

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>
---	---

(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
--------------------	--	---------------	---	--------------------

S 000	<p>Initial Comments</p> <p>Complaint Investigation 1977417/IL116442 Facility Reported Incident Investigation of 10/3/2019 - IL116574</p> <p>Statement of Licensure Violations</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All</p>	S9999	<p><b>Attachment A</b></p> <p><b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/24/19
--	-------	-----------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>
---	---

(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	<p>Continued From page 1</p> <p>nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a resident's safe positioning when she received a bed bath. This failure resulted in the resident rolling off her air mattress to the floor and sustaining fractures to both of her legs.</p> <p>This applies to 1 of 3 residents (R1) reviewed for air mattress safety in the sample of 9.</p> <p>The findings include:</p> <p>R1's October 4, 2019 hospital Admission Documents after her fall showed R1 had "bilateral distal femur fractures which were both displaced ..." R1's hospital note further showed the fracture to her right femur was splintered into more than two fragments.</p> <p>R1's Face Sheet showed she had diagnoses of hemiplegia after a stroke that affected her dominant right side, generalized muscle weakness, muscle contractures at multiple sites, and dementia. R1's Weights list showed she weighed 212 pounds and was five feet tall. R1's August 8, 2019 Minimum Data Set (MDS) showed her cognition was moderately impaired, she required extensive assistance of two people</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>
---	---

(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	<p>Continued From page 2</p> <p>for bed mobility, she was totally dependent on two persons for bathing, and she had impairments to both of her arms and both of her legs.</p> <p>On October 10, 2019 at 3:10 PM, V5 CNA (Certified Nursing Assistant) stated he was giving R1 a bed bath by himself on October 3, 2019 when R1 rolled off of bed. V5 stated R1 was on an air mattress. V5 stated when he rolled R1 away from him to wash her back, the far side of the air mattress squished down so there was more air on one side of the bed than the other, and R1's feet and knees went out of the bed and she fell to the floor.</p> <p>On October 11, 2019 at 12:30 PM, V6 (R1's Physician) stated R1 was extremely fragile and really had no mobility in her lower extremities so she would have had no way to assist herself as she was going off the bed. V6 stated it would not have taken too much force for her to sustain fractures. V6 stated she expected the facility to be aware of how fragile and frail R1 was, and to roll her over slowly in the bed and not near the edge of the bed. V6 stated she knew R1 used an air mattress and she expects staff to have an understanding of how the beds can work. V6 stated air mattresses "can be tricky."</p> <p>R1's air mattress 2002 Service Manual showed the option of "Max Inflate - The air mattress can be maximally inflated by pushing the 'Max Inflate' button on the control unit, to assist in patient ingress/egress as well as normal nursing procedures ..."</p> <p>On October 11, 2019 at 9:15 AM, V13 (mattress company representative) stated "the Max Inflate setting is designed to create a surface for patient repositioning, transfers, or CPR." V13 continued</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>		
(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)	
S9999	<p>Continued From page 3</p> <p>"Max Inflate creates a firm surface so patients don't sink ...to be on the safe side, [staff] should go to Max Inflate to not get 'dipping'" with the air mattresses.</p> <p>On October 11, 2019 at 1:05 PM, V7 LPN (Licensed Practical Nurse- Restorative Nurse) stated he participated in the re-enactment of R1's fall from her air mattress. V7 stated when R1 was rolled over in bed, all of R1's weight was sent to the far side of her bed and R1's weight compressed the mattress there. V7 stated the combination of R1's mattress compression and her legs going over the side of the mattress was the root cause of R1's fall. After reviewing R1's air mattress 2002 Service Manual, V7 stated if the Max Inflate button is used, the mattress will inflate to the firmest level and you can roll someone over in bed and the mattress will not deflate. V7 stated it turns into a regular mattress and it would stay firm. V7 stated he was not aware of the Max Inflate option.</p> <p>On October 11, 2019 at 2:45 PM, V2 RN (Registered Nurse, Director of Nursing) stated she was not aware of staff ever altering the air mattress settings or using the buttons on the air mattress pump, including turning pressures on or off when getting up or laying back down. V2 stated the only time staff would change a setting would be if CPR were required. V2 stated V8 (Wound Care LPN) does all the training for the air mattresses. On October 10, 2019 at 2:45 PM, V8 stated the training she provides to staff is to tell them not to unlock or change the air mattress pump settings and to report if a resident's family or a resident is seen changing the settings.</p> <p>V8 stated R1's setting was "in the middle (between soft and firm) ...maybe at a five."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>
---	---

(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	<p>Continued From page 4</p> <p>On October 10, 2019, V5 (CNA) stated he did not adjust the setting on the mattress the night R1 fell, and did not recall ever receiving any special training with air mattresses.</p> <p>On October 9, 2019 at 1:15 PM, V12 (CNA) stated she never touches the buttons on the air mattress pumps, and she has never seen other CNAs touch the buttons either. On October 9, 2019 at 3:20 PM, V9 (LPN) and V10 (RN) stated they have never touched the buttons on the air mattress pumps and never adjust the firmness. On October 9, 2019 at 3:45 PM, V4 (LPN) stated R1 used an air mattress and "they don't want us to touch the settings." On October 10, 2019 at 2:55 PM, V17 (CNA) stated she "never messes with the [air mattress] pumps at the foot of the beds."</p> <p>R1's October 3, 2019 Post-Occurrence Documentation showed "Resident was in bed having a bed bath around 7:45 PM by CNA at this time she was laying on her back and was being turned to her right side and started sliding off the bed. Resident has an air loss mattress, and when she was turned the mattress shifted causing the resident to slide ..."</p> <p>The "Safety Precautions" section of R1's air mattress 2007 Operator's Manual showed the mattresses " ...are not intended to be and do not function as a patient fall safety device. Side rails must be used with the [brand name] mattress to help prevent falls, unless determined unnecessary based on the facility protocol or the patient's medical needs as determined by the facility, in these cases, the use of other suitable patient safety measures are recommended."</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>
---	---

(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 5  The facility's June 2019 Alternating Pressure Air Mattress policy showed "5. Allow pad to inflate by setting pressure per manufacturer's recommendations ..."  <p style="text-align: center;">(B)</p>	S9999		
-------	--	-------	--	--