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	IL6007165	A. BUILDING: _____ B. WING _____	C 08/02/2018

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ALDEN PARK STRATHMOOR	5668 STRATHMOOR DRIVE ROCKFORD, IL 61107

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S 000	Initial Comments 1814965/IL104581 1814977/IL104594	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 300.1010h) 300.1210b)d)6) 300.3240 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. 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, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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of five percent or more within a period of 30 days. 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.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations are not met as evidenced by:

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Based on interview and record review the facility neglected to follow their policy and procedure by not notifying the physician of injury when R1 fell and landed on their head and ensure necessary care and services were provided when R1 experienced mental changes. This resulted in a delay of treatment of 4 hours for a resident that subsequently developed a subdural hematoma.

R1's Admission Record printed July 31, 2018 shows R1 is a 76 year old female with diagnoses which include Hemiplegia and Hemiparesis following cerebral infarction, cerebral infarct, and dementia with behavioral disturbances.

R1's Minimum Data Set (MDS) dated June 14, 2018, shows R1's Brief Interview for Mental Status (BIMS) score to be 00, cognitively impaired.

The local hospital radiology report dated July 20, 2018 at 12:11 AM shows "History: headache, post trauma ....Findings: Large extensive left convexity acute subdural hematoma measuring up to 3 centimeters (cm) maximal thickness. There is also a small amount of acute subdural hemorrhage along the right side of the falx and also a small amount in the right frontal and temporal regions as well. Pronounced mass effect including left and right midline shift measuring up to 1.9 cm and transtentorial herniation. The left lateral ventricle is moderately compressed ...."

On August 1, 2018 at 10:50 AM, V12 Registered Nurse (RN) stated when R1 was on the unit she did have behaviors of kicking her leg up to "wiggle" and change her position in her high back recliner. V12 stated R1 was alert and orientated

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times one. R1 did not need noxious stimuli (sternal rub) to interact with her. R1 could not have a meaningful conversation, but R1 would look at you, smile, and attempt to interact.

R1's Care Plan printed on July 31, 2018 shows "[R1] is noted to be at high risk for falls...Frequently exhibits restless behaviors in dhair as evidence by moving her legs in a way that changes her position in chair. Date initiaited June 9, 2015."

On July 31, 2018 at 12:35 PM, V8 Certified Nursing Assistant (CNA) stated during dinner on July 19, 2018, about 5:15 PM, R1 pushed off the table with her foot, flipped over her high back reclining chair's arm rest, and landed on her head. R1 had a wound over her right eye which was bleeding. V8 stated after dinner (6:30-6:45 PM) I went to check on R1. R1 was less responsive and "not herself". R1's eyes were closed, but you could see her eyes quickly moving back and forth under the eyelids. V8 stated V14 CNA supervisor was doing the post fall vitals for R1. V8 stated at 8:45 PM R1 was still less responsive and started vomiting. V8 stated V24 CNA had come to check on R1 at 9:00 PM. V24 performed a sternal rub to arouse R1 enough to open her eyes. R1 vomited again, and V15 RN was notified. V8 stated V2 Director of Nursing (DON) arrived after 9:30 PM. V2 had us (V8 and V14) place R1 in bed to get cleaned up before the ambulance arrived. V14 stated I left the facility close to 10:00 PM, and R1 had not left yet. V8 stated before R1's fall R1 would kick her leg up to change her position in her chair. R1 did this constantly. V8 stated R1 would nod and smile when you talked to her. R1 was easily aroused by talking to her, and would wake up if you moved her high back recliner.

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On July 31, 2018 at 12:45 PM, V14 Certified Nursing Assistant (CNA) supervisor stated that during the 6:30 vital signs R1 was less responsive, had an increase in blood pressure, and a decrease in heart rate. V14 stated "R1 was not herself." V14 stated V16 Assistant Director of Nursing (ADON) was contacted. V14 stated V15 was notified about R1's changes.

On July 31, 2018 at 12:45 PM, V14 stated R1's was placed on a one to one status while post fall neurological (neuro) checks were started on July 19, 2018 at 5:50 PM. V14 stated V16 Assistant Director of Nursing (ADON) was present at the start of the neuro checks. V14 stated R1 was awake at first then as time went on R1 declined in responsiveness and stopped her usual behaviors of moving her legs. V14 stated after 6:30 PM R1's blood pressure was going up and heart rate started slowing down. V14 stated V16 was contacted by phone again. V14 stated, "[V16] told me to contact [V2] (DON) with any changes because R1 could have a head bleed." V14 stated V15 Registered Nurse (RN) and V2 DON was notified. V2 arrived to the facility before 7:00 PM. V14 stated R1 stayed less responsive and at 8:45 PM started to vomit. V14 stated after the vomiting V2 had arrived back to the facility about 9:40 PM. V2 had myself and V8 put R1 into bed to clean R1 up before the ambulance arrived to take her to the hospital. V14 stated on a regular day R1 would watch you when you talked to her. R1 had behaviors of swinging her legs around to change position in her high back chair. V14 stated R1 was definitely different after R1's fall.

R1's Vital Summary printed on July 31, 2018

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shows R1's blood pressure on July 19, 2018 at 5:50 PM started at 123/71 with a heart rate of 69. At 6:50 PM R1's blood pressure was 151/74 with a heart rate of 55.

On July 31, 2018 at 1:10 PM, V17 (CNA) stated between 6:30 and 7:00 PM I reported to V15 R1 was getting "more sleepy" and "not acting herself". V17 stated when I went to check on R1 later in the evening (9:00 PM) R1 was still less responsive, needed a sternal rub to be aroused, and started vomiting.

