STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015648	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF HAZEL CREST	3701 WEST 183RD STREET HAZEL CREST, IL 60429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Post Licensure Visit to the survey of 10-23-14 The Arden Courts Hazel Crest failed to follow their plan of correction for the survey of 10/23/14.	S 000		
S9999	Final Observations Statement of Licensure Violations The Arden Courts Hazel Crest failed to follow their plan of correction for the survey of 10/23/14. Section 330.1110 f) Section 330.1710 d) Based on interviews and record review the facility failed to follow their plan of correction to ensure that physician ' s orders and treatment plans were signed by the physician, and to notify the resident ' s physician of normal or abnormal lab values, and all accidents, injuries and unusual changes and document this notification. This applies to 3 of 4 residents (R2, R3 and R4) reviewed for physician notification and physician signatures in the sample of 4 and 5 residents (R5, R6, R7, R8 and R9) in the supplemental sample. Findings include: Section 330.1110 Medical Care Policies f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition. R3 is an 89 year old resident with diagnoses including dementia, atrial fibrillation, aortic stenosis and hypertension, and prescribed warfarin (blood thinning medication) which requires monitoring of lab values to ensure accurate medication dosing. On 1/27/15 review of R3 ' s 12/2/14 lab coagulation report showed results from R3 ' s	S9999		

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

blood specimen collected at 7:56am for PTT (prothrombin time) 20.6 and INR (International Normalized Ratio) 1.8. R3 ' s Individual Service Notes dated 12/6/14 documents the first entry of staff calling the physician regarding these lab results in an entry timed 3:30pm, signed by E4 (nurse) which stated "Called Z3 (Medical Director) pertaining to resident labs. " The next entry dated 12/7/14 at 10am by E5 (nurse) showed facility had not reached the physician regarding said lab results. An entry dated 12/8/14 by E6 (nurse) documented the nurse spoke to Z3 regarding this lab report.
The facility presented documentation " Laboratory Tracking Guidelines " last revised 8/2012 regarding abnormal or normal values which stated, " If the result is abnormal (outside the normal ranges), but not a panic or critical value, or if the results are indicated normal (within normal ranges), promptly notify the attending physician or authorized designee by telephone before the end of shift during which the lab report was received, unless the physician has ordered a different notification timeframe. "
At interview 1/27/15 4:15pm, Z3 stated he wants to be notified "as soon as the results come in," and further, "it is a standard thing for me to be called about that, " because the (blood thinning medication "needs to be adjusted" according to the results of the lab tests.
On 11/8/14 R5 had an incident of falling to the floor. The physician was not notified until 11/10/14. On 11/23/14 an incident report was generated regarding R6. There is no time documented for the incident. The report showed that R6 told the nurse she fell during the night. The nurse noted discoloration to the wrist and lower extremity. R6 also complained of pain. The physician was not notified.
On 1/27/15 at 4:15pm E3 Medical Director, and

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S9999	Continued From page 2	S9999		

residents primary care physician stated, " I would want to be contacted with any change of condition or incident regarding my resident ' s. I ' ll get angry if they don ' t call me. If they are not visibly injured I still expect to be notified." Z1 did not recall the incident of R6.
An incident report dated 12/6/14 showed that R7 fell to the floor. Z3 was not notified until 12/11/14 when he signed the document. An incident report dated 12/6/14 showed that R8 was found on the floor of the living room area. Z3 was not notified until 12/11/14 when the report was signed.
On 1/20/14 an incident generated showed R9 had complained to family of wrist pain. The incident report showed the family called the facility to notify them they would be picking up their mother at the physicians request and take R9 to the hospital. When R9 returned, the nursing notes for 1/20/14 showed R9 had on a sling and a soft cast for a fracture of the right arm. The facility did not notify R9's primary physician after becoming aware that the family was going to take R9 to the emergency room nor did they notify R9's physician upon return to the facility from the emergency room.
On 1/27/15 at 4:15pm Z3 Medical Director said that all occurrences or changes in condition should be reported to the resident's physician immediately.
The facilities plan of correction showed a completion date of 11/23/14. Under medical care policies the facility documents, "The Resident Coordinator or designee will notify the physician of all accidents, injuries, and unusual changes, and document such notification."

(C)

Section 330.1710 Resident Record Requirements

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S9999	Continued From page 3	S9999		

d) All physician's orders and plans of treatment shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials, is not acceptable.

R2 was admitted to the facility on 5/2014. R2 ' s clinical record for medication administration showed physician order sheets dated 11/1/2014 and 12/1/14 were not signed by the physician.

On 1/27/15 R4 ' s physician ' s order sheet dated 12/1/14 for R4 ' s readmission to the facility was not signed by the physician. On 1/27/15 R4 ' s physician ' s order sheet dated 12/1/14 for R4 ' s readmission to the facility was not signed by the physician.

The facility plan of correction with a completion date of 11/23/14 documents that the " Nurses will ensure physician orders and plans of treatment contain physician signatures. "

On 1/27/15 at 1:00pm E1 Administrator stated, " The physician is suppose to sign all orders within seven days. The Doctor that comes here most does not have an office or fax machine. The physician comes in at least every two weeks."

(C)