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

MOSAIC LIVING CENTER 0046334

7464 NORTH SHERIDAN ROAD , CHICAGO, ILLINOIS 60626
Address

10/25/2004
Date of Survey

ANNUAL AND COMPLAINT
Type of Survey

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):

350.620a)
350.1060h)
350.1230b)1)2)3)
350.3240a)

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 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 training 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.

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

Detecting signs of Illness, dysfunction or maladaptive behavior that warrant medical, nursing or phsychosocial intervention.

Basic skills required to meet the health needs and problems of the residents.

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First aid for accident or illness.

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 the following:

A. Based on observation, interview and record verification the facility failed to provide adequate monitoring by ensuring audible oximeter alarms, and apnea alarms that have been set to meet individual respiratory and heart rate baselines for 18 of 18 individuals who have tracheostomies (Rs 6, 18, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31,32,33,34,36 and 37), 2 individuals who expired (R12 and R13), and 4 individuals who are monitored with apnea and or pulse oximeter monitors (R8,R14,R19 and R38).

1. Per the clinical record, R18 is a 5 year old male diagnosed with Profound Mental Retardation, Tracheostenosis, Severe Pulmonary Hypoplasia, GERD and Spastic Quadriparesis.

Per the clinical record and observation throughout the survey, R18 has a tracheostomy and uses 5 liters oxygen via a trach collar (per respiratory workload form). His respiratory status is monitored by a pulse oximeter (measures oxygen saturation and heart rate) and an apnea monitor (measures heart rate and respiratory rate). The Physician's Orders read "Apnea monitoring continuously" "Pulse ox continuously." On 8/31/04, R18 was transferred to the hospital due to oxygen saturations ranging from 88 - 92% (per resident transfer form).

On 10/13/04 at 5:12 p.m., surveyor observed E9 (Respiratory Therapist) come into the hallway outside of room 121 and call E10 (Respiratory Therapist) and yell "code blue". No alarm signals were heard in the hallway. A nurse entered the room with an emergency cart. At 5:17 p.m. surveyor was told by E1 (Administrator) that R18 is o.k.

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On 9/29/04, surveyor asked E4, Director of Nursing, how individuals in the facility with tracheostomies are monitored when staff was not in the area. Per E4 they are monitored with either an apnea monitor or oximeter when in bed. E4 said there are baby monitors that have both an auditory and visual alarm outside the rooms of all people with oximeters. Per E4 the monitors are on all of the time. E4 demonstrated how the baby monitors function.

On 10/13/04 at 5:35 p.m., surveyor entered room 121, R18 was in an infant seat in his bed. No staff was in the room. The apnea monitor and oximeter were attached. The baby monitor outside of room 121 was turned to 0, sound could not be picked up in the hallway. Surveyor approached E10 in the hallway and asked why the alarm was not on. E10 said he thinks the baby monitors are obsolete.

Surveyor asked E9, what happened when the "code blue" was called. He said the alarms were not going on in the room and he thought they were broken down. E9 said, R18 got cyanotic and threw up.

Surveyor asked why 911 was not called when the "code blue" was called. E10 was also present during this time and said if it is just a respiratory arrest, the facility doesn't call 911, if there is no heart rate 911 is called or if the lead nurse decides to call 911. On 10/14/04 E5 (Respiratory Therapy Director) and E13 (Registered Nurse) confirmed that 911 is not always called when a code occurs.

On 10/14/04 at 12:15 p.m. E5, (Respiratory Therapy Director) stated the respiratory arrest happened due to a displaced trach tube. He said that R18 is prone to vomiting and he can push the trach half way out. Since the airway was re-established they knew he was fine and didn't need to be in the room. Per E5, the facility would not leave him alone if they didn't know the reason he had a respiratory arrest. Surveyor asked how do you know he wouldn't vomit again? E5, said he can do it anytime.

