

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002760	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2022
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NAME OF PROVIDER OR SUPPLIER ALDEN VILLAGE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 267 EAST LAKE STREET BLOOMINGDALE, IL 60108
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Z 000	COMMENTS ANNUAL LICENSURE SURVEY INSPECTION OF CARE	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.700a) 350.1230d)1) 350.1230d)2) 350.1230d)3) 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 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident Section 350.1230 Nursing Services d) Direct care personnel shall be trained in,	Z9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Z9999	<p>Continued From page 1</p> <p>but are not limited to, the following:</p> <ol style="list-style-type: none"> 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interviews, the facility neglected to implement their Cardiopulmonary Resuscitation policy and procedure when 1 of 1 client (R9) was found unresponsive on 3/26/22 at 11:55pm. R9 was pronounced dead on 3/27/22 at 12:46am. In addition, the facility failed to thoroughly investigate this incident. This has the potential to affect all 121 clients residing in the facility (R1 through R8 and R10 through R121).</p> <p>Findings include:</p> <p>The facility's notification of death dated 3/27/22 was reviewed. Under summary it includes; "On 3/26 at approximately 11:55pm, client was noted by staff unresponsive in bed. No respirations and no pulse noted. CPR (cardiopulmonary resuscitation) initiated and 911 summoned. Paramedics arrived and took over CPR. At 12:46am, on 3/27, client was pronounced dead (via phone) by Z1 (Emergency Room Physician) from the local hospital."</p> <p>The facility's death investigation completed by E1</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>(Administrator) on 3/30/22 was reviewed. Under "below summarizes R9's condition 72 hours prior to expiration" it includes; "Approximately 11:55pm, client (R9) was noted by E7 (Direct Support Person) unresponsive and called for nurses. R9 noted with no pulse and no respirations. CPR started by staff nurses and 911 called at approximately 12am..."</p> <p>The following staff interviews include:</p> <p>E6 (nurse) - E6 heard Direct Support Person (E7) calling for assistance. E6 came to resident's room immediately. E6 noted resident to be pale and checked pulse and breathing and then CPR began..."</p> <p>E7 - When E7 was checking and changing her residents at approximately 11:55pm, she walked in R9's room and she noted R9 on his back with eyes and mouth wide open and skin color pale. She ran into the hall and yelled for help. E6 came to room to assess the resident. E6 checked vitals, code blue was called by another nurse and CPR began..."</p> <p>E8 (Direct Support Person) - E8 went to resident's room at approximately 11:55pm, when she heard E7 calling for assistance. Nurse went to room and code blue was called; CPR began..."</p> <p>The facility's conclusion includes; "On 3/26 at 11:55pm, R9 was noted in his bed, pale with no pulse and no respirations. CPR initiated and 911 was summoned. ..."</p> <p>E7 was interviewed via phone on 5/26/22 at 10:38am. Surveyor asked E7 what happened that night. E7 stated, "I went in the room, I looked to my left, R9 was lying flat on the bed with his</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>mouth and eyes opened. He looked pale." E7 added, "R9 is usually on his side when asleep". E7 continued, "I left the room. I went to B wing nurses' station and saw E8 . I told her can you come here and look at R9. E8 and I went to R9's room. E8 said, "He doesn't look good". We both ran out (of R9's room) and went to the B wing nurses station towards the A wing nurses station yelling for someone to check on R9. All the nurses came to the room and CPR was started." Surveyor asked E7 did she check for R9's pulse and breathing. E7 answered, "No., I didn't check for pulse or breathing." E7 added, this is my first time to experience something like this.