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	IL6007165	A. BUILDING: _____ B. WING _____	C 04/26/2024

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ALDEN PARK STRATHMOOR	5668 STRATHMOOR DRIVE ROCKFORD, IL 61107

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S 000	Initial Comments Complaint Investigation 2413271/IL172390	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)3) 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 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	S9999		

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure a complete assessment was completed with R2's initial change in condition and immediately notify the physician of the change in condition. The facility failed to obtain physician orders for an increase in oxygen per nasal cannula. This failure resulted in R2 being transported to the local emergency department	S9999		

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S9999	Continued From page 2 on 3/25/24, 4.5 hours after her intial change in condition. R2 was in respiratory distress and failure upon arrival to the emergency department. This applies to 1 of 4 residents (R2) reviewed for quality of care in the sample of 12. The findings include: The Face Sheet, dated 4/29/24, for R2 showed medical diagnoses including acute respiratory failure, pneumonia, neuromuscular dysfunction of bladder, muscle weakness, unspecified abnormalities of gait, cognitive communication deficit, chronic obstructive pulmonary disease, low back pain, cardiomegaly, gastroesophageal reflux disease, obstructive sleep apnea, transient ischemic attack, dependence on supplemental oxygen, edema, hypertension, nicotine dependence, osteoporosis, allergic rhinitis, muscle spasm, intervertebral disc displacement, spondylosis, neuralgia and neuritis, fibromyalgia, heart failure, disease of pancreas, solitary pulmonary nodule, opioid dependence, non-rheumatic aortic valve insufficiency, disorders of kidney and ureter, history of Covid 19, congestive heart failure, moderate protein calorie malnutrition, cervicalgia, and chronic pain syndrome. The Pulmonary Consult, dated 3/4/24 for R2 showed, "(R2) seen today for in-house pulmonary consultation. Resting comfortable in bed and in no acute distress. (R2) denies any shortness of breath, chest pain, fever or chills, cough. Does report chronic oxygen use. Pulse 72 beats per minute; oxygen saturation 93% on 3 liters per nasal cannula; respiratory rate 18 breaths per minute. Lungs: diminished to auscultation bilaterally, no wheeze, crackles, or rhonchi. Nonlabored respirations. Plan: severe COPD	S9999		

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(chronic obstructive pulmonary disease). On supplemental oxygen by nasal cannula. Albuterol, 2 puffs every 4 hours as needed. Breztri, 2 puffs twice daily. Plan/Recommendations: continue current management. Please call pulmonary for any changes to patient respiratory status."

The Physician Orders, dated 3/1/24 for R2 showed, "Oxygen per nasal cannula @ 2-4 liters per minute continuous every shift."

The Care Plan, dated 3/14/24, for R2 showed R2 in on antibiotic Cefdinir and doxycycline related to pneumonia. Monitor/document/report to MD (medical doctor) signs/symptoms of delirium: changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness, and agitation, and altered sleep cycle. R2 is noted with potential for respiratory difficulty secondary to sleep apnea. Administer oxygen as ordered. Monitor for any changes in respiratory status and notify MD as needed. R2 is noted with potential for respiratory difficulty secondary to diagnosis of chronic obstructive pulmonary disease. Unable to lie flat due to shortness of breath. Administer oxygen per MD orders. Monitor for signs of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence. R2 requires oxygen therapy secondary to respiratory failure and chronic obstructive pulmonary disease. Adjust oxygen to maintain saturation within adequate parameters (no parameters given). Administer oxygen per MD orders. Monitor for changes in respiratory status. Report any acute changes to MD. Monitor for signs and symptoms of respiratory distress and report to MD as needed. Respirations, pulse oximetry, increased heart

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rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color.

The Nurse's Notes, dated 3/15/24 for R2 showed, at 12:55 AM, "receiving oxygen at 3 liters per nasal cannula; head of bed elevated to prevent shortness of breath." At 6:34 AM resident was diagnosed with pneumonia on 3/14/24 by chest x-ray. Resident was started on levofloxacin 500 mg per day and received the first dose last night. Resident on 3 liters oxygen continuously by nasal cannula. Resident oxygen saturations monitored at 2:30 AM and (oxygen) saturation was 93% on 3 liters; upon next round at 4:00 AM resident saturation was 88% and resident was given breathing treatment. Resident's head was lowered to change her adult brief and resident's saturation dropped to 77%. Resident oxygen temporarily increased to 5 liters and oxygen saturation increased back up to 88%. There was not a complete assessment documented or notification to the doctor of a change in condition when R2's oxygen saturations started to drop, continued to stay lower than normal, and oxygen was increased to 5 liters.

The Resident's Vitals Record for R2, dated 3/15/24, showed at 2:29 AM, her oxygen saturation was 93% (no liters of oxygen documented). At 6:05 AM, R2 was 88 % on 5 liters of oxygen per nasal cannula. At 8:34 AM, R2's oxygen saturation was 84% (no liters of oxygen documented).

