DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. ALDEN VILLAGE HEALTH FACILITY FOR CHILDREN AND YOUNG ADULTS D/B/A ALDEN VILLAGE HEALTH FACILITY, Respondent.	)	Docket No. NH 15-S0227

NOTICE OF TYPE "B" VIOLATION(S
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the ID/DD Community Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on April 3, 2015, at Alden Village Health Facility, 267 East Lake Street, Bloomingdale, Illinois 60108. On May 28, 2015, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Intermediate Care for the Developmentally Disabled Code, 77 Ill. Adm. Code 350 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

A Plan of Correction is required to be submitted by the facility within two weeks from the date the violation notice was sent. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice. Please email the Plan of Correction to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "B" Violation(s). In order to obtain a hearing, the

licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of this Notice. **Please email the hearing request to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.**

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

Debra D. Bryars 19

Debra D. Bryars
Designee of the Director
Illinois Department of Public Health

Dated this 29th day of May, 2015.

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PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s) and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Kenneth Fisch
Licensee Info:	Alden Village Health Facility for Children and Young Adults
Address:	4200 W. Peterson Ave., Ste 140 Chicago, IL 60646

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 29th day of May 2015.

Leona Juhl
Long Term Care/QA
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
	IL6002760	A. BUILDING: _____ B. WING _____	C 04/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VILLAGE HEALTH FACILITY	267 EAST LAKE STREET BLOOMINGDALE, IL 60108

(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) COMPLETE DATE
Z9999	FINDINGS STATEMENT OF LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)2) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 resident. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility failed to ensure skin integrity was maintained for 3 of 4 facility acquired pressure wounds reviewed, affecting R1, R2, and R3. 1. R1 developed a stage 3 pressure wound to the right occipital lobe, which required surgical debridement with a flap closure, and IV antibiotics for infection cultured from the skull bone(Morganella, Klebsiella, and Methacilin Resistant Staph Aureus) and tissue(Methacillin Resistant Staph Aureus); 2. R2 developed a stage 3 pressure wound to the right lateral foot and a stage 2 pressure wound to the coccyx, and was treated with antibiotics for a positive foot wound culture of MRSA(Methacilin Resistant Staphylococcus Aureus); 3. R3 developed a stage 2 pressure wound to the right outer ankle, which was treated with IV Vancomycin for a positive culture of Methacillin Resistant Staph Aureus. 1. Ensure nursing thoroughly communicated her assessment upon discovery to R1's physician; 2. Ensure a treatment order received from R1's physician include the location of where the treatment was to be applied; 3. Ensure the nursing staff documented her assessment of R1's decubitus in the nursing notes, and time she performed her assessment;	Z9999		

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4. Ensure nursing documented the time her order was received to send R1 out to the hospital for evaluation.

Findings include:

The Incident Report involving R1 dated 3/15/15 at 1:00pm was reviewed. It reads, but is not limited to, "Aide called RN to room due to scant blood noted on resident's sheets under head. RN to assess resident. Noted open area to back of head, length- 2.0cm(centimeters) x width 2.8cm and 0.8 cm in depth." The physician assistant, E11 was contacted at 3pm, and orders were received for a silvadine application daily."

A second Incident Report involving R1 dated 3/15/15 at 8:15pm was reviewed. It reads, but is not limited to, "Resident transferred to ER for evaluation of wound on back of head....2.4cm x 2.8cm x 0.8cm open area at back of head...hospital diagnosis, wound check."

The nurses notes for R1 were reviewed. The entry for 3/15/15 at 3pm, authored by E5(Registered Nurse) reads, but is not limited to, "....Aide reported scant blood noted on sheets near head. RN in to assess resident. Noted open area to back of head measuring 2.4cm x 2.8cm x 0.8cm...E11(physician assistant) notified at 3pm. Paged at 1:50pm and 2:15pm. Informed of open area..order obtained for new treatment orders. Orders carried out..."

The next entry for R1 on 3/15/15 is noted at 11:25pm, and was authored by E8(Registered Nurse). It reads, but is not limited to, "Resident was transferred to ER around 8:15pm to evaluate wound at back of head. Resident in her usual

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behavior. Tylenol given around 7:30pm for possible discomfort..." There is no description documented of E8's assessment of the wound, or what was discussed with the physician to warrant a visit to the ER for evaluation of the head wound."

The Weekly Assessment of Skin Alteration Form for R1, dated 3/15/15 and authored by E5 was reviewed. It notes that the wound type is pressure, and is staged at a 3, with slough and redness present, and a scant amount of serosanginous exudate(clear with bloody drainage).

The Physician's Order Sheet for R1 was reviewed. The entry of 3/15/15, timed at 3pm was reviewed. It reads, "Apply silvadine daily and PRN(as needed) after cleansing with NSS(normal saline), then cover with non adhesive dressing and secure with kerlix until healed. To start when available." This order does not indicate where to apply this dressing, nor to what type of wound this dressing is to be applied to. The order that follows is dated 3/15/15, which reads to send to ER for evaluation. This order does not indicate what is to be evaluated, nor does it indicate a time this order was received from the physician.

The facility Prevention and Treatment of Skin Breakdown policy dated 6/13 was reviewed. It reads that the facility will properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers. The facility will implement preventative measures and provide appropriate treatment modalities for skin impairments according to industry standards of care. The facility will develop a plan of care to promote healing of skin impairments and prevention of

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wounds, and identify causal factors and clinical conditions which indicate the risk of skin breakdown, including skin and hygiene practices, activity, mobility and positioning, skin protection and nutrition.

