SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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**S 000 Initial Comments**

Complaint Investigation

#2024048/IL123239

**S9999 Final Observations**

Statement of Licensure Violation:
1 of 1 violation

300.610a)
300.1210b)
300.1210d(1)2)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 300.1210 General Requirements for Nursing and Personal Care

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**Attachment A**

Statement of Licensure Violations

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**State Form**

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X3) DATE
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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ALEDO REHAB & HEALTH CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
304 S.W. 12TH STREET
ALEDO, IL 61231

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These Requirements are not met as evidenced by:

Based on record review and interview, the facility failed to promptly identify a change in condition and notify the Physician for one of three residents (R3) reviewed for change of condition in each sample of eight. This failure resulted in a delay of R3 being sent to the local hospital and a delay in treatment for R3's heart attack, therefore worsening R3's condition and requiring hospitalization of R3.

Findings include:

R3's Profile Face Sheet, undated, documents that R3 admitted to the facility on 9/7/19.

Facility Oxygen Policy, Revised 3/19, documents that, "Oxygen therapy may be used provided there is a written order by the Physician. The order must state liter flow per minute, mask or cannula, time frame. On an emergency basis, oxygen may be administered until the Physician is notified."

Facility Notification of Change in Resident Condition or Status Policy, Revised 12/7/17, documents that: The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, Director of Nursing/DON, Physician, Guardian, Health Care Power of Attorney, etc.) of changes in the resident's medical/mental condition and/or status; The nurse supervisor/charge nurse will notify the

**STATE FORM**

T94311
resident’s attending Physician or on-call Physician when there has been any symptom, sign or apparent discomfort that is sudden, a marked change or unrelieved, a significant change in the resident's physical/emotional conditions, a need to alter the resident’s medical treatment significantly or instructions to notify the Physician of changes in the resident's condition; The nurse supervisor/charge nurse will notify the DON or Physician, unless instructed by the resident representative, when the resident has any of the aforementioned situations; And the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status.

R3’s Nursing Note, dated 3/29/20 at 6:18 pm, documents that R3 was on two liters of oxygen and had an oxygen saturation of 90 percent, heart rate of 100 to 130, blood pressure of 100/54 and respirations of 36. It also documents that R3 had faint, muffled heart sounds, severe shortness of breath and that R3 was sent via ambulance to the local hospital.

R3’s Physician Orders, dated 3/1/20 through 3/30/20, do not document an order for Oxygen, liter flow per minute, mask, cannula or time frame or a medication for anxiety.

R3’s Medication Administration Record/MAR, dated 3/29/20, does not document Oxygen administration, flow rate, mask or cannula or time frame or as needed medication for anxiety.
On 8/19/20, at 9:59 am, V15/LPN stated, ",(R3) asked me to call her Granddaughter because (R3) felt anxious and was having trouble breathing. (R3's) Granddaughter arrived at the facility around 10:00 am. (R3's) Oxygen saturations were low so I started her on Oxygen. She had anxiety sometimes and only had low oxygen saturations, so I did not think she was unstable enough that she needed to go to the hospital. I gave her Anxiety medication and put the oxygen on her and her oxygen saturation level came up. (V16/Nurse) sent her (R3) out just as I was leaving my shift. I did not fax or call the Doctor to notify him that I started her on oxygen or her change of condition."

On 8/21/20, at 9:00 am, V15 stated, "I did not give her (R3) any anxiety medication, I must have given her only scheduled medication. I did not do anything for anxiety."

On 8/19/20, at 10:20 am, (V16/Nurse) stated, "I came onto shift at 6:00 pm and (R3's) Granddaughter caught me, first thing, coming down the hallway and asked me to come assess (R3). (R3) had a very high heart rate and labored breathing. Her condition warranted me to call the Doctor and he said to send (R3) out to the Emergency Department. I had to convince her to go out, she did not want to go. She was not having any pain, just her vital signs and breathing were bad."

R3's "A.I.M. for Wellness," dated 3/29/20 at 6:30 pm, documents that R3's Physician was notified, via electronic facsimile, that R3 had pain in chest, started on oxygen and "very short of breath this a.m. (morning)," and "very short of breath now."
Continued From page 5

R3's Nursing Note, dated 3/29/20 at 9:00 pm, documents that R3 was admitted to the hospital with a diagnosis including pneumonia and a heart attack (Myocardial Infarct/MI).

R3's Medical Record documents on 3/30/20 at 2:38 am, the facility received a phone call from the hospital that R3 had expired.

On 8/19/20, at 10:33 am, V14 (R3's POA) stated, "They called me around 10:00 am and told me that (R3) had a bad spell around 5:00 am. Her oxygen was low (88 percent), her pulse was high and she was struggling to breathe and that she was continuing to struggle to breathe. She wanted me to come and see her, so I went and she told me she was dying. I was there all day until (V16/ Nurse) came onto shift around 6:00 pm and immediately sent her by ambulance to the hospital. I kept telling the day shift nurse (V15/Licensed Practical Nurse/LPN) that (R3) needed to go to the hospital but she said it was just anxiety and that the hospital probably would not let me in anyway, due to COVID, so we did not go. (V16) called the hospital and they said I could go with her, so we went. The Emergency Room Doctor asked me why they waited so long to send her in and told me it was too late, that she had had a bad heart attack. I did not see (V15) give any anxiety medication or any medication, for that matter, to help my Grandma. She was already on oxygen when I got there."

On 8/21/20 at 8:15 am, V18 (R3's Physician) stated, "I did not know that (R3) was having issues on 3/29/20 and I was not notified of her condition. I am finding that more facilities are overriding sending out the residents to the hospitals, they are just saying that it is anxiety and not looking at the worst outcome. If I would..."
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<td>Continued From page 6 have been notified earlier in the day of her vitals, difficulty breathing and need for oxygen, I would have sent her to the hospital and it may have changed her outcome.&quot;</td>
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