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| W 482 | Continued From page 38<br>Assistant) on 2/5/09 at 7:15am, E18 confirmed that tube fed clients eat in their bedrooms E18 verified that at noon, just before the trays arrive for the feeders(clients who receive oral intake), all of the tube fed clients are escorted back to their rooms, so the nursing staff can start their feedings. Then the oral eaters are fed at noon in the day rooms. After the tube feedings are finished, clients are changed, and placed in bed for a nap. The second shift gets the tube fed clients up around 3:30pm, and brings them back to the day room. They go back to their rooms around 4:30pm for the 5:00pm feeding. E18 explained that tube fed clients cannot eat in the same room with clients who eat orally, so that is why they go back into their bedrooms for their tube feedings.<br><br>During an interview with E21(Clinical Coordinator) on 2/5/09 at 12:00pm, E21 explained that the intent of the facility practice was not to have all tube fed clients placed in their bedrooms for meals. The intent was if a client needed to lie down for repositioning/changing, that meal time could be an acceptable time to do so, but that it needed to be individualized for each client. E21 stated she can be more clear with the staff, and review each tube fed client to create a schedule that will work best to meet their individual needs. | W 482 | | |
| W9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>390.620a)<br>390.670a)<br>390.670f)<br>390.670h) | W9999 | | |

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| W9999 | Continued From page 39<br>390.1040b)<br>390.1040h)<br>390.1040k)2)<br>390.1610b)<br>390.3240a)<br><br>Section 390.620 Resident Care Policies<br><br>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. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. 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.<br><br>Section 390.670 Personnel Policies<br><br>a) Each facility shall develop and maintain written personnel policies, which are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section.<br><br>f) All personnel shall have either training or experience, or both, in the job assigned to them.<br><br>h) Employees shall only be assigned duties that are directly related to their job functions, as identified in their job descriptions. Exceptions may be made in emergencies.<br><br>Section 390.1040 Nursing Services<br><br>b) There shall be a sufficient number of nursing | W9999 | | |

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and auxiliary personnel on duty 24 hours each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents.

k) Nursing care shall include at a minimum the following:

2) All treatment such as: enemas, irrigations, catheterizations, applications of dressing or bandages, supervision of special diets, restorative and habilitative measures in Section 390.1620(a)(11) and other treatments involving a like level of skill, shall be properly administered.

Section 390.1610 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

Section 390.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These REGULATIONS were not met as evidenced by:

Based on record review and interview, the facility failed to meet nursing services for one of one client in the sample, R2, when:

1. Nursing failed to implement a physician's

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| W9999 | Continued From page 41<br>order for continuous pulse oximetry on the nocturnal shift of 1/19/09 into 1/20/09.<br><br>2. The facility failed to keep R2's head of bed elevated when his tube feeding was running.<br><br>3. Nursing failed to provide proper monitoring of a tube feeding when a Certified Nursing Assistant (CNA) stopped, started, disconnected and reconnected R2's tube feeding, while the Registered Nurse (RN) was aware.<br><br>4. Nursing failed to document suctioning that was performed at 6:45am on 1/20/09, when R2 expectorated approximately one cup of secretions from his mouth and tracheostomy.<br><br>5. Nursing failed to provide report for R2 from the night shift nurse to the day shift nurse.<br><br>6. The facility failed to transfer the client by a two person lift, as per R2's IPP (Individual Performance Plan) dated 6/12/08.<br><br>7. Nursing failed to provide an assigned nurse for R2 from the time frame of 7:15am until 7:29am, when the night nurse left early, and the day nurse arrived late the morning of 1/20/09.<br><br>R2 was found in his bedroom on 1/20/09 at 7:30am. He was sitting up in his wheelchair, unresponsive, without respirations, heart rate or blood pressure. A code was called, 911 responded, paramedics arrived on the seen at 7:35am. Resuscitation was unsuccessful, and R2 was pronounced dead at 7:42am.<br><br>Findings include: | W9999 | | |

