

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2008
NAME OF PROVIDER OR SUPPLIER ALDEN PARK STRATHMOOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5668 STRATHMOOR DRIVE ROCKFORD, IL 61107		
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F 000	INITIAL COMMENTS	F 000			
F 223 SS=G	<p>Original Complaint Investigation #0813820 / IL 36927 - F223, F224, F328 #0813941 / IL37064 - no deficiencies No extended survey was conducted. 483.13(b), 483.13(b)(1)(i) ABUSE</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a resident was not subjected to mental abuse when staff refused a resident (R1) a respiratory treatment until he showered. This failure resulted in the resident calling emergency services to receive medical assistance. R1 was transported to a local Emergency Department for evaluation and treatment 5 hours and 45 minutes after requesting the respiratory treatment.</p> <p>This is for 1(R1) of 3 residents reviewed.</p> <p>The example includes: R1 is a 55 year old resident whose diagnoses include, Respiratory Failure, Chronic Obstructive Pulmonary Disorder, Schizophrenia, Acute Renal Failure, Bipolar Disease, and Anemia, according</p>	F 223			

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	<p>Continued From page 1</p> <p>to the 8/08 Physician Order Sheet (POS). The POS shows that the resident's medications include continuous Oxygen 1-2 liters per nasal cannula, Pulmicort 0.5mg per nebulizer every 12 hours, Xopenex 1.25mg per nebulizer 3 times daily and as needed, Atrovent 0.5mg per nebulizer 3 times daily, and Abilify 20mg daily at 8:00 AM and 10mg in the evening.</p> <p>The July 21, 2008 Monthly Nursing Summary shows that R1 is alert to person, place, and time. On 8/20/08 at 10:20 AM, R1 said that on Monday night (8/18/08) his Oxygen tank was empty all night. He said that he asked the nurse (E2 - LPN) for a new tank and a respiratory treatment. R1 stated that E2 told him, "I'm not doing anything for you if you don't take a shower". The resident told the surveyor, "It was 1:00 AM, why would I want to take a shower in the middle of the night? I needed help, so I called 9-1-1."</p> <p>The Emergency Transport Record shows that the ambulance was dispatched to the facility at 6:13 AM on 8/19/08. The narrative of the report states,..."On the way to (the facility) dispatch stated that the patient called himself because he ran out of Oxygen...According to the patient, the nurse (E2-LPN) had denied the patient a breathing treatment when he asked for it...The nurse (E2) stated patient messed himself and was using offensive language towards her and she denied him an albuterol treatment until he cleaned himself up...".</p> <p>On 8/19/08 at 2:25 PM, Z1 said that E2 (LPN) told him that she did not give the resident a new Oxygen tank or a respiratory treatment because he was using profanity and was incontinent of feces. She said that she told the resident he</p>	F 223			

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F 223	Continued From page 2 would have to shower first. On 8/20/08 at 11:20 AM, E2 said,"He (R1) is loud, he yells, he shouts obscenities, he's very un-nice. He has a very offensive body odor. I get frustrated with all of the residents (on the locked Psychiatric Unit)...He was out of Oxygen (on 8/18/08), I don't know how long he went without it...". E2 said that R1 requested the breathing treatment at 12:30 AM. E2 stated, "I probably told him to take a shower and then I would give him his breathing treatment". The resident's Resistant to Care Care Plan of 5/28/08 lists as some of the approaches to, "Allow resident to choose options (e.g., "Would you like to bathe in the daytime or evenings"?)...Maintain a calm environment and approach to the resident, Convey an attitude of acceptance toward the resident, Avoid power struggles with resident, and Allow resident to have control over situations, if possible". The facility's Abuse/Neglect policy states,"The facility desires to prevent abuse, neglect and theft by establishing a resident sensitive and resident secure environment...On a regular basis, supervisors will monitor the ability of the staff to meet needs of residents; staff understanding of individual resident care needs and situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur...".	F 223			
F 224 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224			

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F 224	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected a resident (R1), in respiratory distress neglected to provide Oxygen in his Oxygen tank and neglected to give a resident a breathing treatment, after he requested one. R1 was transported to a local Emergency Department for evaluation and treatment 5 hours and 45 minutes after requesting the respiratory treatment.</p> <p>This is for 1 (R1) of 3 residents reviewed.</p> <p>The example includes:</p> <p>R1 is a 55 year old resident whose diagnoses include, Respiratory Failure, Chronic Obstructive Pulmonary Disorder and Schizophrenia according to the 8/08 Physician Order Sheet (POS). The POS shows that the resident's medications include continuous Oxygen 1-2 liters per nasal cannula, Pulmicort 0.5mg per nebulizer every 12 hours, Xopenex 1.25mg per nebulizer 3 times daily and as needed, and Atrovent 0.5mg per nebulizer 3 times daily.</p> <p>The July 21, 2008 Monthly Nursing Summary shows that R1 is alert to person, place, and time. On 8/20/08 at 10:20 AM, R1 said that on Monday night (8/18/08) his Oxygen tank was empty all night. He said that he asked the nurse (E2 - LPN) for a new tank and a respiratory treatment. R1 stated that E2 told him, "I'm not doing anything for you if you don't take a shower". The resident told the surveyor, "It was 1:00 AM, why would I want to take a shower in the middle of the night? R1 said that he never received a breathing</p>	F 224			

