STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING: _____ B. WING _____	C 08/09/2019

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NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

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S 000	Initial Comments Investigation of Complaint: #1975757/IL114620	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) (1of 2) 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 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. 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: 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review the facility failed to monitor and supervise a cognitively impaired resident who was left in the uncovered outside patio, being exposed to direct sunlight and heat.

This failure resulted in R1 needing to be sent out to the local hospital emergency room for treatment of hyperthermia and heat exposure. R1 was admitted to the local hospital with a diagnosis of hyperthermia and heat stroke (prolonged sun exposure).

This applies to 1 of 3 residents (R1) reviewed for incident reports.

The findings include:

R1 has diagnoses including paranoid schizophrenia, general muscle weakness, vascular dementia with behavioral disturbance, abnormal involuntary movements, gait abnormalities and mobility, bipolar disorder and intellectual disabilities mental retardation per face sheet.

The MDS (minimum data set) dated 07/23/19 shows that R1 has severe cognitive impairment, requiring limited assistance with one staff assistance with dressing, personal hygiene and bathing.

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R1's current care plan goal showed that R1 continue to need 24-hour supervision.

The facility's SBAR (situation background assessment request) communication form dated 08/03/19 showed:
Situation: The change in condition, symptoms, or signs observed and evaluated, R1 was non-responsive.
Vital signs: Blood pressure - 108/54 pulse - 136 respiratory rate - 24 temperature - 105.4
Resident evaluation:
- mental status evaluation - decreased level of consciousness, unresponsiveness
- functional, behavioral and respiratory evaluation - unresponsiveness,
- skin evaluation - skin hot to touch
- neurological evaluation - decreased level of consciousness
Appearance: Non-responsive, breathing labored, skin hot to touch.
Nurses notes for additional information on the change of condition:

On Observed resident unresponsive with labored breathing. Resident sitting on a patio chair outside. Resident wearing pants and winter jacket. Resident brought inside, placed in his bed, his clothing was removed. Towels with cold water and ice was placed all over his body. 911 was called and resident was transported to the hospital emergency room. Physician and POA (power of attorney) aware.

Paramedics record showed that on 08/03/19 they responded to a call via 911. The record showed that the patient (R1) was unresponsive and breathing. R1 was laying on his bed with edema of both legs, NRB (non-rebreather mask) on. R1

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in his underwear with towels soaked in cold water and ice on his body. Nursing home staff had a thermometer in R1 armpit that was reading 104 degrees. Nursing home staff stated that they found R1 outside unresponsive and he was wearing a winter coat and pants and they believe he was outside all day. R1 was moved to the ambulance where additional medical treatment was given.

Hospital emergency department report dated 08/03/19 showed:
This is a 67 year old male with a medical history of mental retardation, schizophrenia, hyperlipidemia, hypothyroidism, tobacco abuse who presents to the emergency department for evaluation of altered mental status. He is currently staying in the nursing home and was found outside in the sun wearing full winter clothing. He was not acting like his usual self so EMS (emergency medical service) was called.
Patient is no verbal, history limited
Impression: primary impression heat stroke.
Rectal temperature 102.2, history suggestive of heat stroke
Cardiovascular exam - tachycardia

Hospital History and physical exam dated 08/04/19 showed:
Chief complaint: altered mental status
History of present illness: Patient is a 67 year old gentleman with no medical problems who is a resident at a local nursing facility who was found outside the facility in his winter clothes, weak and confused. The patient was brought to the emergency room and found to be hyperthermic possibly secondary to heat stroke. He is unable to elaborate on details the history.
Assessment and plan:
Altered mental status likely secondary to toxic

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metabolic etiology such perhaps dehydration and heat stroke versus new pneumonia. Plan to admit for careful hydration and monitoring.

The nurses notes dated 08/03/19 at 4:45 PM showed: Observed resident unresponsive with labored breathing sitting on the patio chair outside on the patio. Resident wearing pants and winter jacket. Resident was placed in wheel chair and brought back to his bed. Staff removed all his clothing, towels with cold water and ice applied all over his body. Body warm to touch. Oxygen with non- rebreather mask applied Oxygen saturation at 97%. Vital signs: Temperature 105.4, pulse 136, respiratory rate 24, blood pressure 108/54. 911 was called.

