STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

ALDEN VILLAGE HEALTH FACILITY **0038455**

Facility Name **I.D. Number**

267 EAST LAKE STREET
BLOOMINGDALE, ILLINOIS 60108

Date of Survey: 04/26/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

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350.620a)
350.1060h)
350.1210b)
350.1230d)2)3)
350.1235a)3)4)5)
350.3240a)

The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served.

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.

There shall be available sufficient, appropriately qualified nursing staff and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

Nursing **services to provide immediate supervision of the health needs of each resident by a registered professional nurse of a licensed practical nurse, or the equivalent.**

Direct care personnel shall be trained in, but are not limited to, the following:

Basic skills required to meet the health needs and problems of the residents.
First aid for accident or illness.

Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:

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Procedures for providing life-sustaining treatments available to residents at the facility;

Procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;

Procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Sections 2-107 of the Act)

These regulations are not met by the following:

Based on record review, interview, incident review and review of hospital record, the facility failed to implement procedures that prohibited neglect of R1 who was found wedged between the padding and mattress of his bed. R1 was pronounced dead at the hospital after Cardio-Pulmonary Resuscitation failed. a) The facility failed to provide sufficient staff to supervise individuals identified to be in need of constant supervision during sleeping hours. b) The facility failed to ensure the equipment surrounding R1's bed did not restrict his movement. c) The facility failed to develop and implement a policy to ensure all staff initiate CPR when an individual is found to be unresponsive.

1. Per facility roster R1 resided in one of 13 rooms where more than four individuals are housed. Per interview with E1, Administrator on 4/14/04, individuals housed in these rooms have physician certificates stating resident is in need of consistent supervision during all hours. Per E1, the facility procedure is that all individuals must be checked every two hours during sleeping hours.

Per facility measurements validated with surveyor on 4/20/2004 Room 103 is approximately 330 square feet in size. The beds present in the room on 2/20/2004 took up approximately 124 square feet. The room also contained wheelchairs, a toy bin, a card table, bolsters and stuffed toys. This situation led to a crowded environment with obstructed visibility and less than 34 square foot per individual.

Per the Clinical Record R1 was a 12-year-old male diagnosed with Severe Developmental Delay, Seizure Disorder and absence of Corpus Collosum. Psychological evaluation of June 4, 2001, states "he appears to be functioning within the profound range of mental retardation." "(R1) will require 24 hour total care." "Adaptive Level of Functioning: "ICAP score 25, Level 2 adaptive age five months. Total personal care and intense supervision required."

Per the physician certificate, "The above named resident is in need of consistent supervision during all hours for the following reasons. Severely/profoundly retarded with ... Seizures, Non-mobile, Non-Verbal."

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The PT/OT (Physical Therapy/Occupational Therapy) evaluation lists Current Sensory/Motor Factors "legally blind; attains visual attention after movement input; poorly maintained. Mild hearing loss bilat 7/03 slow to process/localize." "Deformities or Movement Patterns - sits in post tilt ataxic movement with tremulous quality." "Functional Reach - R (right) & L (left) reach (with) (decreased) manipulative skills."

Per the Person Centered Plan dated 1/21/04, additional funding was recommended for Health/Medical Services, "Rationale: Due to (R1's) constant need of staff supervision at all times,"..."He is dependent on others to make decisions for his safety and consent for medication. (R1) has poor pro-social behavior to communicate his basic needs." The plan also states "(R1) requires constant supervision due to his medical and physical challenges."

Per the Nursing Care Plan "Potential for injury R/T sudden and unexpected loss of consciousness; seizures." "Potential for impaired gas exchange related to hypoxia during seizure activity hypoventilation secondary to prolonged muscle contraction."

Review of the Physician's Progress notes written by E10, facility physician states: "Called by (facility) staff regarding (R1) being found cyanotic & unresponsive. Taken to (hospital emergency department) by EMS after receiving CPR by staff nurse." "(E2) indicated that on her arrival to dress kids for school she noticed (R1's) bed was empty and covers appeared he had not slept in his bed." "(E2) noted (R1's) body beside his bed behind a toy box, his body was pale (with) red spots on his back. She picked (R1) up noted he wasn't breathing & went to desk to notify R.N. (E4) who began CPR. Staff reports agency CNA (Z2) also present in room." "Family arrived. Spoke (with) dad regarding accident - (R1) found (with) head lodged in bed rail, probably could not breath(e) resulting in heart stopping." During interview with E10 on 4/14/04, she stated something may have happened, don't know if he stopped breathing before or after he was found face down in the bed padding.