During an interview with E5 on 3/24/15 at 10:45am, E5 was asked if she could tell this surveyor what happened on 3/15/15, when she was informed that R1 had a wound to the back of her head. E5 explained that when she first learned about R1's new head wound, she went to assess, but could not really determine where the drainage on her bed sheets was coming from. After R1 had her shower, she could see the wound more clearly, and paged the physician assistant(E11) at 1:50pm and 2:15pm. E5 stated that she received new orders at 3:00pm, but did not receive an order to send R1 out to the ER for evaluation. E5 stated that the next nurse who worked the pm shift received that order. R1's physician order sheet from 3/15/15 was reviewed, and the order reads, "Apply silvadine daily and PRN(as needed) after cleansing with NSS, then cover with non adhesive dressing and secure with kerlix until healed. To start when available." There is no indication as to where this dressing should be applied. E5 was asked if she omitted the location to where the dressing should be applied. E5 confirmed that she had, but stated, "Everybody should know where to put the dressing." E5 was asked why E11 did not send R1 out to the ER for evaluation. E5 stated that E11 asked her if she thought she needed to be sent out, but that she herself did not see the urgency to have her evaluated at the ER. E5 explained that E9(ADON) was coming in on the next shift, and that she does all of the wound monitoring, and figured that she could assess the wound further, so I endorsed that to E9.

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During an interview with E1 on 3/24/15 at 1:45pm, E1 explained that E8(Registered Nurse) was the nurse who received the order later in the day to send R1 out to the ER for evaluation. E1 stated that E8 felt the wound needed more than just a silvadine dressing, and called the physician to obtain an order to send her out to the ER. E8 stated to E1 that she just felt R1 needed to be seen by a physician, and that it was not ok to keep her here.

During an interview with E2(Administrator) on 3/25/15 at 11:50am, E2 stated that E11 told her that when E5 called her on 3/15/15 about R1's new head wound, E5 told E11 that R1's wound looked unusual. E11 asked E5 if the wound needed sutures or staples, and E5 stated that she did not think it needed either. E11 stated that E5 did not think it warranted an ER visit for evaluation, so E11 did not send R1 out at 3:00pm. On a different interview with E2 on 3/24/15 at 3:30pm, E2 stated that E8 notified the physician again about R1 at 6:00pm. E2 confirmed that E8 did not document the conversation with the physician, her assessment, or the time she received the order to send R1 out on the physician order sheet.

1. On 3/15/15, facility staff discovered a stage 3 pressure wound to the right occipital area of R1's head. R1 was admitted to the hospital for surgical debridement, and IV antibiotics for infection in the wound and skull bone. Nursing failed to ensure the initial nursing assessment was communicated thoroughly to R1's physician, failed to ensure treatment orders included location of dressing, failed to ensure nursing assessments were clearly documented, failed to time the order of when R1 was sent out to the ER

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on the physician order sheet, and failed to follow their skin care policy, which includes repositioning.

During an interview with E5(Registered Nurse) on 3/24/14 at 10:45am, E5 confirmed that she did not include the location on the treatment order she received from the physician assistant, E11 on 3/15/15. E5 stated that she did not feel the urgency to have R1 sent out to the ER for evaluation. She confirmed that she endorsed for the next shift to more thoroughly assess R1's wound. E5 stated that the CNA staff repositioned R1 that day, and she only would reposition if R1 seemed uncomfortable. During an interview with E7(Certified Nursing Assistant) on 3/24/15 at 11:30am, E7 confirmed that she did not reposition R1 from 6:30am to 12:30pm, when she got R1 up for her shower. E7 stated that E5 probably repositioned R1, and that if E5 needed to have R1 repositioned, she would have let her know.

During an interview with E1(Asst VP) on 3/24/15 at 1:45pm, E1 stated that when the next shift came in on 3/15/15, E8(Registered Nurse) assessed the wound, called the physician, and received an order to send R1 out to the ER for evaluation. E1 confirmed that E8 did not time her order on the physician order sheet, nor did she document her assessment in the nursing notes, or the time she spoke with the physician. During an interview with E2(Administrator) on 3/24/15 at 3:30pm, E2 stated that E8 told her she notified the physician at 6:00pm.

During observations on 3/24/15 at approximately 11:00am, 4 clients were observed who were on repositioning schedules,(R2, R5, R6, R7), and only one of them (R2) was repositioned correctly.

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2. R2 developed a stage 3 pressure wound to the right lateral foot and a stage 2 pressure wound to the coccyx, and was treated with antibiotics for a positive foot wound culture of MRSA(Methicillin Resistant Staphylococcus Aureus). R2's right lateral foot pressure wound originally developed while under the care of the facility on 11/14/14, and was noted to be a stage 2 upon discovery, which progressed to a stage 3, and on 3/24/15 measured 1.2 by 2.0cm. R2 recently developed a stage 2 pressure wound to his coccyx on 3/18/15.

During an interview with E9(ADON) on 3/25/15 at 3:00pm, E9 stated that R2 should have been wearing his PRAFO(Pressure Relieving Ankle Foot Orthotic) boots at the time of discovery on 11/14/14, but he was not wearing them because they were in the laundry. E9 stated that she is not sure how long his boots were in the laundry, or how long R2 was not wearing them. E9 stated that the coccyx wound was originally excoriation that progressed to a stage 2 pressure wound while under the care of their facility.

3. R3 developed a stage 2 pressure wound to the right outer ankle, which was treated with IV Vancomycin for a positive culture of Methicillin Resistant Staph Aureus. R3's stage 2 wound developed on 9/24/14 and at the time of discovery measured 0.8 x 0.8cm. R3's recent wound measurements from 3/13/15 are 1.4 x 1.8cm.

During an interview with E4(DON) on 3/26/15 at 10:30am, E4 stated that R3 tends to lay with his left leg over his right foot, and that pressure is what caused the pressure wound to develop. E4 stated that now they have added a wedge to assist with repositioning. E4 confirmed the wound developed while under the care of their

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