At 5:04 PM, 911 came to transport resident to hospital. V6 (physician) was called and made aware of resident condition.
At 5:30 PM Administration and POA was also made aware of resident condition.
At 8:42 PM placed a call to the hospital ER and resident is admitted with heat stroke.

On 08/07/19 at 11:28 AM V3 (nurse 7AM - 3 PM) stated "I was the day nurse of R1 that day (08/03/19). R1 likes to go outside the patio/courtyard/smoking area. After meals the patio/courtyard is open. If there is an activity going on, or during meal times they do not allow the resident to go out on the patio. During smoking times there is an activity staff, or a CNA assign to supervise the residents. R1 walks around and comes to get his medications. R1 did not have any untoward behavior that day (08/03/19). When V3 was asked they track their residents, V3 replied, "there is no set standard or rules."

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On 08/08/19 at 10:04 PM, V11 CNA (certified nursing assistant) stated "I was the morning CNA for R1 that day (08/03/19) and that he (R1) was fine and acting normal. R1 walks around and had lunch at 11 AM (first seating). I was assigned to the cigarettes cart that day (08/03/19). On 8/3/19 at 1:30 PM I noticed R1 had a cigarette and was wearing pants and winter coat. Residents were out on the patio for about 15 to 20 minutes. I saw R1 come back inside the facility between 1:45 PM - 1:50 PM. I saw R1 in the dining room around 1:45 PM. I left the door closed but not locked. The residents are able to go in and out to the patio. My shift ended at 2PM."

On 8/7/2019 at 2:30 PM V7 (Certified Nurse's aide) stated "The hours I work are 2 - 10PM. When I get here I make sure what assignment I have and then check on all my residents. V7 added that on 8/3/2019, V7 was in charge of the cigarette cart. V7 stated that she did not see R1 until 4 PM, which not unusual since he paces through the facility. V7 stated, "I didn't think anything of it because that is his norm." At 4 PM during cigarette rounds I saw R1 on the patio sitting in a chair slumped over in the sun with his winter coat on. I went over to him and asked if he wanted a cigarette he mumbled. I went back in the facility and started passing drinks out for the dinner meal. At 4:45 V10(Certified Nurse Aide) went out on patio to get residents ready for dinner and noted R1 sitting in chair slumped over and not responding. V4 (Registered nurse) was alerted to the emergency by V10."

V10 and V4 brought R1 back into facility placed him in bed and called 911.

On 8/7/2019 at 1:00 PM V10 (Certified Nurse's aide) stated "I was making rounds on the patio

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and getting the residents in the dining area for dinner when I noted R1 sitting in a chair slumped over. I proceeded to him and tried to arouse him, but he was unresponsive. I went inside and told R4 (Registered Nurse) there was an emergency on the patio. V4 and I brought R1 inside and placed him in his bed, proceeded to remove all his clothing and place towels with cold water and ice over his body. 911 was called by another staff member but I don't remember who did that. I don't know how long R1 was outside, but he was hot and sweating."

On 08/07/19 at 12:48 PM V4 (3PM -11PM nurse) stated "on 08/03/19 at around 4:30 PM they are about to serve the dinner and V10 CNA went to check on the residents in the outside patio and found R1 sitting on the chair by the wall. V4 said that she was in the dining room and V10 called her and found R1 in the outside patio unresponsive. V4 said that she was trying to arouse R1 but he was unresponsive and R1 had labored breathing. V4 said that V12 (nurse) came and someone brought the wheel chair, and wheeled R1 back to his room, and put him to back to bed. R1 was wearing pants and a winter jacket. V4 stated that they took all R1's clothing off and put cold towels, and ice on R1's face, legs and arms. V4 continued and stated that R1 was hot to touch. V4 said that one of the staff was taking vital signs and V3 (nurse) was putting ice on his armpit and trying to arouse R1 and 911 was called. V4 said that after preparing all the papers she went back to R1's room and the nurses (V3, V12) was still with R1 putting ice on R1's body and R1 was still unresponsive. V3 took R1's temperature and it was 105/axillary. The paramedics came and R1 was still unresponsive and they took over. I did not see R1 on that day (08/03/19) prior to the incident. V4