During interview with E2, habilitation aid, on 4/14/04 she provided the following information. On 2/20/2004, E2 was scheduled to work from 5:00 a.m. until 1:00 p.m.. E2's normal shift is from 3:00 to 11:00 p.m. E2 said she was assigned Room 103 and two other people in different rooms. Per E2, when she entered Room 103 at 5:00 a.m., E2 looked around the room. She saw everyone in their beds but did not notice R1 in his bed. Per E2, she left the room and went downstairs for supplies. She went to the other rooms and dressed the other two individuals before returning to Room 103 at approximately 5:45 a.m.. She did not notice R1 in the bedroom and assumed he was on a home visit. His bed appeared to be made, as if it had not been slept in.

Per E2 (4/19/04), R1 had a bed which was low to the floor without side rails. V-shaped foam wedges were placed on both sides of the bed with a strap in the center holding them together. R1's bed was in a corner with R5's car shaped bed next to it in a L formation. The car shaped bed was also low to the floor. Next to R1's bed was a toy bin approximately two feet high, a stuffed toy, and a locked wheelchair. Interview with Z2 (4/15/04) confirmed this information. On 4/20/04, Z2 provided surveyor with a drawing noting the placement of equipment and beds on 2/20/2004.

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During interview with E2 (4/14/04 and 4/19/04), she stated that after entering the room for the second time at 5:45 a.m., she began caring for the other residents in the room. At this time the night supervisor, E3, came to the room and told E2 to feed R3 and get him to the door by 6:45 a.m. to take the bus to school. E3 confirmed this (4/15/04), E3 said she did not notice R1 at the time.

Per E2 she was feeding R3 and R4 at a table in the room with her back to R1's bed facing R3 and R4. Per E2, Z2 (hospice CNA) entered the room while she was feeding R3 and R4. Z2 confirmed this information. Per Z2, she is assigned to R6 and another resident in another room. Z2 said she left the room and went to see her other client.

After feeding R3 and R4, E2 said she took R3 and R4 downstairs to the door and returned to the room with R4. Z2 had returned to the room and was caring for R6. E2 said she began dressing R5 who was in his car shaped bed. Per E2, she was putting on R5's socks and noticed something between the two beds. E2 said she jumped up and saw R1 between his side pad and bed frame. The wheel chair was locked and the stuffed toy was between the chair and toy box. E2 said she picked R1 up and noticed he had "white stuff on his face." E2 said she noticed R1 was not breathing when she picked him up. Per E2, she laid R1 down on the bed and went to the nurses station to get E4, the nurse. E2 said she asked E4 to check R1. E4 came into the room and started Cardio-pulmonary Resuscitation (CPR). E2 said she has been trained and is currently certified in CPR (confirmed by personnel record review). E2 said she did not start CPR because she was confused and upset and E3 had to calm her down.

The following information was provided by E4, Registered Nurse (RN). E4's written statement from the facility's investigation states bed check is usually done between 11:00 p.m. and 12:00 midnight "in Room 103 by 11:30 p.m. each resident was sound asleep & comfortable in bed. (R1) was lying on his back partially covered, was sleeping soundly (with) no distress noted." "At 5:30 a.m. during the med pass & trach care, R1 was heard (hollering)/whining loud & clear, his usual way. No distress was detected from his voice." E4 heard R1's voice but did not see him.

During interview with E4 on 4/14/04 she stated that she was in and out of Room 103 several times during the night because it was a special care room. The other residents in the room had tracheostomies, gastrostomy tubes, respiratory treatments and oxygen. E4 said her last round in 103 was at 5:30 a.m. Per E4, she gave another boy medication who was eating breakfast. Per E4, she heard R1 making noises like he usually did. He did not sound distressed. At 6:45 a.m., E2 came to E4 while she was sitting at the nurse's station, charting. E4 said E2 asked her to check R1. E4 was not informed that R1 was not breathing. E4 stated when she got to Room 103, R1 was flat on his back, cyanotic in color. E4 said she started CPR and told staff to call 911. E4 said R1 was still warm. When the paramedics arrived, they took over performing CPR and took R1 to the hospital.

