this should not happen. E24 stated he discussed his concern with E2 (Director of Nurses) and later with E53 (Administrator) On 08/02/10 at 11:00 a.m., E2 stated that she was told about R59 not being hooked up to his oxygen on his ventilator all night and stated that R59's doctor was not notified of this error. R59's clinical record including the nurses notes dated 07/08/10 and 07/09/10 do not include any documentation regarding the failure to connect oxygen to R59's ventilator. On 08/05/10 at 10:00 a.m., E2 verified that there was no documentation regarding the failure to connect oxygen to R59's ventilator or the failure to discover this error during ventilator checks throughout the shift. E2 stated R59's physician and pulmonologist were not notified of this error.	F9999		

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E2 stated that no incident report was completed, stating that she did not look at the failures regarding R59's oxygen and ventilator to an incident, but stated, "I suppose I should have." E2 stated that she did an investigation, but did not write anything up.

E2 stated that E6 was rehired on 06/21/10. The Respiratory Care Competency Assessment forms state that E6 was originally hired 03/30/07 and was checked off on competency regarding tracheostomy care, suctioning, and ventilator care on 04/04/07. The surveyor requested (to E2 on 07/30/10) any additional training, updating, or inservice records regarding respiratory care and/or ventilator care since E6 was originally trained, and none were provided.

On 07/29/10 at 3:50 p.m., Z1 (Pulmonologist) stated that anyone on a ventilator should receive oxygen. Z1 said that it (not connecting oxygen to the ventilator) is not an acceptable situation and should never happen. On 08/04/10 at 8:20 a.m., Z2 (pulmonologist) stated that for a resident to not have oxygen connected to his ventilator is a serious problem.

3. History and Physical from hospitalization of 03/29/10 states that R72 has diagnoses including chronic obstructive pulmonary disease with respiratory failure, ventilator dependence, pneumonia, and Methicillin Resistant staphylococcus aureus. This form states that R72 had several mucus plugs and needed bronchoscopies about 3 - 4 times to loosen up the mucus plugs.

On 07/28/10 at 2:30 p.m. and on 07/29/10 at 9:30 a.m., R72 was in bed in an intermediate care

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level room. R72 was in isolation and had a tracheostomy with oxygen via tracheostomy mask. R72 receives tube feeding via gastrostomy tube.

Nurses note dated 07/23/10 6-2 shift (no specific time documented) states that R72 was stable on the tracheostomy mask and his gastrostomy tube was patent, and was moved to A hall.

On 8/02/10 at 8:30 a.m., E24, Respiratory Therapist stated that R72 had been ventilator dependent and had been recently weaned off the ventilator, about a month ago. E24 said that R72 still needed to be watched closely and suctioned frequently. E24 said that he was not consulted about moving R72 off the respiratory unit to an intermediate level bed. E24 stated that when he heard about R72's move, he voiced his concerns to E2 telling her "it was a bad idea." E24 said that most of the nurses that work the intermediate care area have not been trained in respiratory care or signed off on competency for respiratory, tracheostomy, and ventilator care.

On 07/29/10 at 10:22 a.m., E2 stated that the decision to move R72 off the respiratory unit was made by her, E53 (Administrator), E9 (Licensed Practical Nurse, Care plan coordinator), E42 (social service designee, activity director, medical records), and E40 (Licensed Practical Nurse, Infection control). E2 stated that the Respiratory Therapist and the nurses working respiratory care should have followed R72 and seen him on A hall.

On 07/28/10 at 3:45 p.m., E37 (Respiratory Therapist) stated she did not know that R72 had been moved to A hall until late in the shift when

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the intermediate care floor nurse called and asked if she would suction R72. E37 said she did go over and suction him (R72), but would have checked on R72 and suctioned him sooner, if she had known R72 was there.

Respiratory Therapy flow sheets dated 07/11/10 - 07/22/10 (while R72 was on the respiratory unit) document that R72 was checked every four hours. These Respiratory Therapy flow sheet document that R72 required frequent suctioning and was suctioned between 6 and 9 times a day from 07/19/10 - 07/22/10.

On 07/22/10 the day before R72 was transferred to the intermediate care room, he (R72) required suctioning seven times. The Respiratory flow sheets document that R72 was checked once on 07/24/10 at 8:30 a.m. and suctioned twice at 8:30 a.m. and 11:30 a.m. On 07/25/10, the Respiratory flow sheet states that R72 was checked and suctioned at 1:00 a.m., 8:30 a.m., and was suctioned at 11:30 a.m. The nurses notes dated 07/25/10 2 p.m. - 10 p.m. shift (no specific time indicated) state that R72 had an oxygen saturation of 94% and was stable and suctioned one time. The nurses notes contain no entry for third shift on 07/25/10 and there is no documentation that R72 was monitored or suctioned after the undocumented time on second shift. There is no entry from 07/25/10 at 11:30 a.m. until 07/26/10 at 7:30 a.m., twenty hours later.

On 07/26/10, the nurses notes state that at 7:30 a.m., R72 was complaining of difficulty breathing and his oxygen saturation was 68%. This nurses note states that R72 was suctioned, lavaged, and Ambu bagged, and that his oxygen saturation

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F9999	Continued From page 43	F9999		

was brought up to 95%. The nurses notes include no further monitoring of R72 on the day shift. The next entry is on 07/26/10, 2-10 p.m. shift (no specific time documented) when R72's pulse oxygen level is 97% and no distress is noted. The respiratory flow sheet documents that R72's respiratory status was checked on 07/26/10 at 7:30 a.m. and the next check was twenty hours later at 11:00 p.m. (07/26/10), but that R72 required suctioning at 9:30 a.m., 12:00 p.m., and 1:30 p.m.