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was asked how they track their residents. V4 said that residents do not stay in their room, wander around in the TV room, solarium and by the vending machines they do not stay in one place. When there is an incident the staff fills out an SBAR assessment, they do not have incidents reports at the facility so on 8/3/2019 I filled out the SBAR assessment. On 8/3/2019 it was a warm and humid day."

On 08/07/19 at 10:40 AM V1 (Administrator) stated that the residents are free to go out to the patio with no supervision unless its smoking time then they have supervision. V1 said that once the door is open they can go in and out unless weather permitting. V1 continued and stated that the staff need to check on R1 couple of times because he paces through the hallways.

On 08/07/19 at 2:40 PM V5 (Activity director) stated that the patio door is always open unless it is meal times, activities, or severe weather condition.

On 08/08/19 at 9:32 PM V6 (Physician) was asked his expectation from the staff for supervising a resident and how long should a resident be out in the sun. V6 stated "it depends upon the temperature. V6 was told that day (08/03/19) when R1 was found the temperature was 87 - 89 degrees and humid. V6 said residents should not be outside for long periods of time and staff should keep an eye on residents for safety."

Facility's job description for certified nursing assistant showed:
Job summary: Working under the direction of the staff nurses, the certified nurses aide provides personal care and assistance to residents to

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assure their safety and comfort.
Responsibilities:
b. provides for the safety and security needs of the residents by making frequents round checks on residents and responding to the resident's call for assistance in a timely and appropriate manner.

August 2019 activity calendar showed that on 08/03/19 (Saturday) that there was no scheduled activity on that day (08/03/19) and all the other Saturdays were just for leisure time.

Facility's smoking times showed: 10 AM, 1:30 PM, 4 PM, 7:30 PM, 9:30 PM

Meal time schedule:
Breakfast time:
first serving - 7 AM
second serving - 8 AM
Lunch time:
first serving - 11 AM
second serving - 12 PM
supper time:
first serving - 5 PM
second serving - 6 PM

Facility's patio door notification sign showed that the patio door will be open daily from 9 AM to 10 PM. It will be locked for all meals, activities and severe weather conditions.

(B)

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300.690b)c)
(Written in field)

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This Requirement is not met as evidence by:

Based on interview and record review the facility failed to submit a reportable/incident report to IDPH (Illinois Department of Public Health) on a resident (R1) who was found unresponsive after being exposed to direct sunlight and heat for a unknown period of time.

This applies to 1 of 3 residents (R1) reviewed for incident reports.

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Findings include:

The EMR (Electronic Medical Records) showed R1 with admitting diagnoses of Paranoid schizophrenia, Alzheimer dementia, hypothyroid, arthritis, mental retardation, radial nerve palsy.

On 8/8/2019 MDS (Minimum Data Set) dated 7/23/2019 showed a BIMS (Brief interview for mental status) of 7 (severely impaired cognition).

Record Review of the facility Reportable's Binder from January 2019 through August 2019 did not show that a reportable/incident report was filled out for R1 for the 8/3/19 incident.

Record review of Care plans dated 7/19, under goals for care and discharge stated that discharge for R1 was not feasible due to care needs. R1 continues to need 24 hour supervision.

On 8/7/2019 at 1:00 PM V1 (Administrator) stated "I felt that it was not necessary to submit an incident report to IDPH (Illinois Department of Public Health) for the 8/3/19 incident involving R1. Situations involving sutures, altercations with injury, broken bones would be an example of reportable's that I would submit. R1 returned after 2 days in the hospital with no adverse effects so I felt there was no need to file a report. SBAR (situation background assessment request) is a form the staff uses and fills out when an incident happens. I do not go by any criteria of when or when not to submit a incident report to IDPH if the resident did not have an adverse effect I don't send it" Surveyor asked V1 if she thought hyperthermia, unresponsiveness, could have caused physical harm to a resident and

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would have been a reason of submitting a reportable to IDPH. V1 replied back no R1 had no adverse effects and he returned to facility. V1 also stated that she is not medically equipped to answer medical questions."