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R2, per the Physician's Order Sheet dated 1/16/09, was a 12 year old boy whose diagnoses included Profound Mental Retardation, Hydrocephalic, History of Pulmonary Hypertension, Respiratory Distress, and Asthma. R2, per his IPP dated 6/12/08 was non-verbal, and was able to communicate through some sign language, gestures, body language, and eye gaze/contact. R2's ICAP score dated 5/12/08 was 10 months. R2 was nonambulatory, and required use of a wheelchair, which he was able to self propel. R2 required a two person assist with transfers. R2 had a tracheostomy, with a Physician's order dated 9/25/08 for oxygen saturation check every shift, and continuous at night while in bed. R2's diet dated 1/16/09 was NPO (Nothing by Mouth) and received Tube Feedings of Jevity 1 Cal, 1 can at 12 Noon, 3 cans at 6:00pm and 3 cans at 12 Midnight. R2 required an upright position during Tube Feedings, close monitoring, aspiration precautions and HOB (head of bed) elevated.

The incident report for R2 dated 1/20/09 was reviewed. Time of incident was not present on this report. Under describe incident, it reads, "Per nurse, resident was found unresponsive - vital signs unappreciated - 911 call c (with) code - Resident transferred to bed c (with) 3 staff. CPR (cardiopulmonary resuscitation) initiated. Paramedics arrived & (and) took over care/mgt (management). Under Vital Signs, it reads 0 (zero) for B/P (blood pressure), P (pulse), and R (respirations). Under Action Taken by Nurse, it reads, "CPR initiated/Code called/911 called."

The Final Death Investigation for R2 dated 1/20/09 was reviewed. In paragraph two it reads, "1/20/09, R2 was awake and alert and received

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| W9999 | Continued From page 43 his morning care from a CNA (Certified Nursing Assistant) E7 at about 6:45am. He was placed in his wheelchair and received his medication from the nurse, E10. According to E10, the floor nurse, R2 was suctioned routinely. He was alert in his chair and was watching and reaching for his T.V. as he normally does." The third paragraph reads, "At about 7:30am on the 20th of January, a nurse, E6, while conducting her final rounds was heard yelling for help. She found R2 unresponsive and the color of his skin appeared pale. A code blue was called. R2 was transported to the bed immediately, Ambu bag, cpr was initiated to open his airway according to the nurse, E8 and chest compressions was immediately initiated by E5 (Respiratory Therapist) and the nurse, E6. The paramedics arrived at about 7:36 and they took over the process of resuscitation. The paramedics pronounced R2 as expired at about 7:42am." The final paragraph reads, "The death certificate was provided to the facility with the resident's cause of death stated as pulmonary, respiratory arrest."<br><br>During an interview with E1(Administrator) on 1/27/09 at 11:35am, E1 stated that R2 had no issues going on medically the day before the incident, and was very stable, without fever or any abnormal incidents in the past. E1 continued stating that E6 was signing off to leave and doing her final rounds. E6 felt that R2 did not look normal, and called for help. From there a code was called, and 911 arrived at 7:35am. When asked if anything seemed abnormal with the progression of events that day, preceding the code, E1 stated no. E1 stated, "the death seemed of natural causes, and that maybe it was just his time." | W9999 | | |

