

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER ALDEN TERRACE OF MCHENRY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 803 ROYAL DRIVE MCHENRY, IL 60050
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall 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 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>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.</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.</p>	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interviews and record review facility failed to provide adequate and necessary supervision to two cognitively impaired residents (R3), with wandering behaviors and (R24), with swallowing difficulties on aspiration precautions. This applies to one of five sampled residents (R3) reviewed for falls in a sample of 23 and one supplemental sample resident (R24), reviewed with swallowing problems. These failures resulted in R3 having a fall incident with a fracture injury and R24 having a choking incident occur.</p> <p>The Findings include:</p> <p>R3 is one of nine independently ambulatory residents on the 300 unit (Dementia Unit). R3 ' s medical records include : diagnosis to include Alzheimer disease and Psychosis. 4/07/14 Minimum Data Set Assessment (MDS) and/ or current care plan, document presence of severe cognitive impairment, unable to make needs known, highly impaired vision and requires one person assistance with transfer and ambulation activity. R3's care plan also includes daily wandering behavior and history of pacing until the point of exhaustion. R3's May 2014 behavior tracking record documents daily wandering behavior. On 5/23/14 at 10:00AM, E10 (Acting Administrator - Vice President of Operations), said R3 is one of nine cognitively impaired, independent wanderers on the 300 (Behavior), unit. 4/05/14 fall assessment scored R3 as a high risk</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>for falls and stating R3 is confused, independent mobility with steady gait and with history of falls in past 1-6 months. R3's care plan includes intervention to monitor and redirect R3 as needed while wandering.</p> <p>R3's 5/04/14 Occurrence report includes at 11:30PM, R3 was witnessed tripping over a metal door stopper and fell to the floor. R3 complained of left shoulder and elbow pain. On 5/05/14 an X-ray done and revealed an impacted neck and head fracture of left humerus with some degree of subluxation of the Glenohumeral joint. Root Cause: magnetic door stopper on ground.</p> <p>Interventions put in place as a result of this fall: placed a chair over the magnetic door stopper to deter patient from walking by it and staff will re-direct patient when seen walking by potential obstacles. Will continue to monitor for safety and update care plan as needed.</p> <p>5/20/14 during initial tour, R3 was observed in a wheelchair in the 300 wing dining room with her left arm in an over the shoulder sling.</p> <p>5/22/14 at 3:30PM, a 4 inch by 4 inch metal box that was approximately 4 inches high directly on the floor and more than a foot away from the wall in the hallway. There was a dining room chair placed over the magnetic box during this observation.</p> <p>On 5/22/14 at 12:43PM, while sitting at the nursing station, R24 over heard coughing, gagging and attempting to call out " Help Me. " Upon entering R24 ' s room, R24 observed in bed, alone in her room with oxygen in place at 2 litters per nasal cannula and with lunch meal tray on bedside table in front of her. R24 observed short of breath, coughing and asking for help. R24's lunch tray contained thickened liquids. At 12:43PM no staff observed in or around the 300 Unit nursing station and no staff present within audible range to hear R24's cry for help. E9</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>(nurse), was immediately summoned to R24's room.</p> <p>E9, E11 (Alzheimer Unit coordinator) and E6 (clinical supervisor / restorative nurse), came immediately into R24's room and stayed with the resident until she felt better. After this coughing episode, R24 refused to eat or drink anything else. E6 removed R24's lunch tray out of her room, turned off the room lights and left a full glass of thickened liquids on bedside table, within R24's reach.</p> <p>On 5/22/14 at 1:00PM, E9 said R24 has swallowing problems, is currently receiving antibiotics for an upper respiratory infection and always uses oxygen therapy. E9 also stated this resident usually eats all meals in the dining room but she became tired so decided to eat lunch in her room.</p> <p>R24's medical record includes: 5/22/14 10:29AM, Speech therapy evaluation. This evaluation documents presence of oropharyngeal phase dysphagia. R24 takes un-safe intake amounts with decreased self correction, decreased safety awareness and poor self-monitoring skills. Recommendations include " Close supervision, facilitate safety and efficiency. The patient is recommended to use the following strategies and / or maneuvers during oral intake: no straws, specified swallowing precautions and to remain in upright posture for at least 30 minutes after meals. R24's May 2014 physician order sheet includes an order to have speech therapy evaluate and treat - per family request. R24 is on a mechanically altered diet with nectar thicken liquids.</p> <p>R24's current care plan includes: Swallowing / Chewing problem. Observe resident for difficulty swallowing, signs of choking and/ or aspiration. Provide assistance for meals as needed.</p>	S9999		

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S9999	Continued From page 4 On 5/23/14, R24's nursing progress notes were reviewed. R24's 5/22 and 5/23/14 nursing progress notes failed to include the 5/22/14 12:43PM choking and coughing episode or physician notification. (B)	S9999		