STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the Physician of a medical change of condition for one of three residents (R3) reviewed for change of condition in a sample of eight. Findings include: Facility Notification of Change in Resident Condition or Status Policy, Revised [DATE], 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 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 [DATE] at 10:00 am, documents that oxygen was started at one liter per nasal cannula for a low oxygen saturation (88 percent). R3's Nursing Note, dated [DATE], 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 ,[DATE] 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 A.I.M. for Wellness, dated [DATE] 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. R3's Nursing Note, dated [DATE] at 9:00 pm, documents that R3 was admitted to the hospital with [REDACTED]. R3's Medical Record documents on [DATE] at 2:38 am, the facility received a phone call from the hospital that R3 had expired. On [DATE], 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 [DATE], 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. On [DATE], at 10:33 am, V14 (R3's Family/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. On [DATE] at 8:15 am, V18 (R3's Physician) stated, I did not know that (R3) was having issues on [DATE] 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 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.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a timely, interdisciplinary care plan conference and include the resident and/or resident representatives in care plan conferences for four of five residents (R2-R5) reviewed for care plans in the sample of eight. Findings include: The facility's Comprehensive Care Planning Policy, revised 11/1/17, documents: to inform the resident/representative of upcoming care conferences and accommodate schedule as appropriate; and that documentation of the resident/responsible party can be accomplished via signature on the Interdisciplinary Team (IDT) progress note, the new Care Plan or on the Summary/Participation Record or documentation in the Nurse's Notes or Social Services Notes if updates given per phone, refused to sign or attempts to contact have been unsuccessful; and the Care Plan Conference shall be held as necessary to communicate major revisions and that the facility shall make every effort that the conference be attended by a representative from each discipline involved in resident's care, be attended by the resident, unless resident is incapable, be attended by a representative of the Resident's choice, if that person chooses to attend. 1. R3's Physician order [REDACTED]. R3's Nursing Notes, dated 9/7/19 through 3/29/20, do not document a Care Plan meeting. R3's Activity Notes, Dietary Notes and Social Service Notes (dated 9/7/19 through 3/29/20) were reviewed and do not document a Care Plan meeting being conducted. On 8/19/20, at 10:33 am, V14 (R3's family/Power of Attorney) stated, (R3) was admitted to the facility on [DATE], and we did not have a Care Plan meeting until March, and it was the only one we had. I did not know that she was not getting her pain patch or other issues with her care. On 8/21/20, at 9:40 am, V19 (Care Plan Nurse) verified that there was no documentation about R3's Care Plan Conference in the computer, in an office binder or R3's medical record, other than a Care Plan Conference Summary, dated 3/3/20. 2. R4's Care Plan Summary/Participation Record shows a Care Plan meeting was held on 5/7/2020. The only individuals attending this Care Plan meeting were staff members. R4's Medical Record does not contain documentation of resident or family being invited or declining to attend the meeting. 3. R5's Care Plan Summary/Participation Record shows a Care Plan meeting was held on 4/8/2020. The only individuals attending this Care Plan meeting were staff members. R5's Medical Record does not contain documentation of resident or family being invited or declining to attend the meeting.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 4. R2's Face Sheet documents R2 was admitted to the facility on [DATE]. R2's medical record does not contain any documentation that R2 or R2's representative was included in R2's Care Plan meeting in any way. On 8/21/20 at 12:27 P.M., V22 (R2's family member/Power of Attorney) denied ever being asked to be a part of R2's Care Plan meetings or updated on any Care Plan meetings. V22 stated nothing was discussed with V22 and V22 was not aware that R2 was using a wheelchair for mobility. On 8/21/20 at 12:53 P.M., V1 (Administrative Consultant) verified R2's Care Plan Summary/Participation Record was blank. On 8/19/20, at 11:23 am, V19 (Care Plan Nurse) stated, I cannot locate any Care Plan meeting notes. I just started about one and a half weeks ago. The last Care Plan Nurse left at the beginning of June and I have not even been trained yet.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to do conduct discharge planning for one of three residents (R4) reviewed for discharge planning in the sample of eight. Findings Include: The Facility's undated Discharge Policy states: It is the policy of this facility to assist each individual resident to make decisions in advance of discharge about the rehabilitative, psychosocial and health care goals of the resident. Whether resident or facility initiated, it is the intent of the facility to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution, provider, home caregiver or resident themselves to ensure continuity of care and service is maintained by developing and implementing a discharge plan in advance of the actual resident discharge. The Discharge Policy also states, The following procedure shall be implemented to ensure resident oriented discharge is accomplished, communicated to interested parties and documented successfully: 1. The Social Service Director shall serve as the Discharge Chairperson or Discharge Coordinator and will be responsible for providing multi-disciplinary participation in discharge. 