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	145736	A. BUILDING _____ B. WING _____	C 01/28/2011

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ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

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F 323	Continued From page 15 Completion Date: January 8 ,2011 and on going.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)3) 300.1220b)2)6) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and	F9999		

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F9999	Continued From page 16 personal care needs of the resident. b)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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. Section 300.3240 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 interviews and record reviews the	F9999		

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facility failed to ensure that 1 of 11 residents (R4) received necessary care and services to maintain the highest practical physical, mental and psychosocial well being. R4 sustained an elevated temperature and became septic. R4 was not taken to the hospital in a timely manner, but over 28 hours later. R4 continued to deteriorate after her temperature spiked to 103.3F and become less responsive. R4 died 6 days later in the hospital from sepsis and dehydration.

The facility failed to identify signs of deterioration of health and a change in condition. R4 was unable to drink orally and the facility was unable to start an intravenous line.

Findings include:

R4 was admitted to the facility on 8-2-10 with a diagnosis and a history which included urosepsis.

On 8-23-10 around 6:00pm, R4 developed an elevated temperature of 103.3. A urinalysis and a culture and sensitivity was sent. Normal body temperature is 98.6. At 8:00pm, R4's temperature was record to be 100.2. Around 10:15 pm R4's temperature was 100 degrees. R4's condition continued to change and she remained with an elevated temperature and change of responsiveness.

R4's temperature was not taken again nor was there a record of assessment until 4 hours later around 2:00am on 8-24-10 at which time it was 101 degrees. R4's condition continued to deteriorate. R4 was not sent to the hospital even though she had become less responsive.

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E10 (Nurse) stated she was told by E9 (Nurse Practitioner) to increase R4's current antibiotics and antipyretic along with starting two liters of normal saline. Labs were also ordered at this time. Nursing notes reflect that at 2:00pm, 3 hours after the orders were written, an attempt was made by nursing to begin intravenous fluid. The attempt to open venous access was unsuccessful.

E10 stated during interview that she did not know how to start an IV (intravenous). "Only certified nurses can start an IV here. I am not certified." "The DON is certified. She tried and could not get it she stated." When asked what should happen next if the DON cannot get the line, E10 stated, "we call a pharmacist or the doctor." This was not done.

R4's temperature was 99.1 at this time (2:00pm). It was an axillary temperature, which registers approximately one degree less than an oral temperature. At 5:00pm, R4's temperature elevated again to 103.2 (axillary). She still had not received intravenous fluids. The lab results were: WBC (white blood count) was 28.8 normal is (5-10). R4's other urine results were also abnormal with protein and blood in her urine.

R4's temperature at 6:00pm remained 103. At 9:30pm, R4's temperature was 101.4. R4's health continued to deteriorate and she became more unresponsive.

Finally at 10:35 pm, R4 was sent out to the hospital. R4 never received the intravenous fluids as ordered. Nursing notes state that she

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was unable to tolerate oral fluids.

R4 was admitted to the hospital with a diagnosis of sepsis. According to the emergency room records R4 was admitted with a fever, hypotension and increased white blood count. R4 was also noted to be groaning in pain and unable to answer questions. R4's first symptoms of elevated fever began on 8-23-10 at 6:00pm., but R4 was not sent to the hospital until 8-24-10 at 10:00pm, some 28 hours later.

While in the emergency room, records indicate that R4's condition deteriorated more; her blood pressure went from 103/ 75 to 70/ 23.

On 8-25-10 at 3:35am, R4 was discharged from the emergency room to the intensive care unit. Her condition was noted to be poor. R4's health continued to deteriorate during this admission, and she never recovered during this hospital stay. According to her death certificate, R4 died from urosepsis and dehydration 6 days later.

Interview with Z1 (MD) stated that, "I had some concerns why it took so long for the facility to call me. I did not receive any calls regarding how her condition had deteriorated or I would have sent her out. I asked them why did they take so long?" "I would have had her sent out when her temperature reached 103, the nursing home cannot treat fevers that high."