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| W9999 | Continued From page 44<br><br>During an interview with E5 (Respiratory Therapist) RT, on 1/27/09 at 1:00pm., E5 confirmed that she was the RT who responded to R2's code the morning of 1/20/09. E5 stated that her shift had just started at 7:00am. At 7:35am a nurse (E6) called for her to come into R2's bedroom (room 108). E5 explained that upon entry into R2's bedroom, R2's lips and tongue were blue in color. E5 stated they (E5 and E6) got R2 out of the wheelchair and placed him on the bed. They found no pulse and started compressions. E5 stated that R2 had a lot of secretions orally that were creamy, milky looking. His bed was already flat at the time when they placed him on the bed. Paramedics arrived, but did not really do anything. R2 was too blue. E5 explained that nursing would be responsible for his monitoring, medications, tracheostomy care and suctioning. E5 ended her interview by stating, "from the amount of secretions he was coughing out, I do not think it was all mucous. He can control that. Usually the secretions were less. This day there was quite a bit that came from his mouth."<br><br>During a phone interview with E6 (Registered Nurse) on 1/27/09 at 1:20pm, E6 confirmed that she was the nurse that found R2 unresponsive in his chair the morning of 1/20/09. E6 explained that she was not personally assigned to R2. E6 stated that she was just about to punch out for the day, and noticed some respiratory supplies that needed to be brought to the respiratory department, so since it was on her way, she would drop them off. It was then that she noticed some of the supplies belonged to R2, so she entered room 108 to drop them off in R2's bedroom. E6 stated she saw R2 sitting up in his | W9999 | | |

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| W9999 | Continued From page 45<br>wheelchair. She started to joke around with R2, but R2 did not respond. E6 stated that R2's arms were extended down. When she touched R2's forehead, it was cold. R2's arms were cold as well. E6 stated, "I saw a lot of secretions on his shirt in the middle of his chest. I know R2 secretes a lot, but this was unusual." E6 stated that is when she ran outside of the bedroom, and called for help. E6 stated that E5 responded from Respiratory, and two other nurses also responded, E8 and E13. E6 explained that E10 was the nurse that was assigned to R2 for the night shift, but that she had already left because she had an appointment to go to. E6 thought that E10 left around 7:15am. E6 also explained that E8 was the day shift nurse assigned to R2, but that she was running late this particular day. E6 confirmed that from 7:15am until 7:30am no nursing staff assigned to the care of R2 were present. E6 also confirmed that the bed was already flat when they went to lay R2 on the bed to start CPR. E6 also confirmed she was the nurse who disconnected R2's tube feeding, prior to beginning compressions. E6 was not sure if any tube feeding was left in his bag.<br><br>During a phone interview with E7 (Certified Nursing Assistant) on 1/27/09 at 2:20pm, E7 confirmed that he was the nursing assistant assigned to care for R2 the night of 1/19/09 into 1/20/09. E7 stated that his shift is from 10:00pm to 6:00am. E7 explained that he bathed R2 around 6:00am or maybe a little later. He stated that E10 wanted him to bathe R2 last, because she wanted R2 to finish his tube feeding. E7 explained he gave R2 his bath in bed, and laid the bed flat to do so. E7 stated that he stopped the tube feeding while giving R2 his bath, and about five minutes later stated that he kept the | W9999 | | |

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| W9999 | Continued From page 46<br>tube feeding running while R2 received his bath. E7 thought it took about 15 minutes to perform the bathing. E7 then explained he had to stop the tube feeding for dressing, and placing R2 up in his wheelchair. "I transferred him by myself. It takes two people to transfer him, but no one else was around, so I just transferred him by myself." E7 stated that once he had R2 up in the wheelchair, R2 started coughing out body fluids from his mouth and trach (tracheostomy). E7 explained that he went out to get E10 to let her know about all of the fluids R2 was coughing up, and that he needed to be suctioned. E7 stated that R2 coughed up approximately one cup of fluids. E10 told E7 that she had just suctioned him when she did his trach care at 6:00am. Once E10 came into R2's bedroom and saw all of the secretions, E7 stated that E10 said, "Oh my God." E7 confirmed that E10 suctioned R2 at this time, after she saw all of the secretions. E7 stated this was at 6:45am. E7 stated he then left for the day, as his shift ended at 6:00am.<br><br>When asked if R2 wears any kind of a monitor at night, as noted on the Physician Order Sheet dated 9/25/08, for continuous oxygen saturation monitoring while in bed, E7 confirmed that R2 did not have a monitor on that night shift. E7 stated that once R2 is up in his wheelchair, that is when it is removed. E7 speculated that maybe Respiratory removes the monitor, but was sure that R2 never had his monitor on this particular night shift.<br><br>During a phone interview with E10 (Registered Nurse) on 1/28/09 at 11:00am, E10 confirmed that she was the nurse assigned to care for R2 the night of 1/19/09 into 1/20/09. E10 stated during the course of her 11-7 shift, she suctioned | W9999 | | |