On August 2, 2018 at 11:30 AM, V24 (CNA) stated on July 19, 2018 around 9:00 PM, R1 was in her high back recliner still by the nurses station. R1 was lethargic and not responding to verbal stimuli. V24 stated "I did a sternal rub to [R1's] chest." V24 stated R1 opened her eyes for a short time, and then started to vomit. V24 stated R1 was not like that right after the fall. V24 stated when R1 was on the floor in the dining room R1 had her eyes open and was looking around at us (staff).

On July 31, 2018 at 4:25 PM, V19 NP stated , "the first message I received for R1 was on July 19, 2018 at 9:27 PM. V19 stated the answering service texted me the facility name, R1's name, post fall with vomiting, and V15's name.V19(NP) initially contacted by the answering service . V19 stated "I had not received any information about R1 prior to the texting page at 9:27 PM."
I called the facility immediately and gave orders to send R1 to the emergency room." V19 stated if a resident has an emergency the facility can send the resident to the emergency room even if they are on hospice unless the Power of Attorney has stated otherwise.

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On August 1, 2018 at 11:45 AM, V1 Administrator stated if a resident is having a change in condition the nurse should contact the physician or NP. If they do not get a reply within a reasonable amount of time they call again or call the primary physician. V1 stated after 5:00 PM the paging service should be used to contact the on call nurse practitioner.

On July 31, 2018 at 3:10 PM, V2 (DON) stated R1 did have a fall on July 19, 2018 during the dinner hour. V2 stated it is at the nurses' discretion to call the Emergency Medical System (EMS) if there is an emergent situation with a resident. V2 stated after a fall, accident, or change in condition the physician, Power of Attorney, and the family need to be notified per our policy. On August 2, 2018 at 8:45 AM, V2 stated a fall with a head injury has the potential for a head bleed which could be emergent. V2 stated an increase of blood pressure and a decrease in heart rate are changes that can occur with a head bleed. V2 stated on July 19, 2018 at 9:30 PM, V15 RN obtained and order to send R1 to the hospital. "I do not know why there was a delay in the ambulance arriving to the facility."

On August 1, 2018 at 8:40 AM, V15 RN stated, "I originally thought [R1] should go out to be seen because of the wound over her eye after she fell. I do not remember when I was told about any changes with [R1's] condition before she started vomiting (after 9:00 PM). V15 stated I received an order to send [R1] to the hospital at 9:30 PM. V15 stated I did not call 911 (EMS). I called a local ambulance service." V15 stated R1 left the facility around 11:15 PM.

R1's Prehospital Care Report dated July 19, 2018

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shows the ambulance dispatch with a response mode of no lights and sirens. The dispatch time is 10:51 PM, arrived to the facility at 10:55 PM, and departed the facility at 11:15 PM.

On August 2, 2018 at 10:20 AM, V22 Ambulance Manager stated the call for an ambulance was called directly to our ambulance service. If a call is made through 911, the call would have been given to the local fire department. V22 stated the call time is shown on the run sheet as unit dispatch (10:51 PM). That is the time a call comes into the ambulance answering service.

On August 1, 2018 at 10:45 AM, V20 (R1's physician) stated when the facility has a problem getting the on call person they can always call me. I did not receive any calls or notification about R1's fall or when she was sent to the emergency room.

The facility's Change of Condition Policy dated February 2017 shows "Attending physicians or physician on call Nurse Practitioner (NP) ...will be notified of all changes in condition ...Document time of call, physician or nurse practitioner or other person spoken to; reason for call and result or orders received ...follow framework for reporting changes in vital signs or laboratory values based on the American Medical Directors Association (AMDA) Guidelines ....See change of conditions and signs and symptoms from AMDA clinical practice guidelines ..."

The facility's AMDA Clinical Practice Guidelines dated 2014 shows if an immediate sign or symptom occurs with a head injury "Any head injury with change in level of consciousness, other mental status change, or any focal neurological findings ...Any symptom, sign or

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apparent discomfort that is: Acute or Sudden in onset, and: A marked change (i.e. more severe) in relation to usual symptoms and signs, or Unrelieved by measures already prescribed."

The facility's Neurological Assessment Policy dated May, 2010 states "Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasp and vital signs ...Notify physician immediately regarding any changes in the neurological assessment or other signs of possible increased pressure i.e., headache, change in mentation, vomiting, or irregular breathing."

The facility's Abuse and Neglect Policy dated February 2017 states "Neglect is the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm pain, mental anguish, or emotional distress. Serious bodily Injury is an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss of impairment of the function of the bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation."

On July 31, 2018 at 12:20 PM, V15 Registered Nurse stated, "after R1's fall (5:15 PM) I attempted to send a message to V18 Nurse Practitioner (NP) by the computer messaging service after 6:00 PM." On August 1, 2018 at 1:00 PM, V15 stated "I do not remember if V18 contacted me back." V15 stated after hour pages should be done with the paging service.

On July 31, 2018 at 3:50 PM, V18 NP stated after regular hours the facility knows to use the on call

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S9999	Continued From page 9 service. "I was not on call on July 19, 2018 so I would not have answered my phone." V18 stated "I did not have any contact with the facility that night." On August 1, 2018 at 10:45 AM, V20 (R1's physician) stated if the facility has a problem getting the on call person they can always call me. V20 stated "I did not receive any calls about R1 on July 19, 2018." On August 2, 2018 at 8:44 AM, V2 Director of Nursing (DON) stated the physician, Power of Attorney, or family should be notified after an accident of fall. V2 stated it is our policy. (B)	S9999		