STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145403	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Poplar Creek Rehab & Hcc	1545 Barrington Road Hoffman Estates, IL 60169

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** 35174 Based on interview and record review, the facility failed to ensure a residents' care provider was notified after a resident received a Defebrilator Vest (DV) intervention (shock) which applies to 1 of 1 residents reviewed for physician notification in a sample of 3. The findings include: R1's face sheet, printed on 6/3/24, showed R1 is an [AGE] year old man admitted to the facility on [DATE], with diagnoses which include: acute on chronic (congestive) heart failure and rheumatic mitral (valve) insufficiency. On 6/3/24 at 10:30 AM, when asked if the defibrilator vest (DV) ever went off, R1 stated, Yes! R1 stated he was shocked by the vest about a week ago, right here (pointed to bed). R1 stated, It felt like I got shot by a rifle. R1 stated his pillow had some blue stuff on it. R1 then restated, It was like a shot to the chest. R1 stated one of the girls came in and went to go get the nurse. R1 stated a nurse came into his room. R1does not remember the nurse's name, but it was a man. After the nurse left, the girl was back to clean me up. On 6/3/24 at 3:20 PM, V7, Certified Nursing Assistant (CNA), stated she went into R1's room sometime after dinner to round on R1 (5/26/24). The back of R1's neck and his pillow had blue gel on it. V7 stated R1 told her he had been shocked. V7 did not know what the blue gel was. V7 stated she told V5, Licensed Practical Nurse (LPN), about the blue gel, and what R1 had said. V7 waited till V5 was done in R1's room. V7 stated she cleaned up R1 after V5 saw the blue gel. On 6/4/24 at 9:15 AM, V5 stated he did not initially remember R1 having blue gel on his back. After asking V5 if he remembered a CNA coming to him about R1 having blue gel on him, V5 stated he did remember. V5 stated he did not know what the blue gel was for at the time. V5 stated he knew the manual was at the front desk. V5 stated he does not recall calling the physican. V5 stated he thought he called V2, Director of Nursing (DON). On 6/4/24 at 9:45 AM, V5 stated sometime after 9 PM (5/26/24), V7, CNA, told him R1 had some blue gel on R1's back. V5 stated he was not sure what the blue gel was. V5 stated he went into R1's room. The DV control box said the battery needed to be changed, so he changed the battery. V5 stated he assessed R1, did vitals, and checked R1's orientation. V5 did not call the resident physician with an update. V5 stated the manual for the device was available at the nurse's station. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 10:05 AM, V5 (accomponied by V2) stated after seeing R1 (5/26/24), he did not call the physican or the company about the blue gel. On 6/4/24 at 10:30 AM, V8, Cardiologist, stated he did not receive a call on 5/26/24 about R1 having blue gel on him, or any issues with the DV possibly delivering a treatment.V8 stated if something occured with R1's DV, he would expect a call to be updated on the resident's status. On 6/4/24 at 10:45 AM, V2 stated V5 should have contacted the physician after the blue gel was found on R1 due to the possibility a treatment has been delivered. V5 should have called the physician to see if the provider would want to send the resident out, or give new orders. This DV company documentation, dated 6/3/24, showed R1's vest read a treatable rhythm and delivered a treatment (shock) on 5/26/24 at 8:16 PM. The DV Manual, dated 5/1/22, showed the vest is to monitor the patient and deliver a treatment (shock) to the patient if needed to regulate the patients heart rhythm. A gel is released just before a treatment is given. If a treatment is given call you doctor's emergency number immediately to report your treatment. The facility's change of condition policy, dated 9/20, showed attending physicians or physician on call /NP (Nurse Practitioner) .will be notified of all changes in condition. At the time of the survey, the facility was unable to provide a policy regarding the DV.