STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145379	A. BUILDING _____ B. WING _____	C 09/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD 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) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of Complaints: 2077540 / IL127079 - F580, F760 2077432 / IL126956 - No deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		9/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/26/2020

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide notification to a physician and family regarding a resident's significant change of condition. The facility also failed to notify the physician regarding significant medications not being provided. This applies to 1 of 3 (R2) reviewed for medications and change of condition in a sample of 13. The findings include: R2's MAR (Medication Administration Record), dated 9/1/20 to 9/23/20, showed there were six doses of different anti-seizure medications (Dilantin, Keppra and Onfi) that were not administered for a period of approximately one and a half days between 9/12/20 and 9/14/20.	F 580	Alden Valley Ridge Rehab & Hcc Plan of Correction and Allegation of Compliance F 580 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Submission of this Plan of Correction by Alden Valley Ridge Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the Survey Agency.	

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F 580	Continued From page 2 On 9/24/20 at 11:06, V17 (Attending Physician) stated she was not informed that R2 was missing doses of significant medications to prevent seizures. V17 stated if she had been called by the facility, she would have ordered a stat Dilantin level blood draw for R2 and adjust anti-seizure medications as indicated. V17 also stated that R2 required the medications to prevent the occurrence seizures and, without the medications, R2 would experience seizures. V17 also stated she was never informed that R2 had a gran mal seizure on 9/13/20, stated the documentation of the seizure in the clinical record described R2 as experiencing a gran mal seizure, and stated she should have been notified by the facility. V17 stated when R2 was transferred to the hospital from the facility on 9/14/20, R2's Dilantin blood level was a critical low value, was given large doses of Dilantin, and remained in the hospital for a few days of treatment. On 9/25/20 at 9:10 AM, V18 (Mother- Power of Attorney) stated she was extremely upset and angry that the facility had not notified her regarding R2's transferred to the hospital on 9/14/20. V18 stated she called the facility to check on R2's condition and the facility told V18 that R2 had been transferred to the hospital hours prior to her call because he experienced a seizure earlier that morning. On 9/25/20 at 6:20 PM, V15 (Registered Nurse) stated she received a call from V18 around noon on 9/14/20 asking about R2's condition due to R2's seizure that occurred on 9/13/20. V15 informed V18 at that time that R2 was transferred to the hospital at 10:00 AM due to having a seizure. V15 stated V18 was very upset that she	F 580	Corrective Actions taken for those residents alleged to have been affected are: • V14, V10, and all other nurses were educated on facility policy & procedure for change in condition notification. • R2 no longer resides in the facility. Actions taken to identify other resident that may have the potential to be affected are: • An audit was conducted of all residents to verify change in condition notification to family and physician were completed. • No other facility residents affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur. • All nurses were in-services on facility's policy Change in Condition. The Inservice accentuated change in condition notification for physician and family. Quality Assurance plans to monitor facility performance to make sure corrections are achieved. • A QA Tool was initiated to monitor change in condition family and physician notification. This was initiated by the Director of Nursing or designee.	

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F 580	Continued From page 3 was not notified previously that R2 was sent to the hospital. V15 stated R2's "general seizure" was a gran mal seizure. Review of R2's clinical record showed V17 (Attending Physician) was not notified R2 missed several doses of his anti-seizure medications on 9/12/20 and 9/13/20. The record also fails to show V17 was notified of R2's seizure on 9/13/20. The clinical record failed to show V18 (Family) was notified that R2 was transferred to the hospital at the time of R2's transfer. Facility document Seizure, Nursing Management of, undated, shows, "Policy: 1. To prevent injury to the resident .... 3. To implement emergency care and prevent complications .... 12. Continue to observe him in case the seizure recurs. 13. Notify M.D. (Physician)." Facility document Medication Administration: General Guidelines P-7150, undated, shows, "Policy: To ensure that medications are administered safely as prescribed .... 6. If the physician's medication order cannot be followed, the physician should be notified, depending upon the situation .... If and eMAR (Electronic Medication Administration Record) is being utilized, document in the record the reason the medication was not given ...." Facility document Change of Condition (Resident), undated, shows, "Purpose: To ensure that the resident's physician/physician on call/ NP (Nurse Practitioner and responsible party is kept informed regarding the resident's change in condition. Policy: the attending physician or physician on call/NP and responsible party will be notified with changes in a resident's condition.	F 580	• The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.	