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| W9999 | Continued From page 47<br>R2 about 3 times throughout the night. E10 stated that R2's night was nothing out of the ordinary. E10 stated that she did R2's tracheostomy care around 6:00 in the morning, on 1/20/09. E10 explained that she obtained an oxygen saturation at about 5:45am, prior to doing R2's trach care, and his saturation level was 97%. When asked about R2's continuous oxygen saturation monitor while in bed, E10 stated that R2 is not on a monitor and is only a spot check, which means you only have to obtain an oxygen saturation level once per shift. E10 stated that when she performed R2's trach care, she suctioned him as well, and really did not get that much out of him. E10 confirmed that E7 did come to her, and request to have R2 suctioned again around 6:45am. She stated that there was secretions on his shirt, and really did not get that much out when she suctioned him again at 6:45am. E10 stated that she did not perform another oxygen saturation level at this time because she did not really think anything was wrong. E10 also confirmed that she did not document the suctioning in the nursing notes. When asked if the tube feeding was running at this time, E10 confirmed that it was. E10 stated she started the tube feeding late that night, but could not remember what time she started it. E10 stated she checked for placement with an air bolus, but did not check for residual. E10 stated that the tube feeding was stopped and disconnected by E7, while E7 was doing R2's morning care. When asked who was monitoring R2's tube feeding while E7 was stopping, starting and disconnecting the tube feeding, E10 stated that if E7 would have any problems re-connecting and starting the feeding, he would come to her for assistance. E10 confirmed that she did leave early that morning. She stated she gave report to | W9999 | | |

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| W9999 | Continued From page 48<br>a co-worker, E6 (nurse), on some of her residents, but not on R2. E10 did not feel that the amount of fluid on R2's shirt, and amount she suctioned was abnormal, so she did not pass that information on to E6. E10 stated that the last time she saw R2 was somewhere between 7:05am and 7:10am. E10 confirmed that R2 was up in his wheelchair, alert, with his eyes open.<br><br>The punch detail report was requested and reviewed on 1/28/09. This report validates the in and out punch as staff begin and end their shifts. This report confirmed that the out punch for E10 for the morning of 1/20/09 was at 7:15am.<br><br>During an interview with E9 (Housekeeper) on 1/28/09 at 10:35am with the assistance of Licensed Practical Nurse E8, for interpretation, E9 confirmed that she was the housekeeper on duty on the first floor the morning of 1/20/09. E9 stated that she started her shift at 7:00am, and began collecting garbage out of the patient rooms, starting at the other end of the hall from R2. E9 stated that she entered R2's bedroom around 7:15am to collect the garbage, she remembered seeing R2 up in his chair. E9 stated it looked like R2 was sleeping, with his arms in his lap, and his head tilted to the side. E9 stated, "I tried to talk with him, but he did not respond, so I left the room. Later, when I was in Room 118, I saw everyone run into R2's room."<br><br>During an interview with E8 (Licensed Practical Nurse) on 1/28/09 at 10:15am, E8 confirmed that she was the nurse assigned to care for R2 the morning of 1/20/09. E8 explained that she arrived late that morning, at about 7:25am, and did not receive report. E8 stated that usually the nurse will wait for me if I am running late, but she | W9999 | | |

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did not wait this morning. E8 explained that E6 gave her report on a few clients, but not on R2. E8 explained that she was just about to start rounds, when she heard the code called. E8 stated she went to the room, and that E13 (Licensed Practical Nurse) and E6 (Registered Nurse) and E5 (Respiratory Therapist) were already there. E8 stated that they all transferred him to the bed, and got the back board. E8 stated that they did suction R2. The secretions were white to clear. E8 explained that the paramedics arrived, and they stated that he was flat lined. E8 remembered at the time they laid R2 on the bed, the bed was already flat, and the tube feeding had been disconnected. E8 stated that there was no continuous oxygen saturation monitor on since R2 does not require a monitor.