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on observation, interview, and record review, the facility neglected to identify R1 had a defibrillator vest (DV), and failed to ensure facility staff were trained on the DV's set up, monitoring, functioning, and trouble shooting of the device which applies to 1 of 1 residents (R1) reviewed for neglect in a sample of 3. The findings include: R1's medical record showed R1 was admitted to the facility on [DATE], with diagnoses which included: acute on chronic (congestive) heart failure and rheumatic mitral (valve) insufficiency. On 6/3/24 at 10:30 AM, R1 was in his room wearing the DV. R1 stated he got it at the hospital, and it came with him to here (pointed at bed). R1's facility referral, dated 5/22/24, showed the referral was sent to the facility's Central Intake and reviewed on 5/21/24. R1's referral has multiple entries (8) of R1 utilizing the DV during R1's hospital admission, and to be used until R1 was able to have an outpatient Angiogram after discharge. On 6/4/24 at 11:10 AM, V21, Admissions Director, stated, A residents' hospital referral goes to the central intake at our corporate level. We receive a summary from them if the resident is accepted as an admission. Items like medical devices (wound vacs example) would be on this summary, so we know what to be prepared for. On 6/5/24 at 12:30 PM, V1, Administrator, stated V21 receives a referral summary (email) from Central Intake when a resident is going to be admitting to the facility. The hospital referral information is sent to the facility afterward and uploaded into the residents record. V21 is not expected to review the hospital information. V21 uses the summary information provided prior to admission to be aware of anything a resident may need with their care. The facility's Admission Summary sent on 5/21/24 to V21 showed R1's hospital location, diagnoses of shortness of breath and weakness, payer source, needs of physical and occupational therapy, weight, hospital social worker contact information, and patient is a [AGE] year old male with rheumatoid arthritis on chronic steroids. admitted for SOB/weakness-Cleared for d/c. The referral summary had no information regarding R1's (DV), which was in use at the hospital, and the need for ongoing use after hospital discharge. On 6/3/24 at 9:00 AM, V9, Licensed Practical Nurse (LPN), stated she was currently R1's nurse. V9 stated she admitted R1 on 5/25/24. R1 was admitted wearing the (DV) from the hospital. V9 stated she was not aware R1 was possibly going to have the DV until the day of his admission. V9 stated she had not had any in-services involving the DV yet. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24, with multiple interviews between 9:00 AM - 11:30 AM with V10 LPN, V11 LPN, V12 LPN, and V13, Registered Nurse (RN), stated they had not received an in-service for the DV. V10-V13 stated they do get floated to other units and could be assigned to R1's hallway. V10 stated the DV manual was at the desk, but he had not looked at it yet. On 6/4/24 at 9:15 AM, V5 stated he was directed to R1's room after V7, Certified Nursing Assistant, told him about R1 having blue gel on him. V5 stated it was on Sunday (5/26/24). V5 stated he did not know what the blue gel was for. V5 stated he knew there were 2 inservices given so far, but he had not attended one yet. On 6/3/24 at 3:40 PM, V6, LPN, stated on 5/29/24, she replaced the battery onto the vest pack; It went through its initial start-up, and showed something like the 'vest needed to be serviced'. V6 stated she did not know what was wrong, so V6 called the company. V6 stated the tech support person had to walk her through the process of plugging in the vest's box to a phone jack. V6 stated they had not received any data since R1 was admitted to the facility. Later that shift, the company called back to let us know the DV had delivered a shock on 5/26/24, and they would be sending someone to come look at the DV. V6 stated V4, Patient Service Representative (PSR), came to the facility and serviced the vest for R1. On 6/3/24 at 9:45 AM, V4 stated she went to the facility on Wednesday (5/29/24) in the evening. V4 stated she was called to check on R1's DV. V4 stated while at the facility, she initiated the cellular hotspot, which was not set up to transmit data to the company. V4 stated she talked to V2, Director of Nursing, to set up education for the DV after she was at the facility to work on R1's DV. The first DV training class V4 gave was on 5/31/24. On 6/4/24 at 10:15 AM, V2, Director of Nursing, stated, The referral review process is now done at corporate through the Central Intake. They review the hospital referral and let us know if a resident has something we need to be prepared for. We were not notified through Central Intake that (R1) had a DV, or could possibly have it, when he got admitted . If we are notified a resident was coming with a device we have not used before, or have not used in a long time, we could set up in-services. The facility In-service/meeting attendance record, dated 5/31/24, was identified by V2 as the first in-service provided for the DV (6 days after admission to the facility). On 6/4/24 at 3:30 PM, V20, DV Legal Department/Educator, stated, The DV is usually sent with a patient to their home, but we have patients that go to facilities with them. Part of our service is educating facility staff which includes set up (hotspot), how the device works, and what to do after a treatment (shock) was administered to the patient. The facility would need to contact us so we could have a representative set up education times. V20 (while reviewing R1's chart) stated they had no record of any facility interaction before 5/29/24 when the nurse called about the DV having a problem, and a representative was sent out.