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F 224	<p>Continued From page 4 treatment. I needed help, so I called 9-1-1."</p> <p>The Emergency Transport Record shows that the ambulance was dispatched to the facility at 6:13 AM on 8/19/08. The narrative of the report states,..."On the way to (the facility) dispatch stated that the patient called himself because he ran out of Oxygen...According to the patient, the nurse (E2-LPN) had denied the patient a breathing treatment when he asked for it...The nurse (E2) stated patient messed himself and was using offensive language towards her and she denied him an albuterol treatment until he cleaned himself up...".</p> <p>On 8/19/08 at 2:25 PM, Z1 said that E2 (LPN) told him that she did not give the resident a new Oxygen tank or a respiratory treatment because he was using profanity and was incontinent of feces. Z1 said that E2 told him that she told the resident he would have to shower first.</p> <p>On 8/20/08 at 11:20 AM, E2 (LPN) said that R1's Oxygen tank did go empty sometime during the night. She said that the resident asked for a respiratory treatment at about 12:30 AM on 8/19/08. E2 said that she told the resident that she was busy, he should go take a shower, and she could be back later to give the treatment. E2 said that she had an emergency on the ventilator wing. She said that R4 had pulled her tracheostomy out. E2 was asked if Respiratory Therapy (RT) was in the building on the night shift. She said that they were, but they only work on the ventilator unit. The surveyor asked why she didn't have the Respiratory Therapist put R4's Tracheostomy back in. E2 stated, "I was taking care of it." During the interview, E1 (Administrator) was asked if the RTs can help</p>	F 224			

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F 224	<p>Continued From page 5</p> <p>anywhere in the building or if they must stay on the ventilator wing. E1 said that they can assist throughout the building.</p> <p>On 8/20/08 at 1:00 PM, E1 (Administrator) said that R4's Tracheostomy did not come out until 5:00 AM, 4 1/2 hours after R1 requested the respiratory treatment.</p> <p>The Emergency Transport Sheet documents that upon their arrival to the facility at 6:21 AM on 8/19/08, "...witnessed a staff member removing a large wheeled Oxygen cylinder from patient's room. Patient was standing next to bed, conscious and alert x 3, having difficulty breathing. Patient was speaking in 2-3 word sentences. Patient's color was pale and patient was agitated due to trouble breathing. Patient stated that he had been having difficulty all night. Patient also stated that he alerted his nurse to the fact that his oxygen was out and nothing was done...placed on 15 liters of Oxygen via non-rebreather mask and listened to lung sounds hearing tight wheezing in all fields...asked patient about receiving breathing treatment and patient stated the nurse refused to give him a treatment...". The paramedic also documented that the resident was slightly diaphoretic.</p> <p>The Emergency Medical Transport record shows that the resident arrived at the local Emergency Department at 6:32 AM, on 8/19/08. The Emergency Department record shows that the resident was given 2 nebulizer treatments and Solu-Medrol 125mg Intravenous. The Emergency Department diagnosis, according to the physician dictation, was "Acute Dyspnea secondary to exacerbation Chronic Obstructive Pulmonary Disease".</p>	F 224			

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F 224	Continued From page 6 The facility's Abuse/Neglect policy states,"The facility desires to prevent abuse, neglect and theft by establishing a resident sensitive and resident secure environment...On a regular basis, supervisors will monitor the ability of the staff to meet needs of residents; staff understanding of individual resident care needs and situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur...". R1's 5/21/08 care plan "Potential for shortness of breath related to the diagnosis of Chronic Obstructive Pulmonary Disease and Respiratory Failure lists the following as some of the approaches: encourage resident to report shortness of breath to staff as it occurs, administer oxygen as ordered, and administer meds per MD order".	F 224			
F 328 SS=G	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a resident's Oxygen	F 328			

