STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145864	A. BUILDING _____ B. WING _____	C 05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF FOREST EDGE	**8001 SOUTH WESTERN AVENUE CHICAGO, IL 60620**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1682624/IL85507	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement monitoring a resident's vital signs on the onset and during a residents's mental status change. This applies to one of five residents (R1) reviewed for nursing services in a sample of five. This failure resulted in R1 being transferred to the hospital more than 2 hours after a change in the mental status. R1 was later diagnosed with sepsis, sepsis associated hypotension, dehydration, kidney failure with metabolic acidosis, and septic shock. Findings include: On 5/24/16 at 2:30pm, E5 (Nurse Aide) stated R1 was usually very talkative, but was not her usual self on 5/15/16 at "breakfast time". E5 changed R1 that day before breakfast, and R1 was not	F 309		

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

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able to assist with the care as R1 usually did. E5 stated R1 "did not look very good" and did not respond verbally. E5 stated she informed Z3(Nurse), but E5 did not know what Z3 did at that time.

On 5/24/16 at 2:50pm E4 (Nurse Supervisor) stated on 5/15/16 the nurse aide told the nurse (Z3, name not given at the time of interview) that "something was going on with R1." E4 stated R1 had a low blood pressure, the nurse called the doctor for orders. E4 stated the nurse started an IV on R1 to administer fluids, and the doctor wanted to monitor R1's blood pressure every 10 minutes. E4 stated she did not record any vital signs on 5/15/16, E4 told the nurse to chart vitals. E4 stated R1 could not say what was wrong, and would only moan and look at the staff when her name was called. E4 could not recall the times that all of this occurred on 5/15/16.

On 5/24/16 at 5:30pm by phone, Z3 (Nurse) stated she went into R1's room on 5/15/16 when the shift started at 7am, visually observed R1. Z3 went into R1's room again between 10-11am and noticed R1 was having difficulty breathing. Z3 stated vital signs were taken and R1 had a low blood pressure, a fast respiratory rate, an IV was inserted, fluids were started, breathing treatments were given, and then the physician was called, though she did not remember which physician. Z3 stated the doctor said to continue monitoring R1's vital signs. Z3 stated she did not chart any vital signs other than what is in the progress note of 5/15/16 at 2pm, and R1 remained with a low blood pressure, low heart rate, high respiratory rate, difficulty breathing, was nonverbal, and did not respond to verbal stimuli. Z3 stated R1's condition did not improve, so R1 was sent to the

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hospital via 911, but does not remember the time. Z3 stated the vital signs in the 2pm note of 5/15/16 were the first set of vital signs taken for the 7am-3pm shift.

Nurse Progress Note 5/15/16 2pm (documented after R1's transfer) documents, R1 is noted with a change in mental status, is unresponsive to verbal command, and has the following vital signs which are abnormal for this resident: blood pressure 92/58, temperature 97.5, respiratory rate 52, pulse 49, oxygenation 95% on 3 liters of oxygen. An intravenous line (IV) is inserted, 0.9 normal saline fluid is started, 2 breathing treatments are administered, and the physician is contacted with patient status. R1 was transported by 911 emergency at 12:50pm 5/15/16.

According to R1's medical record, the only previous vital signs available were charted 2 days earlier on 5/13/16 4pm: blood pressure 120/70, temperature 98.6, respiratory rate 18, pulse 80, oxygenation 98% on 2 liters of oxygen. Physician Orders 5/15/16 (no time) document a chest x-ray, electrocardiogram (EKG), and blood work. There is no evidence of a physician order for an IV, fluids, or breathing treatments. Chest X-Ray Report documents the time of the x-ray was 12:29pm on 5/15/16.

On 5/25/16 at 3:30pm, E2 verified there was no evidence of additional vital signs in R1's medical chart, in the daily Medicare charting, or on the 2nd and 7th floor nursing unit report books where R1 resided during her facility's admission prior to her transfer to the hospital..

Fire Department Log 5/15/16 documents the paramedics were dispatched at 12:44pm, arrived

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at the facility at 12:49pm, and arrived at the hospital at 1:22pm; Complaint is noted as respiratory distress with wheezing lung sounds bilaterally; R1 is nonverbal and only opens eyes to pain and withdraws from pain.

Hospital Record History of Present Illness 5/15/16 1:37pm documents respiratory complaints and sob (shortness of breath). On arrival to the emergency room, R1 had shortness of breath, a fever, and was non verbal. Vital signs in the emergency room are temperature 102.2 F (degrees Fahrenheit), blood pressure 80/52, pulse 109, respiratory rate 56. Physical Examination includes lungs have scattered wheezes, poor air movement, and tachypnea (fast respiratory rate). Neurologically, R1 localizes and withdraws from pain only. Course of treatment is documented as clinically appears to be septic, sepsis protocol started, labs show kidney failure with metabolic acidosis, dehydration, low blood count, and sepsis. Primary impression is documented as sepsis associated hypotension (low blood pressure).

On 5/25/16 at 10:25am, by phone, Z1(Physician) stated sepsis has to be recognized early to decrease the mortality rate. Signs and symptoms of sepsis are fast respiratory rate, mental status changes, and low blood pressure, all of which R1 had. Z1 stated that once R1 had a low blood pressure it is already too late and there is an increased mortality rate from septic shock. Z1 stated it is "basic nursing home knowledge" to check a blood pressure and all other vital signs if a resident has mental status changes.

Z1 stated R1's unstable vital signs, low blood pressure, low pulse of 49, and the very fast

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F 309	Continued From page 4 respiratory rate of 52 (normal 12-20) are all signs and symptoms of sepsis, 911 should have been called immediately, and R1 should have been transferred to the hospital for emergent care, antibiotics, and IV fluids. Z1 stated sometimes the whole picture is not presented to the physician during the phone call, but R1's condition was not stable and she needed to be transferred to the hospital for this rapid decline in condition. Z1 stated the IV and fluids started by the nurse were "just a band-aid", when 911 was needed for an emergency transfer to the hospital. Z1 stated R1's vital signs should have been checked that morning when mental status changes were noted and 911 should have been called right away for R1's unstable vital signs (blood pressure 92/58, pulse 49, respiratory rate 52) for an emergency transfer to the hospital. On 5/25/16 at 11:30am, E2(Director of Nursing) stated nurses do not need an order to call 911 because it is an emergency. E2 stated nurses call 911 for changes in condition and dependent on the assessment of the patient condition. Emergency Management policy - Emergency guidelines refer to actions given to residents with urgent and critical needs. When an emergency situation arises, emergency procedures are initiated which include sending the resident to the closest emergency room. Have someone stay with the resident at all times. Monitor and treat, as much as possible the following areas: Take vital signs and provide reassurance to the resident. Vital signs should be taken every 10-15 minutes based on resident need until the resident is stable or transferred. Guidelines for Specific Medical Emergencies -	F 309		

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F 309	Continued From page 5 Acute Respiratory Distress: Take and record vital signs including pulse oximetry. Document events in the medical record.	F 309		