The following information was provided by E5, Licensed Practical Nurse (LPN). E5's written statement reads as follows: "(E4) and I were charting at the nurses station when (E2) asked (E4) if she could come and look at (R1). Her voice sounded calm et casual non-specific as to why she needed (E4) to come and see him. (E4) got up and followed (E2) to (R1's) room.

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Within a few moments (Z2) came to the nurses station and asked me did I know that there is a code Blue in the room I immediately grabbed the emergency cart running (with) it to (R1's) room yelling to staff in the hall "Code blue please call 911" as I went by. (E6 and E7, RNs) were in the med room at the time and saw me run by (with) the emergency cart et proceeded to follow me, both unaware what was going on, until we got to (R1's) room, to find E4 kneeled over him on the bed giving chest compressions. (R1) was unresponsive, face et lips blue. Skin still warm.....It was 6:55 a.m. 911 arrived within a couple minutes and took over the CPR." This information was confirmed in interview with E5 on 4/15/04. E5 said she has never seen a CNA initiate CPR, the CNA's call the nurse.

Per interview with E1, Administrator on 4/19/04, the facility does not have a policy detailing how CPR is to be initiated.

Z2 was interviewed on 4/15/04 and 4/20/04. Z2 said she arrived on 2/20/2004 between 6:00 a.m. and 6:30 a.m. Per Z2, she is very visual and noticed the room was different than it usually was. The normal staff was not in the room. Z2 noticed E2 sitting at the card table back toward R1's bed. Z2 said she asked where R1 and R5 were. Per Z2, her view was blocked. Z2 said she comes to the facility 2-3 days per week. Usually R1 was up in his wheelchair. R1's bed looked like it wasn't slept in. Per Z2, E2 told her that R5 was in bed and she thought R1 went home.

Z2 left the room and went to the room of her other resident. Z2 returned to the room 20 minutes later. Z2 asked about R1 and R5 again. At that point E2 stood up and both Z2 and E2 saw R1 at the same time. R1's feet were sticking up between the pad and bed. E2 picked him up and placed him on the bed, his body was "mottled." E2 ran out of the room, per Z2. Z2 called for help. Z2 said it all happened quickly - the nurses came to the room with the crash cart.

During interview with E8, CNA on 4/15/04, she stated R1 was not in distress during the 11-7 shift. E8 said she made her last rounds in Room 103 at approximately 3:40 a.m. Per E8, she was assigned three special care rooms from 11:00 a.m. - 5:00 a.m., a total of 17 residents. At 5:00 a.m. assignments are changed, when the 5:00 a.m. - to 1:00 p.m. shift arrives. E8 said she changed R1's diaper during her shift because he was wet and he was placed on the fitted sheet and covered with a flat sheet. Per E8, a bedspread was not used because it was warm in the room. E8 said when she made her first rounds in the room there were two locked wheel chairs next to R1's bed.

The following information was provided by E3, night supervisor in interview on 4/15/04. E3 said R1 normally played through the night and always had a bolster by his bed to keep him from falling out.

E3 said she makes assignments for the 11-7 shift and 5 a.m. - 1 p.m. shift depending on the number of people on duty. The staff working from 11:00 p.m. - 5:00 a.m. do life checks, take temperatures, lay out clothes, change and reposition and clean wheelchairs. The assignment is written out by room number unless a partial room is assigned. E3 said the CNA's are assigned 12-15 resident and that she has a similar assignment. On 2/20/04, E3 was orienting two new employees. E3 said the CNA's do not give each other report, comments are written in the assignment book.

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Per E3, when a person is found unresponsive the CNA's call the nurse.

During interview with E1 on 4/15/04 and 4/19/04, she said there was concern about R1 falling out of bed because he moved around a lot. He had been placed in at least three different beds. There was a lot of padding around his bed to prevent injuries. R1 was reviewed at the accident/incident monitoring meeting in 10/02. Notes from the meeting state "The resident has side rails and he manages to wedge himself in (between) the spaces of the side rails. He also can manage to go around the side rails and ends up on the floor."

He was reviewed by the committee in 9/03. Notes state "Resident is awake and playful at night, rolls around and bumps legs and limbs." R1's bed was changed on 11/02, 5/1/03 and bolsters were added 10/23/03 due to rolling out of bed.

The facility failed to provide supervision to meet the needs of R1 by not providing sufficient staffing. The facility also did not provide sufficient space in the room causing the area to be cluttered reducing visibility. R1's bed was surrounded with equipment which acted as a restraint restricting his movement.

(A)