On 8/7/2019 at 1:00 PM V10 (Certified Nurses aide) stated "I was making rounds on the patio and getting the residents in the dining area for dinner when I noted R1 sitting in a chair slumped over. I proceeded to him and tried to arouse him but he was unresponsive. I went inside and told R4 (Registered Nurse) there was an emergency on the patio. V4 and I brought R1 inside and placed him in his bed, we proceeded to remove all of his clothing and place cold water and ice over his body. 911 was called by another staff member but I don't remember who did that. I don't know how long R1 was outside but he was hot and sweating."

On 8/7/2019 at 2:30 PM V7 (Certified Nurses aide) stated "The hours I work are 2-10 PM. When I get here I make sure what assignment I have and then check on all my residents. On 8/3/2019 I did not see R1 until 4PM which was not unusual since he paces through the facility. I didn't think anything of it because that is his norm. On my assigned I was in charge of the cigarette cart. At 4 PM during cigarette rounds I saw R1 on the patio sitting in a chair slumped over in the sun with his winter coat on. I went over to him and asked if he wanted a cigarette he mumbled back no. I went back in the facility and started passing drinks out for the dinner meal. At 4:45 V10 went out on patio to get residents ready for dinner and noted R1 sitting in chair slumped over and not responding. V4 (Registered nurse) was alerted to the emergency by V10."

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On 08/07/19 at 12:48 PM V4 (3PM -11PM nurse) stated "on 08/03/19 at around 4:30 PM they are about to serve the dinner and V10 CNA went to check on the residents in the outside patio and found R1 sitting on the chair by the wall. V4 said that she was in the dining room and V10 called her and found R1 in the outside patio unresponsive. V4 said that she was trying to arouse R1 but he was unresponsive and R1 had labored breathing. V4 said that V12 (nurse) came and someone brought the wheel chair, and wheeled R1 back to his room, and put him to back to bed. R1 was wearing pants and a winter jacket. V4 stated that they took all R1's clothing off and put cold towels, and ice on R1's face, legs and arms. V4 continued and stated that R1 was hot to touch. V4 said that one of the staff was taking vital signs and V3 (nurse) was putting ice on his armpit and trying to arouse R1 and 911 was called. V4 said that after preparing all the papers she went back to R1's room and the nurses (V3, V12) was still with R1 putting ice on R1's body and R1 was still unresponsive. V3 took R1's temperature and it was 105/axillary. The paramedics came and R1 was still unresponsive and they took over. I did not see R1 on that day (08/03/19) prior to the incident. V4 was asked how they track their residents. V4 said that residents do not stay in their room, wander around in the TV room, solarium and by the vending machines they do not stay in one place. When there is an incident the staff fills out an SBAR assessment, they do not have incidents reports at the facility so on 8/3/2019 I filled out the SBAR assessment. On 8/3/2019 it was a warm and humid day."

On 8/8/2019 at 1:30 PM V13 (Psych Rehab Director) stated "R1 is on her case load. I'll see him throughout the facility pacing or sitting in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING _____ B. WING _____	C 08/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

lounge area. R1 is one of the more needy residents here due to his behavioral issues, and needs to be observed frequently." R1 never misses the cigarettes schedule times so when I heard about the 8/3/19 incident it surprised me staff did not catch it earlier."

On 8/8/2019 at 3:00pm V3 stated "Ususally R1 comes to the medication cart when meds are due. Occasionally he does not come to the cart so I go looking for him. R1 usually is pacing the halls, in the TV day rooms, the solarium by the vending machines or on the patio. He is easy to find. When I can't locate my residents I immediately go looking for them."

Policy & Procedure:

V1 stated that facility does not have a policy/ procedure or criteria of how or when to file a reportable/incident to the State.

Allegation of not reporting an incident was cited under incident/accident 300.690

(B)