On 08/05/10 at 3:35 p.m., E2 stated that neither R72's attending physician nor pulmonologist had been notified of R72's condition on 07/26/10, because they were able to get his (R72's) pulse oxygen saturation level back up.

On 08/04/10 at 8:20 a.m., Z2 (Pulmonologist) stated that he was not consulted regarding moving R72 off the respiratory care unit. Z2 stated that R72 should remain on the respiratory care unit. Z2 said that R72 requires frequent suctioning and close monitoring.

4. Nurses notes dated 06/17/10 document that R80 was admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, tracheostomy, and pulmonary hypertension.

On 06/19/10, 2:00 a.m. - 10:00 p.m. shift (no specific time entered), nurses notes document regarding R80's anxiety and medication, gastrostomy tube and feedings, urinary catheter, and that R80 is in no distress. This nurses note does not include any documentation of R80's tracheostomy, need for suctioning, or respiratory status. Nurses notes include no documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145987	A. BUILDING _____ B. WING _____	C 08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALESBURG TERRACE	1145 FRANK STREET GALESBURG, IL 61401

(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 44 for the third shift 10 p.m. - 6:00 a.m. on 06/19 -20/10. Nurses note dated 06/20/10 at 7:40 a.m., states that nurse was doing rounds and that R80 had pulled her tracheostomy tube completely out. This note states that R80's pulse oxygen saturation level was 88% and her heart rate was 130. The Respiratory flow sheet documents that R80 was monitored at 1:00 a.m. on 06/20/10 and had an oxygen saturation of 95% and a heart rate of 110. There is no documentation until 06/20/10 at 7:40 a.m. Staffing forms dated Friday, 06/18/10, document that after 2:00 a.m. (06/19/10) there were only two nurses available in the facility, one assigned on the house (intermediate halls) and one assigned on vents (ventilator residents). The staffing form for Saturday, 06/19/10 also states that after 2:00 a.m., there were only two nurses available in the facility. The next entry is at 7:40 a.m., when E37 documents that she came into the room and R80 had pulled out her tracheostomy tube. E37 documents (on the respiratory flow sheet) that R80's oxygen saturation was 78% and her heart rate was 141. E37 documents that she inserted a new tracheostomy tube and suctioned R80 three times. E37 documents that R80's heart rate was still 130 and her pulse oxygen saturation was up and down 88-94. E37 documents that ten minutes later R80 was groggy, sleepy and not answering questions. On 08/03/10 at 2:49 p.m., E37 stated that she	F9999		

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F9999	Continued From page 45	F9999		

came in the morning of 06/20/10 at 6:00 a.m. and began doing ventilator checks . E37 said at 7:40 she was called to R80's room and R80's tracheostomy tube was out. E37 said there was "no way of knowing" how long R80's tracheostomy tube had been out. E37 said that there had only been one nurse on duty that night. E37 said that one nurse can only do the bare necessities and cannot give good care.

Nurses notes dated 06/20/10 at 8:05 document that Z1 (Physician) was notified and ordered R80 to be sent to the Emergency room. Hospital History and Physical report dated 06/20/10 states that R80 was brought to the emergency room after a tracheostomy tube came out and had to be replaced. This report documents that R80 was still hypoxic in the low 80's (oxygen saturation) and in respiratory distress. This form states that R80 was noted to have a nursing home acquired pneumonia and was admitted to the intensive care unit.

5. Respiratory care flow sheets for R18, R72, R17, R4, R31, R11, R60, R59, and R62 were left blank or have documentation stating that no one was available to provide monitoring and respiratory care and /or ventilator checks at 5:00 a.m. on 06/19/10 and 06/20/10.

On 08/03/10 at 2:49 p.m., E37 stated that she came in at 6:00 a.m. on 06/19/10 and 06/20/10 and that she had written on the respiratory care flow sheets "no one available" for the 5:00 a.m. checks, because no one was available from 1:00 a.m. to 6:00 a.m. when she came in. E37 said that she (E37) was very upset that only one nurse was on duty to provide both the nursing care and respiratory monitoring and care. E37

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F9999	Continued From page 46 said this is not manageable, one nurse can only provide the bare necessities and can not give good care. On 08/04/10 at 5;40 a.m., E57 (Registered Nurse) stated that the facility is staffed with three nurses at night. E57 stated that one nurse covers the four intermediate halls, one nurse works the as the skilled nurse for the respiratory/ventilator unit and one nurse is the respiratory nurse for the respiratory/ ventilator unit. E57 stated that in June, there were two night shifts (06/18/10 and 06/19/10) when he (E57) was assigned to both the nursing duties and the respiratory nurse duties from 2:00 a.m. until day shift arrives at 6:00 a.m. E57 stated that this is not a manageable work load. E57 said that both the nurse assigned for the nursing duties and the nurse assigned for respiratory are busy and running to complete all that they need to do. E57 stated that the nurse on the intermediate care halls is too busy and cannot help on the respiratory unit. E57 said that it takes at least an hour to do the ventilator/respiratory care checks. E57 stated that he did not do the 5:00 a.m., checks on the mornings of 06/19/10 and 06/20/10. E57 stated he was running as fast as he could to do all the breathing treatments, blood glucose checks, pass medications, and suctions residents and there was no way to get the ventilator/respiratory care checks done. E57 said that the facility needs two nurses on the respiratory care/ventilator unit at night. E57 said it is unsafe (to only have one nurse), that anyone can crash anytime (their condition can dramatically decline quickly). E57 stated that E2 (Director of Nurses) knew and did not care that he was alone, and no one came to help him. On 08/05/10 at 3:35 p.m., E2 stated she was aware	F9999		