Nurses notes documentation about the 10/13/04 code blue, state " 5:15PM Code Blue was called to room 121, noted that 2 respiratory technicians, are in the room, patient was being ambu bagged O2 sat 75%, noted resident is Pale (with) circumoral cyanosis. Ambu bagging continues O2 sat went up to 99 - 100%. MD aware of resident's condition (with no new orders), monitor closely. (no) emesis noted. Lips turned pink and skin turned pinkish as well". there is no further nurses note documentation until 10/14/04 at 6:00 a.m.

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Clinical record review of the respiratory therapy summary dated 8/8/04, states "Res. Has low potential for the (self-extubation) but his trach. ties have to be adjusted & monitored at all times!!! velcro ties use only!"

Surveyor asked E5 why R18 had velcro trach ties instead of twill ties. E5 stated twill ties are safer but they have to follow the family request. E5 said the family requested velcro due to skin breakdown caused by the twill ties.

Observations throughout the survey indicated the oximeter alarms cannot always be heard in the hallway. When E5 was asked about this (10/14/04), he said they are not for patient safety but for staff convenience. He stated the apnea alarms are for patient safety and are louder. They can be heard in the hallway. On 10/14/04, E5 said the apnea alarms are not individualized for every resident. The facility uses the factory settings, which are set for infant standard values.

During interview with Z2 on 10/19/04, he said pulse oximeters are very important because some kids can not tell you if they are short of breath. It is an expectation that when the alarm sounds, they need to respond immediately.

There are 39 residents housed on the first floor. According to information provided by the facility, 18 individuals have tracheostomies, 7 of whom are on ventilators. Fifteen individuals need staff physical assistance to eat. At the time the code was called there were 6 CNAs working on the first floor. Surveyor observed 5 of the 6 CNAs (Certified Nursing Aides) engaged in feeding, and monitoring the day room. There were 3 Registered Nurses and 2 Respiratory Therapists. The nurses were passing medications and assisting with feeding. Since most of the staff were engaged with other care activities it was necessary that the alarms were audible so staff could respond immediately to protect R18 from any further respiratory problems.

R18 was being monitored by an oximeter which could not be heard in the hallway. He was also connected to an apnea monitor which was not individualized. He was left alone in his room 25 minutes after experiencing a respiratory arrest caused by his trach becoming dislodged. The trach was dislodged when R18 vomited. The trach tube is held in place by velcro ties which have to be adjusted and monitored at all times. He was at risk for potential respiratory problems without adequate monitoring.

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2. Per the clinical record, R12 was a 4 year old female diagnosed with Congenital Hydrocephalus, static Encephalopathy, Seizure Disorder and Tracheostomy. R12 had a respiratory and cardiac arrest at approximately 6:15 p.m. on 9/17/04 at the facility. She was transported to the hospital by the paramedics and expired at 7:11 p.m.

During interview with E23 (CNA) on 10/12/04, she said when she went into R12's room to take her temperature she noticed blood coming from her mouth and called the Respiratory Therapist to come to the room. Both E10 and E21 (Respiratory Therapists) said they could not hear alarms. They were alerted to come to the room by E23, CNA, who noticed blood coming from R12's mouth when she was in the room taking temperatures.

Per E21, (10/14/04) she was in another room attending to someone on a ventilator, the alarm in that room was loud. She was called to R12's room by E23. R12's alarm was ringing but she could not hear it. E21 said R12 was in a different position than when she had last seen her at 6:00 p.m. Per E21, R12 did not open her eyes like usual when she shook her, so she called E10 for help.

Per E10 when he was called to the room, by E21, R12 was dusky with no chest movement and no readings on the oximeter. E10 and E21 (Respiratory Therapists) confirmed that the trach tube had to be changed during the code.

During interview with E13 (Registered Nurse) on 10/14/04, she said R12's trach was dislodged. She said the pulse oximeter did not alarm it was quiet. E13 said the pulse oximeters don't alarm that loud. When the apnea alarms go off they are loud.

