STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. BUILDING _____ B. WING _____	C 08/29/2007

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ALDEN PARK STRATHMOOR	5668 STRATHMOOR DRIVE ROCKFORD, IL 61107

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F 323	Continued From page 25 "located". Staff will be inserviced on the amendment to the CPR policy, beginning 8/28/07 at 3 PM and will continue for staff not otherwise on duty, and new staff, before they go on duty. The facility developed guidelines for residents bringing in personal wheelchairs or medical equipment. The facility will request any available users' and maintenance manuals from the resident and/or family members, through on-line searches, or from the manufacturer/seller of the equipment. The Director of Nursing or Designee will review any resident equipment for the purpose of conducting proper inservice education for the resident's personal wheelchair or medical equipment prior to the equipment being put to use.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030a)1) 300.1210a) 300.1210b)6) 300.1220b)8) 300.3240a) Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute	F9999		

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F9999	Continued From page 26 respiratory distress, failure, or arrest). 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 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: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility neglected to assess and monitor a ventilator dependent resident left in the lobby unsupervised. The facility neglected to suction a ventilator dependent resident on 8/21/07 at 11:35 AM. The facility failed to educate the resident on the consequences of not being suctioned when he needed it. The facility neglected to immediately initiate resuscitative measures after R1 was found by the respiratory therapist cyanotic, unresponsive, and pulseless. The facility neglected to have staff knowledgeable on ventilator alarms and how to adjust the volume so it could be heard by staff. These failures resulted in an alert, ventilator dependent resident (R1) suffering a significant anoxic brain injury which has lead to Anoxic Encephalopathy with Anoxic Seizures. The resident is currently in a local hospital, only responsive to deep painful stimuli.

The neglect related to supervision began on 8/21/07 at 10:45 AM when the facility placed R1 unsupervised in the lobby. The neglect related to respiratory assessment and suctioning began on 8/21/07 at 11:35 AM when R1 was not assessed or suctioned. The neglect related cardio pulmonary resuscitation began on 8/21/07 at 12:50 PM when the facility did not immediately initiate CPR for R1.

Findings include:

R1 is a 44 year old resident whose diagnoses

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include Traumatic Quadriplegia leading to full ventilator support and a history of Brain Stem and Cerebral Stroke, according to the 8/20/07 Ventilator Rounds Assessment report. Review of R1's Advanced Directives dated 7/16/07 shows that the resident was to be a full code.

R1's 7/20/07 care plan for Potential for Complications related to Ventilator/Respirator use was reviewed. Some of the approaches include: monitor and report signs of respiratory distress, monitor and report signs of complications from mechanical ventilation, position resident in upright position for optimal breathing, monitor/document respiratory status, assess for change in level of consciousness, and maintain tubing and monitor for obstructions, kinks, or accumulation of water.

Nursing Notes of 8/21/07 at 12:50 PM written by E4 state, "Called to lobby per RT. Resident unresponsive, grey, unable to obtain pulse. Resident taken back to room, placed in bed. Code blue called and CPR started. CNP (Certified Nurse Practitioner) at bedside. Eyes fixed and remains unresponsive..."

On 8/23/07 at 10:40AM E4 (Licensed Practical Nurse - LPN) said that R1 had not been sick. E4 said prior to him arresting he was alert and responsive. She said that he had not offered any complaints on 8/21/07. She said that he was able to communicate to staff by "mouthing words." E4 said that R1 required frequent suctioning. E4 said that the last time she saw R1 prior to him arresting, was at approximately 11:00 AM on 8/21/07 when she went to start his tube feeding. At 12:50 PM she was called to the lobby. R4 said that the ventilator alarm was sounding, signifying that something was wrong with the ventilator. R4

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said that the resident was grey, unresponsive, and not breathing. E4 said that the ventilator was working and was plugged into the electrical outlet. E4 said that the resident was taken back to his room, and resuscitative measures were begun. E4 said that upon suctioning the resident, his secretions were thin and clear in color.

On 8/23/07 at 10:40 AM E6 (Respiratory Therapist) said that E4 (LPN) assisted her in getting R1 from his room to the lobby near the front entrance at 10:45 AM. E6 said that at 11:35 AM she was summoned over head to suction R1. R1 refused the procedure because he did not want to leave the lobby. E6 stated, "Maybe I should not have trusted him. I had problems with ventilators alarming low oxygen... These are new ventilators for me. I know the family takes R1 out in the lobby. I am not aware of any family training on R1's ventilator." E6 confirmed that at 12:50 PM, when she went out to give R1 a treatment, his ventilator alarm was sounding. E6 verified that R1 was reclined in his wheel chair and that there was no chest rise or spontaneous respirations observed. E6 was asked why R1 was transported back to his room before CPR was initiated. E6 said, "I have never initiated a code for a resident on a ventilator. I have initiated codes on residents while they are in their room where equipment is available to clear the airway and bag (manual ventilation with Ambu-bag)." E6 said that she did not try to establish R1's airway while he was in the lobby. E6 confirmed that she waited until R1 was out of his wheel chair and in bed before she attempted to establish an airway.