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for 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** 35174 Based on observation, interview, and record review, the facility to ensure a resident had ongoing monitoring after a Defibrillator Vest (DV) treatment (shock) was delivered, and failed to ensure a DV hotspot was set up to assist with remote monitoring which applies to 1 of 1 residents (R1) reviewed for quality of care in a sample of 3. The findings include: R1's face sheet, printed on 6/3/24, showed R1 is an [AGE] year old man admitted to the facility on [DATE], with diagnoses which include: acute on chronic (congestive) heart failure and rheumatic mitral (valve) insufficiency. R1's Careplan, printed on 6/3/24, showed no entries referencing R1's DV. On 6/3/24 at 10:30 AM, R1 was in bed wearing the DV. R1 stated he started wearing the DV in the hospital and it followed him here. When asked if the vest ever worked, R1 stated yes. R1 stated he was shocked by the vest about a week ago right here (pointed to bed). R1 stated, It felt like I got shot by a rifle. After that there was some blue stuff on my neck and pillow. On 6/3/24 at 3:20 PM, V7, Certified Nursing Assistant (CNA), stated she went into R1's room sometime after dinner to round on R1 (5/26/24). The back of R1's neck and his pillow had blue gel on it. V7 stated R1 told her he had been shocked. V7 stated she told V5, Licensed Practical Nurse (LPN), about the blue gel, and what R1 had said. V7 waited till V5 was done in R1's room. V7 stated she cleaned up R1, and did not see him again during her shift. On 6/4/24 at 10:05 AM, V5, Licensed Practical Nurse (LPN), stated he was R1's nurse 5/26/24. V5 stated some time after 9:00 (5/26/24) V7, Certified Nursing Assistant, told him R1 had some blue gel on R1's back. V5 stated he went to the room, and R1 did have blue gel on his back. V5 stated he took some vitals and assessed R1. V5 stated he did not contact the physician of the company after he assessed R1. R1 was stable at the time. V5 stated he gave report to V15, LPN, at the end of his shift. R1's Electronic Medical Record (EMR) showed no vitals were documented from 12:18 AM on 5/26/24 through 2:21 AM on 5/27/24. This medical record also had no assessment documented for this timeframe, or progress notes reflecting any issues with R1's DV. The DV company documentation, dated 6/3/24, showed R1's vest read a treatable rhythm and delivered a treatment (shock) on 5/26/24 at 8:16 PM. Comparing R1's EMR and the DV documentation showed the first recorded vitals for R1 was approximately 6 hours after R1's DV treatment was administered. On 6/4/24 at 7:40 AM, V15 stated he had no issues with R1's DV, and had not been told about any blue gel or DV issues when he he took report from V5 on 5/26/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 3:40 PM, V6, LPN, stated on 5/29/24, she had to contact the company for an issue with R1's DV. The person she talked to said they had not received any data on R1's DV. V6 stated they walked her through the process to send data via telephone chord outlet. Later in the shift, the company called and said R1 had been given a treatment (shock) by the DV on 5/26/24. V6 stated she had not been told that in any report, and she had taken care of R1 previously in the week. V6 stated the company was going to send out someone to look at R1's vest. The DV documentation, dated 6/3/24, showed the first time data was transmitted after R1's admission (5/25/24) was on 5/29/24 at 6:30 PM. This documentation showed ongoing data transmitting on a daily basis after the hotspot was set up on 5/29/24. On 6/3/24 at 9:46 AM, V4, Patient Service Representative/PSR, stated she had been contacted by the company to check on R1's DV. V4 stated she went to the facility on [DATE]; she had to set up the cellular device (hotspot) so R1's DV could upload data in a timely manner. On 6/4/24 at 3:30 PM, V20, DV company Legal Department/Educator, stated, When the DV is set up, we use a cellular hotspot to transmit data to the company. It transmits data once a day, usually when the resident is sleeping. It does transmit data when a treatment is detected to ensure a patient get medical attention if needed in a timely manner. At the time of the survey, the facility was unable to provide a policy regarding the DV. .