Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI/		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
				A. BUILDING:						
IL6		IL6003529		B. WING		C 08/21/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
ALEDO REHAB & HEALTH CARE CENTER  304 S.W. 12TH STREET  ALEDO, IL 61231										
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DEFICIENCY)  (X5)  COMPLETE DATE					
S 000 Initial Comments				S 000						
	Complaint Investiga	ation								
	#2024048/IL123239	)								
S9999	9 Final Observations			S9999						
	Statement of Licens 1 of 1 violation	sure Violation:				N:				
	300.610a) 300.1210b) 300.1210d)1)2)3)									
	Section 300.610 Resident Care Policies		;							
	procedures governing facility. The written be formulated by a formulated by a formulated by a formulated consisting administrator, the admedical advisory coof nursing and other policies shall comply. The written policies the facility and shall by this committee, do and dated minutes of the consistency of the procedure of the consistency of the procedure of the	dvisory physician or the mmittee, and representate services in the facility. The with the Act and this Parshall be followed in operate be reviewed at least annulocumented by written, signs the meeting.  General Requirements for	y the shall lives he rt. ating ually gned		Attachment A Statement of Licensure Vic	<b>Nations</b>				
	tmont of Public Health				<del></del>					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 10/28/2020 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6003529 08/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **304 S.W. 12TH STREET ALEDO REHAB & HEALTH CARE CENTER** ALEDO, IL 61231 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 The facility shall 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 resident care plan. 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. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Objective observations of changes in a 3) resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect An owner, licensee, administrator. employee or agent of a facility shall not abuse or

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING IL6003529 08/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **304 S.W. 12TH STREET ALEDO REHAB & HEALTH CARE CENTER** ALEDO, IL 61231 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on record review and interview, the facility failed to promptly identify a change in condition and notify the Physician for one of three residents (R3) reviewed for change of condition in a sample of eight. This failure resulted in a delay of R3 being sent to the local hospital and a delay in treatment for R3's heart attack, therefore worsening R3's condition and requiring hospitalization of R3. Findings include: R3's Profile Face Sheet, undated, documents that R3 admitted to the facility on 9/7/19. Facility Oxygen Policy, Revised 3/19, documents that. "Oxygen therapy may be used provided there is a written order by the Physician. The order must state liter flow per minute, mask or cannula, time frame. On an emergency basis, oxygen may be administered until the Physician is notified." Facility Notification of Change in Resident Condition or Status Policy, Revised 12/7/17.

Illinois Department of Public Health

documents that: The facility and/or facility staff shall promptly notify appropriate individuals (i.e.,

Administrator, Director of Nursing/DON. Physician, Guardian, Health Care Power of Attorney, etc.) of changes in the resident's medical/mental condition and/or status; The nurse supervisor/charge nurse will notify the

PRINTED: 10/28/2020 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6003529 08/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **304 S.W. 12TH STREET** ALEDO REHAB & HEALTH CARE CENTER ALEDO, IL 61231 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 3 S9999 resident's attending Physician or on-call Physician when there has been any symptom, sign or apparent discomfort that is sudden, a marked change or unrelieved, a significant change in the resident's physical/emotional conditions, a need to alter the resident's medical treatment significantly or instructions to notify the Physician of changes in the resident's condition; The nurse supervisor/charge nurse will notify the DON or Physician, unless instructed by the resident representative, when the resident has any of the aforementioned situations; And the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status. R3's Nursing Note, dated 3/29/20 at 10:00 am. documents that oxygen was started at one liter per nasal cannula for a low oxygen saturation (88 percent). R3's Nursing Note, dated 3/29/20, at 6:18 pm. documents that R3 was on two liters of oxygen. and had an oxygen saturation of 90 percent. heart rate of 100 to 130, blood pressure of 100/54 and respirations of 36. It also documents that R3 had faint, muffled heart sounds, severe shortness of breath and that R3 was sent via ambulance to the local hospital. R3's Physician Orders, dated 3/1/20 through 3/30/20, do not document an order for Oxygen, liter flow per minute, mask, cannula or time frame or a medication for anxiety. R3's Medication Administration Record/MAR. dated 3/29/20, does not document Oxygen administration, flow rate, mask or cannula or time frame or as needed medication for anxiety.

