Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigation 1993022/IL111661	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	**Attachment A** **Statement of Licensure Violations**	

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a 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

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to immediately transfer a resident to the hospital after noticing a significant change in the resident's level of consciousness for one of three (R1) residents reviewed for significant change of condition in a total sample of 11. This failure resulted in R1 waiting in the facility unresponsive for approximately 55 minutes before being transferred to the local hospital where R1 was pronounced brain dead after suffering a stroke.

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Findings Include:

Per the facility Facesheet, R1 is a 65 year old with the following diagnosis: cerebral infarction, hemiplegia affecting the left side, atherosclerosis of the aorta, and hypertension. The Minimum Data Set (MDS) dated 4/14/19 documents R1's Brief Interview for Mental Status (BIMS) score is 15 (no cognitive impairment).

A Nursing note dated 4/24/19 documents at approximately 5:10AM while trying to administer medications, R1 was observed lying in bed, sleeping. R1 not responsive to a pat on the shoulder. R1 verbally unresponsive, not easily aroused. Sternal rub given and still no verbal response. Resident looks peacefully asleep. Vital signs and blood sugar obtained. All normal except increased respiratory rate of 22 (normal rate 12-20). Respirations unlabored. The doctor was called at 5:15AM but did not respond. The ambulance was called at approximately 5:16AM with estimated arrival time of 30 minutes. The Director of Nursing (DON) was called at 5:17AM and made aware of R1's condition. The DON assessed R1 upon arrival. The doctor was called again at 5:41AM and left a voicemail. Occasionally R1 will move extremities; crossing legs and arm across chest over other arm. Paramedics arrived at approximately 5:45AM. Paperwork prepared for paramedics while they were in R1's room. A few minutes after the nurse went over to R1's room to find out what was taking so long. Paramedic was observed trying to start an intravenous (IV) catheter and was unsuccessful. R1 observed with multiple taped gauzes on arms of failed IV attempts. Paramedics were advised to leave facility with R1. Prior to finding R1 in current condition, the nurse completed every two hour checks. R1

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easily awakened on one occasion, and R1 asked the nurse in Spanish "What's going on?"

The Ambulance Run Sheet dated 4/24/19 documents the facility called the ambulance company at 5:22AM and arrived at R1 ' s bedside at 5:54AM. The crew was met at the first floor nurse's station by the nurse and the nurse stated (with attitude) "Room ***. Just go there." The crew asked what was going on with R1 and for paperwork. The nurse responded, "Just get R1 out of here." Upon arrival to R1's room, R1 found lying in the bed unresponsive to verbal and sternal rub. R1's oxygen level low at 89% and apneic with respirations 28-30. R1 placed on oxygen via nasal cannula at 3 liters. IV attempted twice on R1 but unable to obtain due to the nurse rushing the crew out the door. The nurse did not want the crew providing Advanced Life Support (ALS) in the building. The crew asked the nurse for R1's medical history, but the nurse refused to answer. The crew asked the nurse again for R1's medical history, and the nurse stated "cerebral palsy" (with an attitude). The crew still has no information on R1 at this point. The crew asked the nurse why 911 was not called, and the nurse remained silent. The nurse finally gave the crew R1's information as the crew was leaving the building. During transport to the hospital, R1 went into full cardiac arrest and cardiopulmonary resuscitation (CPR) was started.

A Nursing note dated 4/24/19 documents the hospital emergency room called, and the nurse stated R1 is likely to go up to the intensive care unit due to cardiac arrest. R1 admitted to the hospital.

The Hospital Records dated 4/24/19 document R1 was in the nursing home and apparently fine

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last night, but this morning he was unable to be woken up. R1 arrested in the ambulance and was given CPR. The CT scan of the brain showed a brain bleed involving the entire brain and the brain stem. R1's pupils are fixed and fully blown with no light response at all. No gag reflex or response to painful stimuli.

On 5/2/19 at 2:17PM, V4 (LPN) stated, "R1 was fine all night long when I would say probably around 5:10 in the morning I went to give R1 medication, but R1 wouldn't wake up. R1 looked just like R1 was sleeping. I almost didn't want to wake R1 up but I decided to try and when I patted R1's shoulder, R1 didn't respond to me. I started to shake R1 harder and sternal rub R1, but R1 still wasn't waking up. I do my rounds every 1 to 2 hours and I last saw R1 probably around 4AM. I walked into R1's room to check on R1 and I woke R1 up by accident. At that time, R1 was fine. R1 even woke up and asked me in Spanish, 'What's going on?" I told R1 I was just checking on R1 and left R1's room. I called the doctor, and the doctor didn't answer so then I called the ambulance and they gave me a time of about 25 to 30 minutes to pick R1 up. We called the doctor again and left a message and that's when the ambulance showed up. It was right around 5:45 when they walked in. I called Elite ambulance. I called them and not 911 because I didn't see anything that was too alarming. R1's vital signs were fine; R1 just wasn't responding to me. Looking back, I should have called 911 knowing now that the ambulance was going to take so long. R1 never changed the whole time. R1 kept R1's eyes closed and never responded to anything we did or said to R1. R1 would sometimes move R1's arms and cross them over R1's chest, but that's it.

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On 5/3/19 at 2:08PM, V2 (DON) stated, " I got here right around 5:30 and I walked right back to R1's room to see what was going on. As I was walking back the ambulance was walking in the door. When I went and saw R1, it was like R1 was in a stupor. R1 would scrunch R1's face when we did sternal rubs. No, R1 wouldn't open R1's eyes. R1 never responded to us verbally either. R1 was having random movements in R1's arms and legs too. I didn't feel that 911 needed to be called. R1 was still able to respond to us touching him. I didn't feel that this was an emergency. R1 has a history of having a stroke so R1 normally is slow to respond anyway. People are normally slow to respond at that time in the morning. R1 had been sleeping."

On 5/3/19 at 2:20PM, V10 (medical doctor) stated, "I would expect the nurses to call 911 for emergencies like a change in vital signs, if the resident becomes hypotensive, showing a delay, change in mental status, or if they aren't stable. I do remember this situation with R1. I didn't get the call that morning. I believe my nurse practitioner (NP)got the call that morning or they left a message for the NP. Retrospectively speaking if I would have gotten the call that morning about R1's condition change, I would have told them to call 911."

The facility policy titled, "Code Blue/Medical Emergencies," dated 10/2017 documents "911 will be notified, if indicated." The facility policy titled, "Change of Condition (Resident)," dated 02/2017 documents " follow suggested guidelines for reporting clinical problems based on AMDA Guidelines. " The AMDA Clinical Practice Guidelines (provided by the facility) dated 2011 documents "Immediate Notification: any symptom, sign, or apparent discomfort that is

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S9999	Continued From page 6 acute or sudden in onset and is a marked change (more severe) in relation to usual symptoms. Altered Mental Status: Abrupt change in cognitive function from usual with or without altered level of consciousness. Consciousness, altered: sudden change in level of consciousness or responsiveness." (A)	S9999		