7. Factors that shall be evaluated by the Inter-disciplinary-team (IDT) in determining discharge potential are as follows: A. Information relative to medical, cognitive and psychosocial needs; B. Rehabilitation potential and ADL (Activities of Daily Living) assistance required; C. Course of current and prior treatment; D. Physician orders [REDACTED]. Social information; F. Resident desire for discharge; G. Community/family support services; H. Medical equipment needs or modifications to the home; 8. Should discharge become evident, the IDT shall provide information to the resident and family members as indicated. A discharge conference shall be conducted prior to the actual discharge. Information exchanged shall include as appropriate: medication and schedule, current MD orders, diet/fluid specifications, and outside agency purpose and schedule. R4's Social Service Notes shows that R4 was admitted to this facility on 4/23/2020 with plans to discharge to the community closer to family. R4's Medical Record was reviewed and contains no further documentation regarding discharge planning. On 8/20/2020 at 1:15 P.M. V13 (Director of Assisted Living Facility that R4 was discharged to) stated I got a completely inaccurate account of what (R4) could and could not do for himself. I was told by the Social Service Director at the facility that this resident could walk, make his own needs known and that he could perform all of his own cares. V13 stated When (R4) got to our facility he was in a wheelchair and could not walk, did not communicate well and had no safety awareness and he fell within an hour of being here and was sent to the hospital. V13 stated that the local hospital transferred R4 to a neurological unit at a different hospital and V13 was told that R4 was not appropriate for Assisted Living and would not ever be due to the progressive nature of [MEDICAL CONDITION]. R4's Occupational Therapy Discharge Summary dated 5/22/2020 shows Pt (patient) requires assist for safety with transfers and use of walker around facility. Recommend resume OT (Occupational Therapy) at new NH (Nursing Home) if possible. R4's Physical Therapy Discharge Summary dated 5/19/2020 shows Impact on Burden of Care/Clinical Impression: Complicating factors, including confusion hinders the patient from achieving all goals and Precautions: fall risk, confusion and agitation. On 8/20/20 at at 2:20 P.M. V21 (Therapy Program Director) stated that R4 was discharged from therapies with the understanding that R4 was going to remain in a skilled care nursing facility. On 8/20/2020 at 2:50 P.M. V1 (Administrator) stated that V1 had no further information or documentation regarding R4's discharge. V1 stated I can't answer or explain anything to do with (R4)'s discharge, I didn't work here then and the staff member who would have been responsible for this no longer works here.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 a sample of eight. This failure resulted in a delay of R3 being sent to the local hospital and a delay in treatment for [REDACTED]. Findings include: R3's Profile Face Sheet, undated, documents that R3 admitted to the facility on [DATE]. Facility Oxygen Policy, Revised ,[DATE], 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 [DATE], 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 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 [DATE] at 10:00 am, documents that oxygen was started at one liter per nasal cannula for a low oxygen saturation (88 percent). R3's Nursing Note, dated [DATE], 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 ,[DATE] 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 [DATE] through [DATE], do not document an order for [REDACTED]. On [DATE], 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 [DATE], 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 [DATE], 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 [DATE] 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. R3's Nursing Note, dated [DATE] at 9:00 pm, documents that R3 was admitted to the hospital with [REDACTED]. R3's Medical Record documents on [DATE] at 2:38 am, the facility received a phone call from the hospital that R3 had expired. On [DATE], at 10:33 am, V14 (R3's Family/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 [MEDICAL CONDITION]. 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 [DATE] at 8:15 am, V18