Excerpts from the nurse's notes related to this death read as follows: "One RT (E10) ambu bagging the above resident. Crash cart was taken right away. Cardiac compression was done by this nurse writer as RT (E10) continues to ambu bag & @ the same time suction the resident. O2 saturation & HR (heart rate) were checked in between CPRs & O2 sat still noted (decreased) to 0 & HR still 0. Suctioning continually done by the RT & still residents parameters is not going up & RT (E10) mentioned trach appears kinked since he can't depress the suction catheter. RT (E10) then decided to change tracheostomy & when the trachea was changed, ambu bagging is still continued as well as cardiac compression. Resident's O2 sat went back up to 99 - 100%."

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R12 was in respiratory distress 15 minutes after being checked by a Respiratory Therapist. Alarms were not heard by the nurse or respiratory therapists. Per subsequent interview with E5 (Respiratory Therapy Supervisor) and E4, DON, rounds are made on residents by the Respiratory Therapists every 2 hours and by the nurses every 2 hours at alternating hours. This practice equates to the tracheostomy residents being seen hourly. CNAs make rounds every 2 hours. With rounds made at these intervals it is critical that the alarm system is functioning at an audible level that all can hear.

3. Per the clinical record, R13 was a 4 year old male diagnosed with Severe Mental Retardation, Apneic episodes, Static Encephalopathy, Ventilator Dependent and Tracheostomy. On 8/27/04 at 6:15 a.m. R13 had a respiratory and cardiac arrest.

During interview with E24 (CNA) on 10/12/04, she said she was changing R13 and noticed the Oximeter reading 88%. She called the RT and RN.

During interview with E25 (RN) on 10/14/04, she said she did not hear any alarms because she was in another room.

Nurse's notes read as follows: "(5:30) O2 sat 100% HR 95 (beats per minute) Trach & G Tube intact & patent." 6:15AM RT & Nurse was called to resident's room by CNA who rendered am. care to resident. CNA noted resident's saturation dropped to 88%. Upon entering the room RT was already bagging resident after disconnected from ventilator. Per Apnea monitor, pulse 164 O2 sat 41% Then after about 5 sec. heart rate ceased."

R13's oxygen saturation dropped from 100% to 88% within 45 minutes and he sustained a respiratory and cardiac arrest. He passed away at 7:29 a.m. The oximeter could not be heard by the RN who was in another room.

4. Per the clinical record R21 is a 22 year old female diagnosed with Profound Mental Retardation, Spastic Cerebral Palsy, Quadriplegia and Asthma. R21 has a tracheostomy and uses 5 liters oxygen via a trach collar (per respiratory workload form). On 9/29/04, R21 was sent out to the hospital due to an oxygen saturation of less than 84% per interview with E11 and E15, Registered Nurses.

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On 10/13/04 at 5:05 p.m., surveyor observed R21 in her bedroom with her oximeter alarming in a steady tone which could not be heard from the hallway. The monitor read 0/0, it was not on her finger. E1 (Administrator) entered the room and was aware that the oximeter was not on R21's finger. E1 got E5 who stated, the oximeter cannot be heard from the hall but the apnea alarm is audible.

Physician orders state "02 sats maintain (greater than) 90%." Two weeks prior to this incident, R21 was sent to the hospital due to oxygen saturation of 84%.

Other examples :

5. Surveyor observed R14 attached to pulse oximeter in room 101 on 9/28/04 at 11:15 a.m. R14's monitor was alarming. Heart rate read 22. E12 (Community Life Assistant) was not responding to the alarm. Surveyor asked her why the alarm was sounding. E12 asked E26 (CNA) "What's wrong?" E26 immediately got E11 (RN) who repositioned the sensor.

On 10/14/04 at 5:18 a.m. surveyor observed R14's oximeter alarming for approximately 22 minutes before staff responded. Surveyor was continuously observing R14 who was not in any type of distress during this time period. When E28 (CNA) entered the room she attended to the individual in the other bed before addressing the alarm after surveyor called it to her attention. Interview with E28 on 10/14/04 stated R14's monitor goes off a lot when she is uncomfortable."

