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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 309</td>
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<td>FINAL OBSERVATIONS</td>
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**LICENSURE VIOLATIONS**

- 300.610a)
- 300.1010h)
- 300.1210b)
- 300.1210d(3)b)
- 300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more 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...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Peterson Park Health Care CTR  
**Street Address, City, State, Zip Code:** 6141 North Pulaski Road, Chicago, IL 60646

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<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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Section 300.1210 General Requirements for Nursing and Personal Care

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. Restorative measures shall include, at a minimum, the following procedures:

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:

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.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
F9999 Continued From page 11

These requirements were not met as evidence by:

Based on interview and record review the facility failed to thoroughly assess, and did not follow their own facility policy to obtain physician orders for treatment after an incident of hot soup was spilled on one (R1) of three residents reviewed for assessments and physician orders. This failure resulted in a delay of treatment for R1 who was subsequently sent to the hospital for evaluation and was assessed to have sustained a 2nd degree burn that required hospitalization and treatment on a hospital burn unit.

Findings include:

R1 per the facility's physician order sheet print date of 4/28/13, has a diagnoses which include mental status change, dementia, arthritis, history of aspiration precautions. R1's diet orders per the physician's order sheet print date of 4/28/13 has a diet order of mechanical soft, honey thickened liquids, aspiration precautions, sit upright with meals.

On 5/22/13 at 11:37 am E5 (registered nurse) stated "I heard commotion in the resident's room. He was half naked and being clean by CNA's (certified nurses assistant). They said the patient spilled noodles on himself. They said the resident asked the roommate to heat the soup and he put it in the bed. It spilled on the resident. I assessed him and didn't see any redness on his groin or bottom. I paged the doctor. We have a standing order for silvadene cream so I put the silvadene cream on him. I forgot to write it down in the
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<td>F9999</td>
<td>Continued From page 12 endorsement book that this patient had an incident. I should have written it in the endorsement book so that all the shifts would have known what happened. I should have told my supervisor.&quot;</td>
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On 5/22/13 at 12:28 pm E9 (certified nurses assistant) stated the roommate was screaming "help, help", R1 was sitting on the bed and she called the CNA in charge and we went there and changed and cleaned everything. "They asked the roommate what happened. He said he asked the roommate to prepare noodles for him and he got burned."

On 5/22/13 at 11:22 am E8 (certified nurses assistant) stated the "Roommate made the noodles hot. I don't know if the roommate put the noodles on the table or bed but the noodles spilled in the bed. R1 "was in the sitting position. His skin was red a little on the butt area. It wasn't real red, it was a light color."

On 5/22/13 at 11:56 am E6 (registered nurse) stated "A CNA came to me and said his buttock was pinkish color. I went to check, his buttock was pinkish in color with a little skin peeling off. He's incontinent so I applied moisture barrier cream. I went to recheck his skin at 3:30 - 4:00 pm and it changed to a red color with more skin peeling in the genital area and buttock." She stated she informed the director of nurses and called the covering doctor since R1's primary doctor was on vacation. The doctor ordered to send the resident out to the hospital for evaluation.

On 5/22/13 at 12:11 pm E7 (registered nurse
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<td>Continued From page 13 supervisor) stated E5 &quot;didn't tell me anything about it. I found out about it on 5/13/13 when I came back to work from 5 pm to 1 am. I supervise at night. I was in the building and usually they inform me. They would page me if they are on another floor. I didn't know, I could have assessed the resident or done something but I didn't know.&quot;</td>
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<td>On 5/11/13 at 10:38 am E11 (registered nurse) stated &quot;I work the 11-7 shift. I know it happened on 3-11 shift. It was not endorsed in the book. It was documented in the chart that the resident got burned by the soup. I assessed the resident on my shift. It was slightly reddened. There was no reports of complaints of pain. The doctor was paged by the 3-11 nurse but the doctor didn't call during my shift. It was just slight redness. I didn't see any progress and the silvadene was put on the resident.&quot;</td>
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|               | Per the local hospital Emergency Physician Evaluation dated 5/13/11 Present History initial comments: "This is a 97 year old male who is a resident of a nursing facility presents to the emergency room with a chief complaint of a burn to his buttocks penis and scrotum. Patient apparently spilled hot soup on his perineum yesterday however according to the nursing home records there was no discovery of the burn until this afternoon. The patient is unable to give any further history."
Comments: There is a second-degree burn over both buttocks completely scrotum as well as penis. Disposition: Other acute inpatient hospital |   |                                                                                                  |                 |
|               | The facility policy for Management of Pain reads: |               |                                                                                                  |                 |
### Continued From page 14

3. Nursing Involvement: A. Pain Screening

Upon admission, readmission, each MDS assessment, change of condition or when new pain or an exacerbation of pain is suspected, the Pain Questionnaire will be filled out with input from the resident, family member, or responsible party. By receiving input from someone who knows the resident well, pain management can be more specific to the resident. If the resident scores 5 or above on the Pain Questionnaire, the Comprehensive Pain Assessment must be completed.

The facility policy for Resident Condition Changes/Documentation dated 5/21/13 reads:
- Accidents/Incidents with or without injuries Service given and key points for documentation.
- Notification of physician and family member
- Date/time physician notified. Results and follow-through of orders, if any

The facility policy for Procedures to follow in cases requiring Physician attention:
- In case acute condition change/s not requiring NH facility to call 911, the following procedures are to be followed:
  1. Call and/or page residents physician and landline and wait for MD to call back.
  2. If MD does not call back within a prudent amount, nurse may call/page the physician again, if no response and condition of patient requires treatment, Medical Director will be followed.
  3. If no reply in received from PCP, nurse must send resident to the hospital depending on the resident's medical condition, using her nursing judgement, then notify her supervisor or designee. Receiving Hospital will be advised to inform respective patient's attending physician.
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<td>There is no documented evidence that the pain questionnaire was completed after the incident on 5/12/13.</td>
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<td>On 5/28/13 at 1:38 pm Z1 (doctor) stated he was covering for Z2 (doctor) at the time of the incident. Stated he doesn't remember when he was notified of the incident &quot;I think it was the day after. Z1 stated when he was notified he ordered that R1 be sent to the local hospital. Z1 stated it was hard to say whether he would've sent the resident to the hospital had he been notified the day of the incident because &quot;They didn't call me until the day after.&quot;</td>
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(B)