

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2014
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NAME OF PROVIDER OR SUPPLIER AMBERWOOD CARE CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)8) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>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. 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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by: Based on observation, interview and record</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>review, the facility failed to ensure a physician ' s order was obtained prior to changing a tracheostomy for R1. The facility failed to notify the physician when a resident was exhibiting a change in condition.The facility failed to develop and implement policies and procedures relating to tracheostomy care and emergency response actions after a resident (R1) succumbed following a respiratory emergency in the facility. These failures contributed to R1 ' s death and has the potential to affect R2 who currently resides in the building and has a tracheostomy.</p> <p>This applies to 2 residents (R1 & R2) reviewed for trach cares in the sample of three. The findings include: 1. R1 was a resident with diagnoses to include Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Airway Obstruction, Sepsis and Gastroenteritis/Colitis according to the diagnosis list in the facility ' s computer generated medical record. According to the facility ' s face sheet, R1 was initially admitted on 2/22/13 at 4:00 PM. R1 was discharged back to the local hospital on 2/28/13 and did not return to the facility until 3/13/13 at 4:00 PM. The Hospital Discharge/Transfer Orders dated 2/15/13 documents: " O2 (oxygen) therapy; Passy-Muir/capped during day. Humidified Air via trach collar at night. " The 2/22/13 Discharge/Transfer communication sheet documents Passy-Muir valve/cap trach during day. The facility documented the following orders for R1 dated 2/22/2013: Trach care every shift; Cap trach during day; Trach size is (name brand) 8; Apply humidified room air per t-collar at night; and Suction trach as needed for increased secretions. The facility Admission Flash Sheet documents: Trach - #8 (name brand) - capped during the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>day/aerosol t-mask humidified RA at noc (night). The facility Registration Notice Sheet showed: Trach - capped #8 (Name Brand)/RA during day - humidified room air-aerosol collar at noc. On 2/26/13, Z5 (Medical and Rehab Physician) documented, " Tracheostomy in placecan be clampedRespiratory Care: consider to use oxygen by nose. "</p> <p>The facility nursing notes dated 2/23/13 at 4:12 PM documents: " Resident (R1) has new dressing to trach site. Resident ' s trach capped per orders and O2 via NC (nasal cannula) disconnected for the day. "</p> <p>The Hospital nursing notes dated 3/12/13 identified R1 as having a "cuffed" style trach with "cuff deflated."</p> <p>Z2 ' s (Physician) Progress Note dated 3/13/14 at 11:19 AM documents R1 " overall doing ok ...denied shortness of breath. Has Trach. Secretions are lessOverall: awake, alert, not acute distress, no respiratory distress. Sitting in a chair. Pleasant. Cooperative ...trach site ok. "</p> <p>On 3/14/13, the nursing note at 11:21 AM showed R1 " stopped coughing and his lips turned cyanotic in color, " " immediately " after a tracheostomy change was completed by the nurse (E6 - Registered Nurse). The note showed E6 was in the room with R1 ' s wife who was sent out of the room to obtain another nurse for assistance.</p> <p>R1 ' s Nursing Note dated 3/14/13 at 12:30 AM documents, " Blood tinged mucus noted from trach. " The 3/14/13 note at 7:42 AM documents, " Suctioned blood tinged mucus. " These entries showed a change in secretions in the prior 12 hours. The documented Oxygen Saturations for R1 on 3/13/13 at 2:00 PM was 100% and on 3/13/13 at 8:01 PM was 99%. The 3/14/13 documentation of 90% showed a declining condition. E6 wrote she took the time</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>to complete nebulizer treatments, suctioning and trach cleaning without success. E6 did not notify the physician of R1 ' s change in condition.</p> <p>E2 (Director of Nursing) and Z1 (Nurse Practitioner) stated E6 should have called to notify the physician of the changes and obtain orders. Z1 stated a trach should never be changed without a physician ' s order. E2 acknowledged E6 did not seek assistance until after R1 stopped breathing.</p> <p>The facility documented the following orders for R1 dated 2/22/2013: Trach care every shift; Cap trach during day; Trach size is (Name Brand) 8; Apply humidified room air per t-collar at night; and Suction trach as needed for increased secretions. The facility Admission Flash Sheet documents: Trach - #8 (Name Brand) - capped during the day/aerosol t-mask humidified RA at noc (night). The facility Registration Notice Sheet showed: Trach - capped #8 (Name Brand)/RA during day - humidified room air-aerosol collar at noc.</p> <p>The facility ' s Minimum Data Set ' s dated 2/28/13 and 3/13/13, both scored R1 as having no cognitive impairments.