Final Observations

LICENSEUR VIOLATIONS:

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

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 300.1010 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 notification.
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.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on record review and interview, the facility failed to promptly notify the physician of abnormal lab results resulting in a delay in obtaining new treatment orders for one of three sampled
S9999 Continued From page 2

Residents (R1) reviewed for infection, in a sample of six. This failure resulted in a delay of treatment for R1's infection, decline in condition and R1's transfer to the hospital with diagnoses of acute renal failure, sepsis and hypotension.

Findings Include:

R1 is a 68 year old male admitted to the facility on 3-26-14 with the diagnoses which includes essential hypertension, diabetes mellitus and cerebral vascular accident.

Lab results dated 4-18-14 notes positive for Clostridium difficile (C-Diff) GDH Ag and toxin A and B. The lab report had documented: "C-Diff (result) faxed and called to E5 (Nurse) on 4-18-2014 at 1852 (6:52PM). Reported to: Skilled nursing and Living.

On 4-22-14 at 1:00PM, E5 explained she was contacted about the abnormal lab results on 4-18-14 for R1 from the lab. E5 stated she told E7 (Nurse Manager) of the results but did not implement any care for R1 because she was not R1's nurse for that particular day.

R1 nursing notes dated 4-18-14 at 7:34AM stated, "left message for medical doctor related to patient, 3 or more loose watery stools with foul odor. Patient also has productive sputum with yellow color. C-diff culture in progress. Awaiting medical doctor call back, endorsed to next shift."

R1's nursing notes dated 4-19-14 at 11:02PM stated, "certified nurse's aide (CNA) reported to nurse and supervisor that resident had times 5 large watery stools tonight on clostridium difficile isolations. Nurse instructed to notify medical doctor and to follow up with nurse relieving him."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:**

**B. WING:**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** IL6001689

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:** 04/24/2014

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**NAME OF PROVIDER OR SUPPLIER**

**BRONZEVILLE PARK NSG & LVG CTR**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3400 SOUTH INDIANA

CHICAGO, IL  60616

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R1’s nursing notes dated 4-20-14 at 11:14PM stated, "received results resident positive for clostridium difficile. Medical doctor paged; no response, will endorse to 11-7 nurse."

R1’s nursing notes dated 4-21-14 at 6:06AM stated, While patient was receiving care, patient was noted with redness to the scrotum, barrier cream applied until evaluations by wound care. Patient medical doctor (Z1) called and made aware, gave order to refer to wound care. New order for Flagyl every 8 hours times two weeks.

On 4-22-14 at 2:00PM E6 (staff nurse) stated, he tried to contact the medical attending and the nurse practitioner several times about R1 abnormal lab results. E6 stated he did not communicate with Director of Nursing, Assistance Director of Nursing nor did he call the Medical Director for direction or guidance about R1’s abnormal lab results for treatment.

R1’s nursing notes dated 4-21-14 at 8:35PM stated, R1 was lethargic, slow to response, non-verbal, assessment was done and Z1 (R1’s medical attending doctor) made aware and order to send to hospital emergency room.

R1’s nursing notes dated 4-21-14 at 8:47PM stated the following: called facility made nurse aware that resident was diverted to closest hospital emergency room due to hypotension. Pulse 60, respirations 22, temperature 99.1, blood pressure (B/P) 101/68. B/P then taken again and blood pressure 72/40 (below normal).

Ambulance report dated 4-21-14 at 3:40PM denotes: accident, injury or acute illness/chief complaint is decreased blood pressure and
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decrease level of consciousness.

R1’s nursing notes dated 4-21-14 at 11:04PM stated, R1 was admitted to hospital with the diagnoses of sepsis, acute renal failure and hypotension.

On 4-24-14, Z1 (R1’s medical attending doctor) explained, if he was called on the day the lab results were called in, he would have given the medical treatment. The treatment probable would have prevented R1 hospitalizations and diagnoses of acute renal failure and sepsis.

Review of the facility's policy, “Change in the Residents’ Condition” dated July, 2008 stated the following:

1). Should there be a change in the resident's physical, mental or emotional status the attending physician should be notified.

2). If the attending physician does not respond within 30 minutes, contact the Medical Director.

3). If the Medical Director does not call within 30 minutes, contact the Director of Nurses.

On 4-22-14 at 10:00AM, E1 (Director of Nursing) explained, A change in condition must be follow up immediately and the Director of Nursing and Assistant Director of Nursing must be notified.