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) (R3's Physician) stated, I did not know that (R3) was having issues on [DATE] 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 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.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate, report, and implement immediate fall prevention measures after a fall for three of four residents (R2, R4 and R5) reviewed for falls in the sample of eight. Findings include: The facility's Fall Prevention policy, revised 11/10/18, states, 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM (Assess Intercommunication Manage) for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan. The facility's AIM for Wellness Communication Form (Assess Intercommunication Manage), dated 10/23/18, states, Policy: To communicate effectively between nurses and primary care providers the facility has developed standardized criteria. This form will be used on residents who have had a change in condition or for shift to shift communication among nursing staff. 4. Complete the AIM for Wellness form and Progress Note. The Progress Note should be used to document the physical assessment, Physician and POA (Power of Attorney) notification, treatment ordered and given, etc, 7. Place the AIM for Wellness Form and Progress Note in the Nurses Notes section of the medical record. The facility's Notification for Change in Resident Condition or Status policy states, 1. The nurse supervisor/charge nurse will notify the resident's attending Physician or on-call Physician when there has been: b. An accident or incident involving the resident. 1. R2's Face Sheet documents that R2 was admitted to the facility on [DATE]. R2's Fall Risk Assessment, dated 4/10/20, documents R2 as a high risk for falls. On 8/21/20 at 10:39 A.M., V9 (LPN) stated that on 5/16/20, V9 was passing medications when V9 noted R2 to be sitting on the floor, in the hallway, in front of R2's wheelchair. R2 was taken to R2's room and placed in R2's bed to be assessed. V9 stated, after R2 was placed into the bed, V9 left the room to check R2's medical record to see if R2 was on blood thinners. R2 was left unattended immediately after R2's fall in the hallway, and R2 fell out of R2's bed onto the floor, near the bedside table. V9 stated R2 had a laceration and a large bump on R2's head. R2 was then sent to the local area hospital for evaluation. V9 denied that any immediate fall interventions were put in place after R2's fall in the hallway. V9 stated that R2 should not have been left alone while V9 left to check R2's medical record. V9 stated V9 was instructed to fill out only one fall investigation report and AIM for Wellness sheet for the fall on 5/16/20. V9 confirmed only R2's fall out bed was reported to V18 (R2's Physician) and R22 (R2's Power of Attorney/Family Member). R2's AIM for Wellness form, dated 5/16/20 and completed by V9 (Licensed Practical Nurse/LPN), states, Nurse doing med (medication) pass seen pt. (patient) on floor nurse assessed eye was bloodshot and had a goose egg and laceration on head pt. on [MEDICATION NAME] (blood thinner) Sent to E.R. (emergency room) for eval (Evaluation) and tx (Treatment). Only one AIM for Wellness form was completed for R2's falls on 5/16/20. R2's Nurses Notes, dated 5/16/20 at 1:00 P.M., documents R2 was transferred to an outlying hospital from the local area hospital. These same Nurses Notes documents R2 was diagnosed with [REDACTED]. on 5/16/20. R2's IDT (Interdisciplinary Team) Progress Notes, dated 5/18/20 at 9:00 A.M. states, QAT (Quality Assurance Team) met to review incident on 5/16/20 5:15 A.M. Res (Resident) was sitting on edge of bed attempting to get up .poor safety awareness et (and) lack of lower ext (extremity) strength. Will request order for PT/OT (Physical Therapy/Occupational Therapy) for strengthening. This same form documents only one fall for R2 on 5/16/20 was discussed. R2's current Care Plan does not contain interventions for two separate falls on 5/16/20. On 8/21/20 at 11:57 A.M., V18 (R2's Physician) denied being notified of two falls for R2 on 5/16/20. V18 confirmed R2's fall was suspected for R2's head injuries on 5/16/20. On 8/21/20 at 12:27 P.M., V22 (R2's Family member/Power of Attorney) stated, I was only told of (R2's) fall out of bed (on 5/16/20). I didn't know about (R2) falling out of the wheelchair in the hallway. On 8/21/20 at 10:45 A.M., V1 (Administrative Consultant) stated absolutely not should only one AIM for Wellness form and fall investigation have been completed for R2's falls on 5/16/20. V1 stated the AIM for Wellness form documents physician and resident representative notification and is completed every time there is a fall. V1 verified that had the AIM for Wellness been filled out for each of the two events on 5/16/20, V18 and V22 would have been notified twice. V1 was not able to verify that the local state agency was notified of R2's fall on 5/16/20. 2. R4's Physical Therapy Notes show that R4 had falls on 4/24/2020 and 4/25/2020. R4's Nurse's Notes do not document any falls on these dates. R4's Care Plan dated 5/7/2020 does not have any new fall interventions for these falls. On 8/19/2020 V1 (Administrator) was not able to provide any documentation of an investigation or root cause analysis on these falls. R4's Physical Therapy Notes show that R4 had a fall on 5/18/2020. R4's Nurse's Notes do not document any falls on this date. R4's Care Plan dated 5/7/2020 does not have any new interventions for this fall. R4's Care Plan dated 5/7/2020 documents that R4 had falls on 5/20/2020, 5/23/2020, and 5/25/2020. R4's Nurse's Notes do not document any falls on these dates. On 8/19/2020 V1 (Administrator) was not able to provide any documentation of an investigation or root cause analysis on these falls. 3. R5's Nurse's Notes document a fall on 2/28/2020. R5's Care plan dated 2/28/20 does not have any new fall interventions for this fall. On 8/19/2020 V1 (Administrator) was not able to provide any documentation of an investigation or root cause analysis of this fall. On 8/19/2020 at 1:15 PM V1 (Administrator) stated It is the policy of this company that every fall be investigated, documented and the care plan should show what our new intervention for every fall.