</p> <p>A hospital Speech Therapy Report dated 2/8/13 documents, " the patient (R1) received a tracheostomy on 1/17 (2013) and a G-Tube (Gastrostomy Tube) on 1/31 (2013)Passy-Muir valve was used during the evaluation. "</p> <p>According to Johns Hopkins Medicine titled Tracheostomy and a Passy-Muir Valve, " the Passy Muir Valve is commonly used to help patients peak more normally. This one-way valve attaches to the outside opening of the tracheostomy tube and allows air to pass into the tracheostomy, but not out through it. The valve opens when the patient breathes in. When the patient breathes out, the valve closes and air</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>flows around the tracheostomy tube, up through the vocal cords allowing sounds to be made. The patient breathes out through the mouth and nose instead of the tracheostomy. Some patients may immediately adjust to breathing with the valve in place. Others may need to gradually increase time the valve is worn. Breathing out with the valve (around the tracheostomy tube) is harder work than breathing out through the tracheostomy tube. Patients may need to build up the strength and ability to use the valve, but most will be able to use the speaking valve all day after a period of adjustment. How to use the Passy-Muir: ... If the tracheostomy tube has a cuff, deflate it (remove the air from it) before placing the valve ... Safety Precautions: The valve must not be used on Trach ' s that have the cuff inflated. "</p> <p>On 4/1/14, E1 (Administrator) stated she looked throughout the day for nursing in-services on Trach Care. E1 stated she could not locate any training that had been completed prior to or since R1 ' s death.</p> <p>On 4/4/14 at 12:30 PM, Z4 (Respiratory Therapist), stated a " Trach that is capped or has a Passy-Muir Valve in use must have a deflated cuff. If the cuff were inflated, the patient would be unable to breathe. " Z4 stated during R1 ' s time at the Hospital, documentation showed he was able to speak to staff. Z4 stated, in order for a resident with a Trach to be able to speak, either the trach is capped or a speaking device such as Passy-Muir is used. Z4 stated she is able to deduce from the hospital documentation that R1 ' s cuff was NOT inflated. Z4 said if the valve became occluded, and a trach cuff was inflated, suctioning should be attempted to remove the " blockage. " If suctioning efforts are unsuccessful, " the balloon (cuff) should be deflated and/or the trach removed or breathing will stop. " Z4 acknowledged if an airway is not</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>established the resident will ultimately die.</p> <p>On 4/8/14 at 8:30 AM, Z3 (Pulmonologist) stated unless a resident is on a ventilator, typically, the cuff of the trach is not inflated. If the trach is capped, plugged, or a Passy-Muir Valve is in place and the cuff is inflated, the patient would not be able to breathe.</p> <p>On 4/2/14 at 2:00 PM, E2 (Director of Nursing) stated R1 's trach was a (name brand) #8 which is a " one piece unit. " At 3:30 PM, E2 stated " routine care " given by the nurses at the facility is " inner cannula cleaning and changing, (on a two piece Trach unit). " E2 acknowledged that complete removal of a Trach is beyond " routine care. " E2 stated a " physician ' s order " would be needed for the removal or changing of the Trach.</p> <p>The Hospital nursing notes dated 3/12/13 identified R1 as having a "cuffed" style trach with "cuff deflated."</p> <p>2. On 4/1/14 at 12:40 PM, R2 was observed seated in a wheel chair in her room. R2 was receiving a nebulizer treatment via mask to trach. Extra equipment and supplies were noted to be taped above her bed within easy reach.</p> <p>R2 ' s Nursing Notes dated 3/14/14 at 4:31 AM, described the following event: at 3:20 AM, " (R2) called this RN to her room complaining she could not catch her breath, sat (oxygen saturation) at this time was 68% (normal is 95-100%) on 4l/tm (liters per minute to trach) at 30% humidity. Performed suction of trach utilizing sterile procedure. Replaced O2 sat elevated only slightly to 74%. Encouraged patient to cough and deep breath, which she complied with, again only with slight elevation of O2 sat was achieved with a high of 78% only briefly before plummeting back to 65%. Raised O2 to 7l/tm, sat raised to 68% and then dropped dramatically to 48% from the time this RN entered patient ' s room until her</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>O2 sat decreased to 48% approximately 20 minutes passed. " At 3:39 AM, " while still at bedside, (E2) DON (Director of Nursing) via phone for assistance. Advised contacting physician and emergency treatment. " At 3:41 AM, " Still at bedside, contacted (PCP) on call coverage (CNP) via phone who ordered patient to be sent for emergency care via stretcher ambulance. " At 3:42 AM, " (ambulance) contacted via phone to coordinate ambulance transport. Was assured unit would arrive momentarily. " At 3:51 AM, " ambulance arrived "</p> <p>R2 remained with O2 saturations at less than 78% with complaints of difficulty breathing for 31 minutes prior to the facility obtaining emergency intervention.