The Change in Condition Evaluation form completed and dated 3/15/24 at 8:32 AM (4.5 hours after her initial change in condion) showed, Respiratory evaluation - "other respiratory

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S9999	Continued From page 5 changes. Specify other: pneumonia." The assessment did not include if there was shortness of breath present or lung sounds. The Transfer Form completed by V12, RN (Registered Nurse), and dated 3/15/24 at 8:38 AM for R2 showed R2 was sent to the hospital on 3/15/24 at 8:25 AM for respiratory arrest. Pulse 102, respirations 20, oxygen saturation 84% via nasal cannula. Devices/treatments: oxygen at 6 liters per minute by nasal cannula/mask. The Nurse's Note written by V12, RN, and dated 3/15/24 at 1:53 PM for R2 showed resident oxygen saturation dropped to the low 80's while on 6 liters of oxygen with a continuous pulse oximeter on. R2 was sent to the emergency room. The Emergency Department Provider Note, dated 3/15/24 for R2 showed, "(R2) ...presents with altered mental status. The patient currently resides at a nursing home. The paramedics state the patient was noted to be altered over the past two days. The patient was noted to be hypoxic on room air today. As such, she has been transferred to the ED (emergency department) for evaluation. On arrival to the ED, the patient was in severe respiratory distress, with altered mental status, and unable to provide a medical history. Physical exam: blood pressure 143/46; pulse 124; temperature 102.7 degrees Fahrenheit; respiratory rate 38. Pulmonary: tachypnea, accessory muscle usage and respiratory distress present. Decreased breath sounds present. Neurological: she is unresponsive. Medical decision-making: On arrival the patient was unresponsive, hypoxic and in respiratory failure. As such, the patient was emergently intubated."	S9999		

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S9999	Continued From page 6 On 4/26/24 at 11:57 AM, V13, RN, stated shortly before R2 went to the hospital, her oxygen saturation dropped some, so he bumped her up while he tried to contact the doctor. V13 stated R2 was maintaining her oxygen saturation in range, his shift ended, and another nurse came in. V13 stated if R2's baseline oxygen stauration was in the mid 90's on 3-4 liters and she dropped to 88%, that would be a change in condition for the resident. V13 stated he would have called the doctor. V13 stated he normally documents he contacted the doctor or that the doctor was contacted. V13 stated R2 was alert and talking to him. On 4/26/24 at 11:37 AM, V12, RN, stated she received report at 6:00 AM on 3/15/24 from V13, RN, who told her R2 had been diagnosed with pneumonia and was maintaining her oxygen saturation. V12 stated V13 told her he bumped up R2's oxygen to maintain her oxygen saturation at 88%. V12 stated V13 said he had put a continuous pulse oximeter on R2 because she had been "de-satting" (oxygen saturation level was dropping). V12 stated R2 de-satted quickly later. V12 stated after she spoke to the doctor, she put R2 on 6 liters. V12 stated she was told by the physician to send R2 out. V12 stated they have to follow the phsycians orders for oxygen. V12 was not sure if having an oxygen saturation of 88%-92% for somone with chronic obstructive pulmonary disease was in the policy or not. V12 stated she did not remember if she wrote the order from the doctor to increase R2's oxygen to 6 liters or not. On 4/26/24 at 12:20 PM, V11, NP (Pulmonology Nurse Practitioner), stated R2's baseline oxygen saturation was 93% - 96% on 3 liters of oxygen. V11 stated R2 's oxygen saturation of 88% on 5	S9999		

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liters of oxygen would be a change in condition for her, and the provider should be updated. V11 stated if the nurse could not titrate the oxygen back down and go to R2's basline oxygen saturation, that should be relayed to the provider. If R2 needed more oxygen and was at 6 liters then R2 needed to be sent out; she was unstable. V11 stated if they knew R2 had severe chronic obstructive pulmonary disease, had pneumonia, and needed an increase in oxygen, then the provider should have been notified right away

On 4/26/24 at 1:54 PM, V15, CNA (Certified Nursing Assistant), stated R2 was not her resident on the day she was sent out, but she helped the other CNA with her. R2 was breathing heavily, had her oxygen on, and a full oxygen tank next to her that was working. V15 stated they reported it to the nurse.

On 4/26/24 at 1:59 PM, V16, CNA, stated R2 had continuous oxygen. R2's oxygen saturation was unstable and it started at night and was lower than it should have been. "When (R2's) oxygen saturation monitor beeped, I got the nurse. (R2's) pulse oximetry was on the lower end before I came in. (R2) wasn't speaking; she mumbled, but it wasn't clear. (R2's) breathing did not sound right. (R2) sounded more congested, a heavier sound." V16 stated R2's oxygen was at 5 liters before the pulse oximeter machine started alarming

The facility's Oxygen Titration policy (9/2020) showed, oxygen will be titrated to maintain oxygen saturation levels greater than or equal to 92% unless prescribed otherwise.

The facility's Change of Condition (Resident) policy (9/2020) showed, attending physicians or

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S9999	Continued From page 8 physician on call/NP (nurse practitioner) and responsible party 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. (A)	S9999		