Illinois Department of Public Health

PRINTED: 10/28/2020

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6003529 08/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **304 S.W. 12TH STREET ALEDO REHAB & HEALTH CARE CENTER ALEDO, IL 61231** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 On 8/19/20, at 9:59 am, V15/LPN stated, "(R3) asked me to call her Granddaughter because (R3) felt anxious and was having trouble breathing. (R3's) Granddaughter arrived at the facility around 10:00 am. (R3's) Oxygen saturations were low so I started her on Oxygen. She had anxiety sometimes and only had low oxygen saturations, so I did not think she was unstable enough that she needed to go to the hospital. I gave her Anxiety medication and put the oxygen on her and her oxygen saturation level came up. (V16/Nurse) sent her (R3) out just as I was leaving my shift. I did not fax or call the Doctor to notify him that I started her on oxygen or her change of condition." On 8/21/20, at 9:00 am, V15 stated, "I did not give her (R3) any anxiety medication. I must have given her only scheduled medication. I did not do anything for anxiety." On 8/19/20, at 10:20 am, (V16/Nurse) stated, "I came onto shift at 6:00 pm and (R3's) Granddaughter caught me, first thing, coming down the hallway and asked me to come assess (R3). (R3) had a very high heart rate and labored breathing. Her condition warranted me to call the Doctor and he said to send (R3) out to the Emergency Department. I had to convince her to go out, she did not want to go. She was not having any pain, just her vital signs and breathing were bad." R3's "A.I.M. for Wellness," dated 3/29/20 at 6:30 pm, documents that R3's Physician was notified.

Illinois Department of Public Health

via electronic facsimile, that R3 had pain in chest. started on oxygen and "very short of breath this a.m. (morning)," and "very short of breath now."

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	IL6003529	B. WING			C 08/21/2020	
NAME OF PROVIDER OR SUPPLIER  ALEDO REHAB & HEALTH CAP	RE CENTER 304 S.W.	12TH STREE	TATE, ZIP CODE T			
	ALEDO, I	L 61231				
PREFIX (EACH DEFICIENCY I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETI DATE		
documents that R3 with a diagnoses incl heart attack (Myocard 2:38 am, the facility rithe hospital that R3 his land and she was stream that (R3) had a bid her oxygen was low high and she was stream to come as the told me she was until (V16/Nurse) can and immediately sent hospital. I kept telling (V15/Licensed Praction needed to go to the high just anxiety and that the not let me in anyway, not go. (V16) called the could go with her, so Room Doctor asked in to send her in and tolhad had a bad heart a give any anxiety medifor that matter, to help already on oxygen when the condition. I am findin overriding sending out hospitals, they are justice.	lated 3/29/20 at 9:00 pm, vas admitted to the hospital luding pneumonia and a dial Infarct/MI).  I documents on 3/30/20 at received a phone call from had expired.  am, V14 (R3's Family/POA) me around 10:00 am and told ad spell around 5:00 am. (88 percent), her pulse was uggling to breathe and that o struggle to breathe. She and see her, so I went and dying. I was there all day ne onto shift around 6:00 pm ther by ambulance to the githe day shift nurse cal Nurse/LPN) that (R3) hospital but she said it was the hospital probably would due to COVID, so we did he hospital and they said I we went. The Emergency me why they waited so long dime it was too late, that she attack. I did not see (V15) ication or any medication, p my Grandma. She was nen I got there."	S9999				

PRINTED: 10/28/2020 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ COMPLETED C B. WING\_ IL6003529 08/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **304 S.W. 12TH STREET ALEDO REHAB & HEALTH CARE CENTER** ALEDO, IL 61231 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 have been notified earlier in the day of her vitals. difficulty breathing and need for oxygen, I would have sent her to the hospital and it may have changed her outcome." (A)

Illinois Department of Public Health STATE FORM