</p> <p>3. The facility Policy and Procedure titled Assessment: Acute Condition Changes, revised 1/2010 shows under #6. " The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response (within approximately one half hour or less). " The facility ' s policy and procedure titled Tracheostomy Care, revised 12/2009, states, Tracheostomy Care as changing Trach ties, clean tube and/or change disposable tubes. Under the Miscellaneous section of the policy, the following are identified, " 6. Provide tracheostomy care as often as needed, at least twice daily for old, established tracheostomies, and at least once per shift for residents with new tracheostomy sites. 7. A replacement tracheostomy tube must be available at the bedside at all times. 8. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. 9. Masks</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>are indicated if the resident is coughing, there is aerosolization of secretions during suctioning, and/or exposure of mucous membranes of the staff person ' s mouth and nose are likely. " The facility Policy and Procedure titled Assessment: Acute Condition Changes, revised 1/2010 shows under #6. " The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response (within approximately one half hour or less). "</p> <p>According to Medscape Reference, Drugs, Diseases & Procedures, 2011 (with update 12/17/13), " The postoperative care of patients undergoing this procedure (Tracheotomy), is often underemphasized. Perhaps the most critical event after Tracheotomy is the tube change, although many other aspects of the care of these tubes are critical (example: suctioning, hygiene, humidity, emergency preparedness). The safety of current practice patterns in tracheostomy management is poorly defined. Little attention has been devoted to the morbidity and mortality associated with postoperative tracheostomy tube changes as part of routine care, despite multiple reports describing the incidents of perioperative complications associated with the proceduresfor stable patients in the routine setting, tracheostomy tube changes are performed in various locations in the hospital, including the general inpatient ward, a step-down unit, or the ICUWhile the process of changing a tracheostomy tube is generally straightforward in the majority of patients, best practice dictates changes be performed only by someone who is skilled in the procedure. Furthermore, it is highly advisable to have 2 people present during any tracheostomy tube change and that prior to removing the old tube, all</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>components of the new tracheostomy tube be checked for integrity. " E6 (Registered Nurse), was identified by the facility as the nurse caring for R1 on 3/14/13 at the time of his passing. On 4/2/14 at 2:55 PM, per phone conversation, E6 was asked about the trach care and subsequent code blue which occurred on 3/14/13 at the facility. E6 stated " I know I changed the trach ties and inner cannula but I don ' t recall the details of the event. " E6 was informed that the trach used was a one piece unit which did not have an inner cannula. E6 responded saying, " I have done trach care numerous times. He (R1) wasn ' t new (to me) and his wife was excitable. " E6 again stated she could not remember the detail of the events as things " happened so fast. " The nursing note documented by E6 on 3/14/13 at 11:21 AM was read to her over the phone to assist in refreshing her memory. The note is written as follows: " Resident (R1) alert and oriented X 3 (person, place and time) this AM. Resident ' s AM blood sugar 325. Given scheduled insulin per POS (Physician Order Sheet). Resident (R1) had numerous clots at the head of trach. Resident lung sounds clear in upper fields; diminished in bases. Resident had a nonproductive, repatative (repetitive) cough. Resident ' s trach assessed and RN this shift noticed the lumen of the trach was extremely narrowed. RN this shift administered a nebulizer treatment to resident in an attempt to moisten the area and facilitate removal with suction which did not remove the occlusion. RN attempted to perform trach care to remove dried blood clots at head of trach, but the clots were unable to be removed. 120/68 (Blood Pressure), 84 (Heart Rate), 16 (Respirations), 98.2 (Temperature), 90% (Blood Oxygenation Saturation - Normal is 95-100%). Resident suctioned after trach care to remove any</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>cares/changes. E6 replied, " No. I worked at that facility with trach residents in the past and I am very comfortable and confident in my abilities to provide trach care. " E6 denied having assistance of other staff while performing " trach cares. "</p> <p>E2 and Z1 (Nurse Practitioner) stated E6 should have called to notify the physician of the changes and obtain orders. Z1 stated a trach should never be changed without a physician ' s order. E2 acknowledged E6 did not seek assistance until after R1 stopped breathing.</p> <p>(AA)</p>	S9999		
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