The punch detail report was requested and reviewed on 1/28/09. This report confirmed that the in punch for E8 for the morning of 1/20/09 was 7:29am.

During an interview with E11 (Respiratory Therapy Manager) on 1/20/09 at 12:12pm, E11 confirmed that R2 did have an order for continuous oxygen saturation during the hours he was sleeping. When informed that R2 did not have a monitor on the night of 1/19/09 into the morning of 1/20/09, E11 confirmed that it should have been on. E11 explained that the oxygen saturation monitor, which should have been attached throughout the night shift to R2, would alert staff to oxygen levels that drop below 95% or 92%, depending on R2's baseline levels. E11 explained further that it would also alarm for a low or fast heart rate as well. E11 stated that the monitor should be removed when the client is up for the day in his chair, which is usually around

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14G365 | A. BUILDING ______ B. WING ______ | C 02/10/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALDEN VILLAGE NORTH | 7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626 |

| (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 |
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6:00am. E11 continued, stating during the day he is a spot check, and his oxygen levels are monitored at least once during an 8 hour time span, which would usually be before school, at school, and when he arrives home.

During a phone interview with E13 (Licensed Practical Nurse) on 1/28/09 at 1:20pm, E13 confirmed that she was the second floor nurse who responded to R2's code on the morning of 1/20/09. E13 stated that when she arrived E6 was turning off R2's tube feeding, and that E5 was bagging him. E13 stated she did assist with suctioning, and thought the secretions were slimy in nature, in the amount of just under half of a cup. E13 stated that she did not assess his lips or tongue, but noticed that his eyes were fixed. E13 confirmed that R2 should have a continuous oxygen saturation monitor during the night time hours.

The Policy titled, Reporting On And Off Duty, dated 6/00 was reviewed. Under A. Policy, it reads, "All nursing care personnel must report on and off duty." Under B Procedure, #3, it reads, "Should it be necessary to leave an assigned area, nursing personnel must report to the supervisor before leaving. Resident care area cannot be left unattended."

The Policy titled, Continuous Pulse Oximeter/Apnea Monitor dated 8/08 was reviewed. Under A .Policy, it reads, "To monitor residents for oxygen saturation and/or apnea. Under B it reads, "Residents on mechanical ventilation, supplemental oxygen and artificial airways - may be monitored for oxygen saturation every shift and PRN(as needed), unless ordered otherwise per physician."

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| W9999 | Continued From page 51<br><br>The Policy titled, Gastrostomy, Duodenostomy, Jejunostomy Feedings dated 6/00 was reviewed. Under A. Policy, it reads, "Gastrostomy, duodenostomy, jejunostomy feedings are given in accordance with a physician's order by an RN (Registered Nurse) or LPN(Licensed Practical Nurse), to provide a means of administering nutrition to residents who are unable to ingest adequate nutrition orally. " Under B Procedure, #11 reads, "Resident should be minimally positioned at a 30 degree angle during infusion of feeding. Allow resident to remain at 30 degree angle for 30-45 minutes following feeding." #12 reads, "Monitor the resident for leaking of gastric contents onto abdominal wall, congested lung sounds, nausea, vomiting, diarrhea, complaints of discomfort."<br><br>During an interview with E1 (Administrator) on 1/28/09 at 11:30am, E1 confirmed that she was not aware the continuous pulse oximetry monitor was not on the night of 1/19/09 into the early morning hours of 1/20/09, as per the physician's order for R2. E1 also confirmed that she was not aware that E7, CNA stopped, started and disconnected the tube feeding the morning of 1/20/09, during am care. E1 stated that CNA's should not be starting, stopping or touching the pumps of clients who are on tube feedings. E1 explained that E7 never told her that he touched the pumps. E7 also confirmed that she was not aware the bed was flat while R2's tube feeding was running.<br><br>(A) | W9999 | | |