6. R8 was observed on 10/13/04 on the second floor with her apnea monitor flashing lead disconnected. Per interview with E4, DON, on 10/14/04, it was still functioning but needed to be reset.

7. R19 was observed on 10/13/04 at 4:50 p.m., her oximeter was alarming high heart rate. The alarm could not be heard in the hallway.

The lack of audible oximeter alarms and apnea alarms that have not been set to meet respiratory and cardiac baselines of the individuals using them also creates potential health issues for Rs 6,22,23,24,25,26,27,28,29,30,31,32,33,34,36 and 37.

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E5 (Respiratory Therapy Director) was interviewed on 10/14/04 at 12:15PM in the third floor conference room. E5 stated, "Pulse oximeter is a convenience and not meant to be responded to but if someone (trained personnel) is around they may check the client". E5 added, "Apnea settings are pre-set by the company for children / pediatric setting." E5 then verified that no one in the facility knows the apnea monitor settings/parameters. E5 further added, "We do not change the settings, the company does that."

On 10/15/04 at approximately 11:00AM , E5 presented the surveyor with a fax from the company supplying the apnea monitors. It showed the Preliminary Control Panel Settings as follows:

CONTROL	SETTING
Apnea period	15 seconds
Heart rate fast	175 beats/min
Heart rate slow	40 beat/min
Sensitivity (Breath and Heart)	automatic
Breath rate low	8 breaths/min

Surveyor asked E5 if the heart rate goes up to 175 beats/ min and that's when the apnea monitor alarms is that something to be concerned about, E5 responded, "175 beats/min is critical guidelines. If the patient has that heart rate we have to be very concerned."

A review of the respiratory baselines with E5 for clients with tracheostomies shows the baseline heart rates as follows:

R18 - 80-130 beats/min
R22 - 66 -120beats/min
R23 - 120-160beats/min
R21 - 60-90beats/min
R24 - 70-110beats/min
R25 - 70-120beats/min
R26 - 60-100beats/min
R27 - 60-100beats/min
R6 - 80-130beats/min
R28 - 60-100beats/min
R29 - 70-120beats/min
R30 - 70-120beats/min
R31 - 60-110beats/min

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350.620a)	R32 - 70-110beats/min
350.1060h)	R33 - 70-120beats/min
350.1230b)1)2)3)	R34 - 70-120beats/min
350.3240a)	
(Cont'd.)	E5 then stated, "We can make the settings lower for everybody including infants too. I can adjust the settings now, the technician showed me how to adjust the settings last night (10/14/04). E5 added, "We will be more comfortable if its (settings/parameters) lowered to protect the residents."

Interview with E3, Corporate Nurse on 10/14/04 at 12:50PM at the third floor conference room stated, "175 beats/min - that's high, it's critical." E3 stated, "we probably need to give the company the clients' height and weight when they set the settings."

Interview with Z1 on 10/19/04 at 10:50PM via phone stated, "Once we deliver them, the therapist has to set the apnea monitors because we don't deal with the patients directly. We test with our own parameters and they (facility) can change it. Once the machines are connected it should automatically go to factory default settings."

Interview with Z4 on 10/20/04 at 10:12AM via phone stated, "typically we don't set it for the facility, the facility sets does it (set the parameters).

Interview with Z2 on 10/19/04 at 11:13AM via phone stated, "Pulse oximeters are very important because some kids can't tell you if they are short of breath." Pulse oximeters - once the alarms sounds they (facility) need to respond immediately." E5 (Respiratory Therapy Director) was interviewed on 10/14/04 at 12:15PM in the third floor conference room. E5 stated, "Pulse oximeter is a convenience and not meant to be responded to but if someone (trained personnel) is around they may check the client". E5 added, "Apnea settings are pre-set by the company for children / pediatric setting." E5 then verified that no one in the facility knows the apnea monitor settings/parameters. E5 further added, "We do not change the settings, the company does that."

(A)