

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

PRINTED: 05/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2015
NAME OF PROVIDER OR SUPPLIER ALDEN TRAILS			STREET ADDRESS, CITY, STATE, ZIP CODE 273 ARMY TRAIL ROAD BLOOMINGDALE, IL 60108		
(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) COMPLETION DATE
W9999	FINAL OBSERVATIONS Statement of Licensure Violations 350.620a) 350.1230d)1)2)3) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by:	W9999	Attachment A Statement of Licensure Violations		

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W9999	Continued From page 7 Based on record review and interview, the facility failed to ensure in the death of 1 of 1 individual, R2, the facility policy on emergency medical protocol was initiated once staff found R2 unresponsive with foam on her mouth, cold and bluish. Staff did not initiate CPR or call 911 immediately. Findings include: The facility's policy on CPR includes: 1) Check the resident for responsiveness. 2) Check for no breathing or no normal breathing. 3) Call for help. 4) Check the pulse for no longer than 10 seconds. 5) Give 30 compressions. 6) Open the airway and give 2 breaths 7) Resume compressions Compressions should be given within 10 seconds of recognition of the arrest. Record review of an Incident Report dated 3/3/15 written by E5, Nurse, states at approximately 5:30am writer received a call from staff for writer to come out right away. Writer found the resident (R2) unresponsive without pulse, BP (blood pressure) and not breathing. 911 was called and CPR was initiated. The facility's investigative report into the death of R2 includes an interview with E3, CNA (Certified Nursing Aide), who stated she worked the night shift of 3/2/15. E3 stated she did rounds at 12:00am, changed R2. At 2:00am E2 observed R2 and she was observed sleeping with her CPAP mask on. At 4:00am E3 observed R2			W9999			

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W9999	Continued From page 8 sleeping with her CPAP mask off which E3 states R2 would do at times. At 5:00am E3 assisted R2's roommate and at 5:30am went to assist R2. E3 found R2 unresponsive and had foam on her mouth. E3 called for E4, CNA, who found R2, to be cold and bluish. E4 called by phone E5, Nurse, who was at nearby facility. At 5:45am 15 minutes after E3 found R2 unresponsive E5 arrived at the facility. 911 was called and CPR was initiated. Nursing note completed on 3/3/15 indicated paramedics pronounced R2 dead at 6:15am while at the facility. E3 in the facility's investigative interview stated the reason she did not begin CPR was because she thought R2 was in a very deep sleep. On 4/1/15 at 6:45am E3, CNA, stated she received training in CPR prior to the death of R2. E3 was asked what training she received stated if someone is not responsive look around area to make sure it is safe. Assess whether the person is breathing or not. Check the pulse. If person is not responsive call for help and start CPR. E3 stated you give 30 compressions, raise the head and blow air into the person. E3 was asked if you found R2 unresponsive why you did not initiate CPR. E3 stated, "I was shaking, we need instruction, actually I was confused." On 3/31/15 E4, CNA, stated on 3/3/15 in her investigative interview around 5:30am E3 told her to come to R2's room. E4 said, "I saw her lying down lifeless. I went and called E5, Nurse, (by phone who was at another facility) and asked her to look at her (R2). I didn't tell her anything just that she had to come. E4 stated E5 asked her what it was and E4 said to E5 you have to come.	W9999			

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W9999	Continued From page 9 On 3/31/15 at 3:20pm E4, CNA, Certified Nursing Aide, stated she had received training in CPR prior to the death of R2. E4 was asked to describe the training stated when you see someone unresponsive try to wake them up and if not responsive start CPR, call 911 and let the nurse know." E4 was asked why CPR and the calling of 911 was not done immediately stated, "I was nervous and scared and I didn't know what to do. It was my first time with this kind of experience." On 4/1/15 E5, Nurse, at 7:15am stated she was contacted by phone on 3/3/15 at 5:30am by E4, CNA, to come to the facility. E5 stated, "I asked what's wrong and E4 said just come over... I got here around 5:45am and I asked E4 what was going on and E4 said it was R2 and go take a look at her. I took my wrist monitor used for BP (blood Pressure) and I said R2 and she didn't respond. I took her pulse and there wasn't any. The BP said error and I told E4 to call 911. I lowered the bed to begin CPR and when I was getting her ready I called the Doctor and told her what I was doing and I would call her with update. I started CPR with E3 and did CPR until the paramedical arrived and took over." E5 was asked should the staff have stated CPR immediately as opposed to waiting 15 minutes for your arrival to begin emergency procedures E5 stated, "People were inserviced right away after the incident to begin CPR immediately if a person is found unresponsive." (B)	W9999			