Interview with E10 (RN) stated that she never started the IV; she called the DON who also could not start it. E10 stated you must be certified to start IV fluids. The labs were not ordered stat as per facility protocol for change of

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F9999	Continued From page 20 condition, and the doctor was never called. E2 stated that she was also unsuccessful in starting a line. E10 stated during interview that pharmacy usually started the IV when they cannot get a line, but pharmacy was never called. This failure in the staff's lack of following procedures and identifying a change of condition resulted in an over 28 hour delay in emergency treatment which led to R4's death. (AA) 300.1210a) 300.1210b)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	F9999		

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F9999	Continued From page 21 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 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 interview and record review the facility failed to: -identify the signs and symptoms and warning signs of substance abuse. Failed to reevaluate the effectiveness of the plan of care. -supervise and monitor 1 of 11 residents (R11)	F9999		

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with a known history of drug abuse.

R11 died the morning after E7 (CNA) found drug paraphrenia in his room and had a positive cocaine test from the previous night. This lack of monitoring and supervision resulted in R11 using a controlled substance. Review of the Coroner report identified the cause of death as an accident related to cocaine use.

Findings include: .

1) R11 was admitted to the facility on 11-2-10 with a diagnosis that included poly substance abuse. He was also a dialysis patient.

Review of R11's plan of care stated, "R11 will be monitored for signs of substance abuse and use." The start date was 11-9-10.

According to social services notes dated 11-3-10, R11 was a loner and spent most of his time in his room. R11 was also said to be verbally abusive with irrational behavior at times.

During interview with E8 (SSD), E8 stated that R11 told him he was not using cocaine, however "he has broken rules frequently and been caught smoking in his room."

Nursing notes dated 11-18-10 state that at 6:20am, R11 was alert and up and walking around, and had been up all night. It also stated that he was having a verbal disagreement with his roommate (R16) at this time.

R16 (R11's former roommate) was interviewed on 12-3-10 at 1:30pm. R16 stated that R11

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moved into his room from the second floor. R16 also stated that R11 would purposely block the entry way to the bathroom and did not like to move. "I reported him to staff. He was moved the next day to another room." I heard that one of the nursing staff moved the dresser and found a piece of tissue while moving him to the next room. In the tissue was a crack pipe with some brown stuff at the bottom. When I go up I heard a code blue."

E7 (CNA) stated during interview on 12-7-10 that as she was cleaning near R11's bedside table she saw a rolled up piece of paper towel. "I unrolled it and it was a clear pipe found on his side of the room."

E8 (Social Service) stated that R11 had roommate problems. "It was reported to me that he denied the pipe was his but was positive for cocaine in his urine and died on Saturday (11-20-10)."

E4 (Nurse) stated on 12-3-10 that she was informed by E8 that an unknown substance was found in a pipe in R11's room.

E4's nursing notes dated 11-19-10 states that she was informed that urine was needed. "I approached him several times to obtain a urine sample he keep saying "ok.'"
.
Nursing notes notes further stated that a urine sample was obtained 11-19-10 at 8:00pm but was not picked up until 11-20-10 at 4:30am.

E4 stated during interview that she gave R11 Tylenol #3 for a complaint of pain at 5:10am on

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F9999	Continued From page 24 11-20-10. E4 further stated, "I was asked to come into R11's resident room because he did not look good at 5:40 AM. E11 stated that "When I arrived in the room R11 was unresponsive and I called 911 and CPR was initiated." Review of his lab report of a urine specimen obtained the previous night showed R11 positive for Opiates and Cocaine/benzoylecgonine. Review of the Coroner's report stated that an autopsy was done on 11-21-10 and R11 was positive for benzoylecgonine, a byproduct of cocaine, and also positive for codeine. The report also stated that the factors which significantly contributed to R11's death were end stage renal disease and cocaine intoxication. The death was ruled an accident. (AA)	F9999		