R1's Ventilator Flow/Assessment Sheet dated 8/21/07 documents that on the night shift R1's breath sounds were clear with moderate amounts

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of thin mucus. On the day shift R1 was assessed to have course rhonchi with moderate amounts of thick mucus. The Ventilator Flow/Assessment Sheet shows that R1 was last suctioned at 10:40 AM. The facility was unable to provide any documentation showing that R1 was counseled about the need to maintain good pulmonary toileting or the risks of refusing to be suctioned when needed.

On 8/24/07 at 10:50 AM E5 (Respiratory Manager) said that the ventilator alarms are pre-set at the factory. E5 said, "The ventilator alarms are as high as they can go they cannot be adjusted at the facility."

All of the mechanical ventilators were observed on 8/24/07 at 11:30 AM. All of the ventilators were found to have a volume control screw located on the back panel of the ventilator. The volume control screw could be turned using a standard screw driver. The mechanical ventilators used for R2, R4, and R5 were observed to be set at the lowest volume setting. E5 was able to locate a screw driver used to turn the volume screw in the Respiratory Office located on E wing. E5 verified that the alarm volume could be controlled by adjusting the alarm volume screw located on the back of each mechanical ventilator.

During an interview on 8/23/07 at 3:35 PM Z2 said that R1 was without adequate ventilation for some period of time. The resident has sustained a significant Anoxic Injury and is non- responsive due to the events of 8/21/07. Z2 said that the resident was now having seizures related to the Anoxia and his prognosis is poor. Z2 said that R1 should have been supervised while out in the lobby. He said that R1 resides in the facility

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F9999	Continued From page 31 because he requires 24 hours nursing care. On 8/23/07 at 10:40 AM E2 (Director of Nursing) said that the staff are trained to respond anytime they hear a ventilator alarm sounding. When ventilator dependent residents are in their rooms, the ventilator alarms are tied into the call light system. When the residents are out of their rooms, staff are to listen for the ventilator alarms. The facility's Operations Manual Policy and Procedure for Resident/Family Education dated 9/2000 states, "Document comprehension of instruction accompanied with return demonstrations on the Resident/Family Education Flowsheet." The Policy and Procedure further states, "Provide education on the following areas...Ventilator Care." On 8/23/07 at 12:30 PM the surveyor, E2 and E9 (Respiratory Therapist - RT) went into R1's room, #E1. The alarm on the mechanical ventilator was tested. The sound of the alarm was noted to be very quiet. E9 said that the alarm is as loud as it can be. The ventilator was taken out into the lobby where staff had reported that R1 was sitting at the time of his arrest. The resident was in his wheelchair at the front of the lobby, in the northwest corner, facing the windows, looking outside. The alarms on the ventilator were again tested. The surveyor walked to the receptionist desk approximately 30 feet away and to the resident's room, approximately 103 feet away. The sound of the alarm was barely audible with the background noise of the milieu. The facility policy,"Management of the Ventilator Resident" (dated 9/00), number 3 states,"Respond to ventilator alarms immediately...."	F9999		

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F9999	Continued From page 32 On 8/23/07 at 10:40 AM E2 (Director of Nursing) said that the staff are trained to respond anytime they hear a ventilator alarm sounding. When ventilator dependent residents are in their rooms, the ventilator alarms are tied into the call light system. When the residents are out of their rooms, staff are to listen for the ventilator alarms. The facility policy, "Management of the Ventilator Resident" (dated 9/00), number 3 states, "Respond to ventilator alarms immediately. Determine cause and correct." Number 10 of the policy states, "Establish a method of communication which enables him or her to call for help and express his or her needs. (i.e.,communication board, finger singles, etc.)." No evidence was provided by the facility that the resident had anyway to communicate to staff that he needed help. The resident was seated in the northwest corner of the lobby, in front of the windows, facing outside, therefore he had no have way to communicate with staff that he was having difficulties. On 8/25/07 at 9:30 AM Z4 said that the facility had reported to Emergency Department staff that there was a 15 minute lapse in time from when the resident was last seen by facility staff to when the resident was found by the Respiratory Therapist in an apparent arrest. (A)	F9999		