</p> <p>E8 was interviewed on 5/26/22 at 3:02pm. Surveyor asked E8 what can she remember from that night. E8 answered, "We did our rounds, shortly after shift change, I notice E7 she was in the hallway, she called me to R9's room. I ran down there to R9's room. R9 looked pale, he looked dead, with his mouth open and laying on his back. E7 and myself went to the B wing nurses station to use the phone, to call CODE BLUE. We saw E6 at the B wing nurses station. Everybody came from everywhere. Nurse brought the crash cart." Surveyor asked E8 if she checked if R9 has a pulse and if he was breathing. E8 answered, "No, I did not check for a pulse or breathing. I just wanted to get to the phone." Surveyor asked when she left to go to the phone did E7 stay behind. E8 stated, "No, both E7 and I went to the B wing nurses station." Surveyor asked if E8 is certified in CPR. E8 answered, "Yes, I am trained in CPR."</p> <p>E6 was interviewed via phone on 5/26/22 at 10:43am. E6 stated, "It was around midnight, I was near the B wing nurses station when I heard someone screaming." Surveyor asked E6 who</p>	Z9999		
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Z9999	<p>Continued From page 4</p> <p>was screaming. E6 answered, "E7 was screaming something about R9, like someone look at R9 or that R9 needs help." Surveyor asked E6 was anyone with E7. E6 answered, "E8 was behind E7, both were by the B wing nurses station." Surveyor asked what happened next. E6 stated, "I went into R9's room. When I saw him, he looks dead. He was pale and white; his upper body was cold. His lower body was a little warm. I checked if he had a pulse and was breathing. He did not have a pulse and was not breathing, then I started CPR."</p> <p>Surveyor asked E12 (Maintenance Supervisor) to measure the distance between R9's room and the B wing nurses station on 5/26/22 at 1:46pm. E12 stated, "It is approximately 100 feet."</p> <p>E4 (Director of Nursing) was interviewed on 5/26/22 at 9:32am. E4 stated, "I don't know why E7 did not start CPR, maybe she got scared." Surveyor asked E4 to explain what happened that night. E4 stated, "E7 found R9, she then ran out of the room, stayed by the door, called for help. Nurse was in the bedroom right around the corner from R9's room. Nurse responded and started CPR." At 10:21am Surveyor asked E4 what is the facility's CPR policy. E4 answered, "We follow the American Heart Association guideline." Surveyor asked E4 to elaborate. E4 stated, "When a staff finds someone unresponsive, they scream for help and to call 911. They then need to check for pulse and breathing." Surveyor asked if E7 followed their CPR policy, E4 answered, "No she did not follow the policy." Surveyor asked E4 if E7 was CPR certified. E4 answered, "All our staff are CPR certified."</p> <p>Surveyor informed E4 and E1(Administrator), that the facility's investigation does not show that E6</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>was not near R9's room at all. Interview with E6 verified that E6 was in fact approximately 100ft from R9's room (near the B wing nurses station) when she heard E7 and E8 screaming for help. Both E7 and E8 also left R9's room and ran approximately 100 ft towards the B wing nurses station to call for CODE BLUE.</p> <p>The facility presented their 9/20 CPR policy. Under policy it includes; "The American Heart Association guidelines will be followed. Cardiopulmonary resuscitation (CPR) will be initiated on all residents, employees or visitors for whom this intervention is indicated. CPR will be initiated by any staff member certified in CPR. "</p> <p>Under Overview of Initial BLS (Basic Life Support) steps it includes; "1. Assess the victim for a response and look for normal or abnormal breathing. If there is no response and no breathing or no normal breathing, shout for help. 2. If you are alone, activate the emergency response system and get an AED (automated external defibrillator) if available and return to the victim. 3. Check the victim's pulse (take at least 5 but no more than 10 seconds). 4. If you do not definitely feel a pulse within 10 seconds, perform 5 cycles of compressions and breaths, starting with compression..."</p> <p>E1 (Administrator) was interviewed on 5/26/22 at 11:13am. E1 stated, "I didn't see any issues with this investigation." Surveyor asked if any staff training was conducted after this incident. E1 answered, "I didn't write it down, so I think I didn't do any re-training on this." (A)</p>	Z9999		