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F 580	Continued From page 4 Procedure: 1. Attending physicians or physician on call / NP and responsible party will be notified of all changes in condition. 2. Follow framework for reporting changes in vital signs or laboratory values based on AMDA (American Medical Directors Association) Guidelines. 3. Follow suggested guidelines for reporting clinical problems based on AMDA Guidelines. 4. Document time of call, physician or nurse practitioner or other person spoken to; reason for call and result or orders received. 5. Place call to responsible party to notify them of the resident's change in condition."	F 580		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident is free of significant medication error when several anti-seizure medications were not provided as ordered by the physician. This failure resulted in 2 occurrences of gran mal seizures causing R2 to be hospitalized and required administration of large doses of anti-seizure (Dilantin Drip) medication. This applies to 1 of 3 residents (R2) reviewed for significant medication in the sample of 13. The findings include: The EHR (Electronic Health Record) report	F 760	Alden Valley Ridge Rehab & Hcc Plan of Correction and Allegation of Compliance F 760 483.45(f)(2) Residents are Free of Significant Med Errors Submission of this Plan of Correction by Alden Valley Ridge Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any	9/28/20

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F 760	Continued From page 5 shows that R2 was admitted to the facility on 9/12/2020 from the hospital. R2, a 42 year old had diagnoses that included clostridium difficile infection, epilepsy and epileptic syndrome with complex partial seizure, intractable without status epilepticus, down syndrome, presence of gastrostomy tube and dysphagia. Review of the R2's MAR (Medication Administration Record) from 9/12/2020 through 9/14/2020 showed the following Physician Medication Orders (Anti-seizure meds) and medications that were not administered: 1) Date Ordered: 9/12/2020: Dilantin Infa tablets chewable 50 mg. Give 3 tablets (150 mg.) via gastric tube every evening scheduled to be given every 5:00 P.M.= missed this dose on 9/12/2020 at 5:00 P.M.=150 mg. 2) Date Ordered: 9/12/2020: Dilantin Infa tablets, 50 mg. 3 tablets daily for seizure schedule to be given daily at 9:00 P.M. = missed this dose on 9/12/2020 at 9:00 P.M. = 150 mg. This was a total of 300 mg of Dilantin that was missed on 9/12/2020. 3) Date Ordered: Onfi Suspension 2.5 mg. /ml. Give 16 ml. = 40 mg. scheduled to be given daily at 5:00 P.M. = this was missed at 5:00 P.M. on 9/12/2020 and 9/13/2020 (missed 2 doses). 4) Date Ordered: Onfi Suspension 2.5 mg. /ml. Give 2 ml. = 5 mg. daily scheduled to be given 9:00 A.M. = this was missed on 9/13/2020 at 9:00 A.M. This was a total 85 mg. of Onfi Suspension that was missed on 9/12/2020 at 5:00 P.M. and 9/13/2020; and 9:00 A.M. on 9/13/2020. 5. Date Ordered: Keepra 100 mg. /ml. Give 22.5 ml. = 2,250 mg. to be given twice a day, schedule	F 760	facts set forth in this allegation by the Survey Agency. Corrective Actions taken for those residents alleged to have been affected are: • V10, V13, and all nurse were educated on Medication Administration Policy and Procedure. Actions taken to identify other resident that may have the potential to be affected are: • An audit was conducted of all residents for Significant Medication Administration errors. The Administration records were reviewed to verify all significant medications were given appropriately and all medications were available. • No other facility residents affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur. • All nurses were in-services on facility's policy and procedure; Medication Administration. The in-service accentuated significant medication availability and timely administration of these medications. Quality Assurance plans to monitor facility performance to make sure corrections are achieved.	

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F 760	Continued From page 6 to be given daily 9:00 A.M. and 5:00 P.M. = this was missed on 9/12/2020 at 5:00 P.M. This was a total of 6 doses of anti-seizure medications for a period of approximately one and ½ day (9/12/2020 at 5:00 P.M. through 9/14/2020 at 6:30 P.M.). R2 was sent to hospital via emergency medical support (911) on 9/14/2020 at 6:30 A.M. due to grand mal seizure. R2 was admitted with diagnoses of status epilepticus. The nurse's notes dated 9/13/2020 at 2:50 P.M. showed that R2 had a "generalized seizure." There was no documentation that V17 (Attending Physician) was notified. Again, on 9/14/2020 at 6:30 A.M., R2 had another gran mal seizure. R2 was sent to the hospital precipitated by this seizure via 911. This was a total of 2 gran mal seizures for a period of approximately one and ½ day (since the day of admission at around 3:00 P.M. to the time of transfer to hospital on 9/14/2020 at 6:30 A.M.). On 9/23/2020 at 6:45 P.M., V10 (Registered Nurse) stated that she had admitted R2 on 9/12/2020 at around 3-4 P.M. V10 further added that she entered the R2's initial assessment into the electronic charting around 5:00 P.M. and finished the documentation at 10:32 P.M. V10 added that R2 has down syndrome, restless, anxious, agitated and had multiple attempts of unassisted transfer. V10 also added that R2 had missed his due scheduled medications that included the anti-seizure medications at 5:00 P.M. and 9:00 P.M on 9/12/2020 because the medications were not available. V10 also added that she did not call the pharmacy for a stat delivery nor had tried to follow up what was going	F 760	• A QA Tool was initiated to monitor Significant Medication Administration. This was initiated by the Director of Nursing or designee. • The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.	

