

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

OAKBROOK HEALTHCARE CENTRE

0034694

Facility Name

T.D. Number

2013 MIDWEST ROAD, OAK BROOK, ILLINOIS 60521

Address

Date of Survey: 03/16/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

- 300.1010h) The facility shall notify the resident's physician of any accident, injury, or significant change in a
 300.1210a) resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to,
 300.1210b)3) the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more
 300.3240a) within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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.

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 record.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT NEGLECT A RESIDENT.

Based on record review and interviews the facility neglected to have nursing staff:

1. Monitor vital signs
2. Report changes in body temperatures, blood pressure, oxygen saturation level and change in condition to the resident's physician.
3. Identify fluid needs, have a hydration plan and monitor fluid intake for residents at risk for dehydration.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

OAKBROOK HEALTHCARE CENTRE

0034694

Facility Name

I.D. Number

"A" VIOLATION(S):

300.1010h) These failures resulted in R2 being admitted to a local hospital on 12/25/03 with a Urinary Tract
 300.1210a) Infection and Septic Shock. R2 expired at the hospital on 12/30/03 from Cardiac Arrhythmia due to
 300.1210b) Acute Renal Failure which was due to Septic Shock. This occurred from 12/20/03 through 12/25/03
 300.3240a) and included 14 shifts.
 (Cont.)

These failures also resulted in R3 being admitted to the local hospital on 1/26/04 with a diagnosis of Acute Hypotension with altered mental status secondary to Dehydration/Sepsis and Urinary Tract Infection. R3 had been identified as having diarrhea for many days on a Dehydration/Fluid maintenance assessment of 1/16/04.

This is for 2 (R2 and R3) of 3 residents in the sample who were at risk for Dehydration and development of Urinary Tract Infections.

The findings include:

1. R2 was admitted to the facility on 12/20/03 with a temperature of 102.4. Nurses notes and medication administration records document that R2 continued to have temperature elevations through 12/25/03. Staffing schedule records document that six Registered Nurses and two Licensed Practical Nurses worked the shifts from 12/20/03 through 12/25/03 and provided care for R2. Per record review only one nurse (E11) notified the physician on 12/23/03 at 10:00 p.m. that R2 had an on and off elevated temperature. Per interview with E6 there was no fluid monitoring for R2 except for one nurses note on 12/21/03 at 4:30 a.m. which documents "Tylenol given with one glass of water."

Nurses notes documented the following changes in R2:

On 12/24/03 at 10:00 a.m. R2's B.P. dropped to 96/52.

On 12/25/03 at 7:30 a.m. R2's B.P. was 110/70 with an oxygen saturation level of 81%.

On 12/25/03 at 9:00 a.m. R2's B.P. was 100/55, T99.4, appears weak, pale, took only 3-4 teaspoons of yogurt, then refused breakfast. Will continue to observe.

On 12/25/03 at 11:30 a.m. opens eyes but with glassy look to her. Does not verbally respond.

On 12/25/03 at 12:10 p.m. Son at bedside, saw resident and verbalized concern over R2's level of alertness/consciousness. BP 100/50, T.99.5, oxygen saturation 88%. Nursing notes and interviews confirmed that the physician was never contacted on 12/24/03 and 12/25/03. When R2's son came into the facility on 12/25/03 at 12:10 p.m. and expressed concern over his mother's condition the physician was contacted and R2 was sent to the hospital.

2. R3's admission assessment of 1/16/04 documents that R3 had diarrhea. A Dehydration/Fluid maintenance assessment of 1/16/04 documents that R3 has had diarrhea for many days. A diarrhea care plan of 1/16/04 documents that R3 is having frequent passage of loose, unformed stools and includes the approach to assess R3's hydration status. An antibiotic care plan dated 1/17/04 documents R3 requires antibiotics for Clostridium Difficile (C-diff) and to encourage fluids. Staff interviews confirmed that R3 had to be encouraged to drink and that she did not drink water. Staff interviews confirmed there was no plan in place to

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

OAKBROOK HEALTHCARE CENTRE

0034694

Facility Name

I.D. Number

"A" VIOLATION(S):

300.1010h) assure R3's fluid needs were being met, nor that her fluid intake was being monitored while
 300.1210a) recovering from C-diff. Per staff R3 had a change in condition on 1/25/04 when she could not wake
 300.1210b) up. Interviews with family indicated that on 1/24/03 R3 was fine, but when family visited on 1/25/03
 300.3240a) R3 could not wake up. The facility conducted an investigation of R3's inability to awaken when it was
 (Cont.) reported to them by R3's family. Per interview with nursing staff, at no time was the physician notified
 of R3's inability to awaken on 1/25/04. When the family contacted the nursing home on 1/26/04 at
 7:45 a.m. to further express concern about R3's mental status, they were told that she might have
 some infection, be dehydrated since her food/fluid intake was poor and that the physician would be
 informed.

A review of the facility's physician notification policy documents that with the following conditions, the physician will be notified: any change in resident's condition, abnormal vital signs, abnormal sign and symptom, any clinical concern from the family and resident.

(A)