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F 328	<p>Continued From page 7</p> <p>Saturation and Lungs were assessed after he ran out of Oxygen, and complained of shortness of breath. The resident requested a respiratory treatment, but staff refused to give it. These failure resulted in the resident calling outside emergency services to receive medical assistance. R1 was transported to a local Emergency Department for evaluation and treatment.</p> <p>This is for 1 (R1) of 3 residents reviewed.</p> <p>The example includes:</p> <p>R1 is a 55 year old resident whose diagnoses include, Respiratory Failure, Chronic Obstructive Pulmonary Disorder, Schizophrenia, Acute Renal Failure, Bipolar Disease, and Anemia, according to the 8/08 Physician Order Sheet (POS). The POS shows that the resident's medications include continuous Oxygen 1-2 liters per nasal cannula, Pulmicort 0.5mg per nebulizer every 12 hours, Xopenex 1.25mg per nebulizer 3 times daily and as needed, Atrovent 0.5mg per nebulizer 3 times daily, and Abilify 20mg daily at 8:00 AM and 10mg in the evening.</p> <p>The July 21, 2008 Monthly Nursing Summary shows that R1 is alert to person, place, and time. On 8/20/08 at 10:20 AM, R1 said that on Monday night (8/18/08) his Oxygen tank was empty all night. He said that he asked the nurse (E2 - LPN) for a new tank and a respiratory treatment. R1 stated that E2 told him, "I'm not doing anything for you if you don't take a shower".</p> <p>The Emergency Transport Record shows that the ambulance was dispatched to the facility at 6:13 AM on 8/19/08. The narrative of the report</p>	F 328			

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F 328	<p>Continued From page 8</p> <p>states,..."On the way to (the facility) dispatch stated that the patient called himself because he ran out of Oxygen...According to the patient, the nurse (E2-LPN) had denied the patient a breathing treatment when he asked for it...The nurse (E2) stated patient messed himself and was using offensive language towards her and she denied him an albuterol treatment until he cleaned himself up...".</p> <p>On 8/19/08 at 2:25 PM, Z1 said that E2 (LPN) told him that she did not give the resident a new Oxygen tank or a respiratory treatment because he was using profanity and was incontinent of feces. She said that she told the resident he would have to shower first.</p> <p>On 8/20/08 at 11:20 AM, E2 said that she was aware that R1 was out of Oxygen (on 8/18/08). She said, " I don't know how long he went without it...". E2 said that no one really monitors the amount of Oxygen in a tank or when the tanks are changed. She said that usually the residents tell the staff when they are out of Oxygen. E2 said that R1 requested the breathing treatment at 12:30 AM. E2 was asked if she assessed the resident. E2 stated,"short of looking at him, I didn't assess him." E2 was asked if she did an Oxygen Saturation level or listened to the resident's lungs. She said that she did not do any of those assessments. E2 said that she never does Oxygen Saturation levels on the resident. She stated, " I have seen him smoke 16 cigarettes in a row, I think it's wrong. He continually is depriving himself of oxygen. Review of the Nursing Notes shows that there is no documentation for the 11p-7A shift on 8/19/08.</p> <p>The facility's policy Resident's Change in</p>	F 328			

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F 328	<p>Continued From page 9</p> <p>Condition/Status states, "...The staff will record in the resident's medical record any changes in the resident's medical condition or status".</p> <p>R1's 5/21/08 care plan "Potential for shortness of breath related to the diagnosis of Chronic Obstructive Pulmonary Disease and Respiratory Failure lists the following as some of the approaches: Encourage resident to report shortness of breath to staff as it occurs, administer oxygen as ordered, elevate head of the bed as needed, administer meds per MD order, and assess for pain associated with shortness of breath".</p> <p>The Emergency Transport Sheet documents that upon their arrival to the facility at 6:21 AM on 8/19/08, "...witnessed a staff member removing a large wheeled Oxygen cylinder from patient's room. Patient was standing next to bed, conscious and alert x 3, having difficulty breathing. Patient was speaking in 2-3 word sentences. Patient's color was pale and patient was agitated due to trouble breathing. Patient stated that he had been having difficulty all night. Patient also stated that he alerted his nurse to the fact that his oxygen was out and nothing was done...placed on 15 liters of Oxygen via non-rebreather mask and listened to lung sounds hearing tight wheezing in all fields...asked patient about receiving breathing treatment and patient stated the nurse refused to give him a treatment...". The paramedic also documented that the resident was slightly diaphoretic.</p> <p>The Emergency Medical Transport record shows that the resident arrived at the local Emergency Department at 6:32 AM, on 8/19/08. The Emergency Department record shows that the</p>	F 328			

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F 328	Continued From page 10 resident was given 2 nebulizer treatments and Solu-Medrol 125mg Intravenous. The Emergency Department diagnosis, according to the physician dictation, was "Acute Dyspnea secondary to exacerbation Chronic Obstructive Pulmonary Disease".	F 328			