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F 760	Continued From page 7	F 760		

with R2's undelivered medications. V10 also that she was again assigned to R2 on 9/13/2020 on the morning shift. V10 added that R2's scheduled anti-seizure medication was not given because it was not available and was not yet delivered from the pharmacy. V10 also stated that on 9/13/2020 at 2:50 P.M., R2 had a generalized seizure, a grand mal seizure which was characterized by involuntary jerking movements throughout the entire body. V10 also stated that she did not call V17 (R2's Attending Physician) for the missed doses of anti-seizure medications and the episode of gran mal seizure on 9/13/2020 at 2:50 P.M.

On 9/23/2020 at 7:00 P.M., V13 (Registered Nurse) stated that he worked on 9/12/2020, 3:00 P.M.-11:00 P.M. shift. V13 also added that he had shared the same floor assignment with V10. V13 added that when he came on duty at around 3:00 P.M. on 9/12/2020, R2 was already been admitted and settled in bed. V13 also added that R2 had missed an anti-seizure medication on his shift on 9/13/2020 when he took care of R2 for the evening shift. V13 also added that he was not sure why the anti-seizure medication (Onfi) was not delivered therefore it was not administered as ordered. V13 also added that R2 had exhibited intermittent agitation, restlessness and multiple attempts of getting out of wheelchair without assistance.

On 9/23/2020 at 6:55 P.M., V14 (Licensed Practical Nurse) stated that R2 was under her care from 11:00 P.M of 9/13/2020 through 6:30 A.M. of 9/14/2020. V14 stated that on 9/14/2020 at around 6:30 A.M., "(R2) had a gran mal seizure jerking involuntary all throughout so I called (V17) and sent R2 to the hospital via 911."

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F 760	Continued From page 8	F 760		

On 9/23/2020 at 6:20 P.M., V15 (Registered Nurse) stated that she came on duty at around 7:05 A.M. on 9/14/2020. V15 also stated that when she came on for duty, R2 was already been sent out to the hospital. V15 also added that she called the hospital at 10:00 A.M. to follow up R2's condition. V15 also stated that R2 was admitted at the hospital with admitting diagnoses of status epilepticus. V15 further stated that when R2 had a generalized seizure on 9/13/2020, this was a gran mal seizure and physician should had been notified.

On 9/24/2020 at 10:49 A.M. and 11:39 A.M., V16 (Registered Pharmacist) stated that R2's medications was sent into their system as an order on 9/12/2020: Keepra at 9:01 P.M. and Dilantin order at 9:04 P.M. V16 also added that a "hard copy for script for Onfi" should have been sent to the pharmacy to fill the prescription." V16 also added that there was no script provided, so the next step was for the facility to fax the physician order and hospital MAR (Medication Administration Record) that would show the Onfi medication was administered to R2. V16 also stated that the facility had faxed the physician order on 9/13/2020 at 8:19 A.M. and faxed the hospital MAR at 3:44 P.M. V16 also stated the pharmacy had paged V17 at 6:39 P.M. on 9/13/2020 for verbal order for the Onfi medication. V16 also stated that something could have been done regarding coordination of obtaining medication order. V16 also added that Keepra and Dilantin orders were not received by the pharmacy until 9:04 P.M. on 9/12/2020, so it was not delivered for timely administration.

On 9/24/2020 at 11:06 A.M., V17 (R2's Attending

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F 760	Continued From page 9	F 760		

Physician) stated that she was not made aware that R2 had a generalized/gran mal seizure on 9/13/2020. V17 also stated that she also was not notified that R2 had missed several doses of the anti-seizure medications. As V17 explained, R2 has severe mental retardation, Down syndrome, history of brain surgery, epilepsy and histories of seizures. V17 added that R2's anti-seizure medications were a must to be administer timely as ordered because these medications were significant and would definitely impact R2's stability and also to prevent seizure and other complications of having seizure episodes. V17 further stated if she had been called by the facility when anti-seizure medications were not administered as ordered, she would have ordered a stat Dilantin level blood draw for R2 and adjust anti-seizure medications as indicated. V17 also stated that R2 required the medications to prevent the occurrence of seizures and, without the medications, R2 would experience seizures. V17 also stated that when R2 was transferred to the hospital from the facility on 9/14/20, R2's Dilantin blood level was a critical low value, was given large doses of Dilantin, and remained in the hospital for a few days of treatment. V17 stated when R2 was admitted to the facility on 9/12/20 from the hospital, R2's seizures and medications had been stabilized enough to be discharged to the facility. V17 stated from the time R2 arrived on 9/12/20 up to the time of discharge on 9/14/20, the missed anti-seizure medications had caused R2's acute seizure episodes at the facility. V18 stated a Neurology consult was obtained for possible transfer in the event R2's seizures could not be controlled, however R2 was able to remain in the hospital and the Dilantin level was stabilized.

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F 760	Continued From page 10 Facility document New Admissions P-7037, undated, shows, "Policy/Purpose: Medications for newly admitted residents are ordered, provided by the pharmacy, and initiated on a timely basis .... 12. Fax the signed physician's orders to the pharmacy immediately .... 13. Call the pharmacy ahead of time if submitting urgently needed orders after delivery cutoff or if an unusual or complicated therapy is anticipated .... 17. Cary out orders as documented. Initiate medication when received from pharmacy ...."	F 760		