STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145828	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTATES OF HYDE PARK, THE	4505 SOUTH DREXEL CHICAGO, IL 60653

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interviews, and record review the facility failed to ensure that 3 meals were provided daily, failed to monitor weights, failed to follow dietary recommendations and failed to administer vitamins/supplements as ordered for one of four residents (R2) reviewed for change in condition. These failures resulted in R2's significant weight loss of 12.32% (within 6 weeks), cachexia (muscle wasting), and failure to thrive. Findings include; R2 was admitted to the facility (5/26/20) with [DIAGNOSES REDACTED]. R2's weights (documented under vital signs) are as follows; (7/3/20) 118.8 lbs. This weight is noted to be documented 5.5 weeks after R2 was admitted . There are no additional weights. On 8/3/20 at 3:55pm, surveyor inquired about the facility policy for monitoring weights. V4 (Nurse Consultant) stated For new admissions we get the weight the same day they are admitted , weekly weights for 4 weeks, and then monthly. Surveyor inquired about R2's weights, V4 affirmed that he attempted to get additional weights from the [MEDICAL TREATMENT] center however was unable to obtain them. Dietary Assessments for R2 include the following information; (5/28/20) per hospital, dry weight was 135.5 lbs. (pounds). Recommend discontinuing multivitamin and adding renal vitamin daily, Prostat AWC 30ml (milliliters) BID (twice daily) x 6 weeks for healing open areas. Talked with renal dietician, she told writer that resident is not getting breakfast before she leaves for [MEDICAL TREATMENT]. Recommend; house supplement 1.7 (4 ounces) TID (three times daily), and increasing vitamin D3 to 2,000units daily. Per renal dietician, resident's dry weight is 124.3 lbs (8.27% loss within 2.5 weeks). (7/9/20) Weight 118.8 pounds. BMI (Body Mass Index) 19.77. Recommend; Prostat AWC 30ml BID, house supplement 1.7 (4 ounces) TID due to low BMI/weight. (12.32% within 6 weeks). On 8/4/20 at 1:39pm, surveyor inquired about R2, V10 (Registered Dietician) stated They never got a weight on this person and I'm not sure why. The most recent weight we have on her is on 7/3/20, that's it. They should have weighed her from the get go. She's kinda thin, she's at the lower end of the BMI scale. I talked with the renal dietician and she told me she wasn't getting breakfast before she left for [MEDICAL TREATMENT]. She needs additional protein because she was on [MEDICAL TREATMENT]. I recommended Prostat and they didn't add it so I recommended it again. R2's (June 2020) MAR (Medication Administration Record) affirms Prostat, renal vitamin and house supplement were not prescribed and vitamin D3 dose was not increased as recommended. Vitamin D3 (1,000 unit) was not documented as administered on 6/5, 6/28, and 6/30. R2's (July 2020) MAR indicated [REDACTED]. House supplement was prescribed TID on 7/13/20 however not documented as administered on 7/14 (all 3 entries), 7/16 (all 3 entries), 7/20 (all 3 entries), and 7/21 (1 entry). Nepro Carb Steady (Nutritional Supplement) was ordered TID on 7/20/20 however on 7/20, 7/21, and 7/22 all 3 entries are blank. Vitamin D3 (1,000 unit) was not documented as administered on 7/7, 7/10, 7/14, 7/16, and 7/20. On 8/4/20 at 12:44pm, V11 (Nurse Practitioner) stated For dietary recommendations they normally give me the forms to approve it. It could be me or the PCP (Primary Care Physician) but I normally sign those. I don't recall if they gave one to me for (R2). We did some labs on her and I suggested putting her on supplementation Nepro. Surveyor inquired about potential harm to R2 if dietary recommendations are not followed and/or supplements are not administered as ordered V11 responded I would imagine malnutrition or failure to thrive. R2's (7/23/20) hospital history & physical states; presenting with failure to thrive, cachectic appearing. Diagnosis: [REDACTED]. The Nutrition/Unplanned Weight Loss Protocol (revised August 2008) states; monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons. The Physician and staff will monitor the nutritional status, response to interventions and possible complications of such interventions of individuals with impaired nutritional status. The Physician will document relevant medical observations and conclusions regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations where multiple active causes may coexist.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview the facility failed to document daily and/or weekly wound assessments as ordered, failed to obtain treatment orders for all wounds, failed to clarify treatment orders (re: affected area), failed to prescribe antibiotic medication for infected wounds, and failed to administer treatments as ordered for one of four residents (R2) reviewed for pressure ulcer. These failures resulted in R2 requiring surgical debridement of devitalized and necrotic tissue on the sacrum and foot. R2 subsequently [MEDICAL CONDITION], dry gangrene of the left foot, and tunneling sacral wound. Findings include; Progress notes affirm that R2 was admitted to the facility on [DATE] with an open area to left heel with discoloration and open area to sacrum however stage, size, exudate and/or description of the wound beds were not documented. On 7/30/20 at 1:51pm, surveyor inquired about R2's wounds V5 (Wound Care Nurse) stated I admitted her to the facility. She had a necrotic foot and an open area on her sacrum. At that time I was not the wound care nurse I called the doctor and verified the meds. He said continue the hospital orders. Surveyor inquired if R2's hospital orders included treatments, V5 responded No, but the wound care nurse is supposed to follow-up within 24 hours and implement treatments. R2's POS (Physician order [REDACTED]. Skin assessments weekly. Venelex ointment to affected area once daily. R2's (May 2020) TAR (Treatment Administration Record) affirms Venelex and weekly skin assessments from 5/27 through 5/31 were not documented. (Daily skin assessments are not inclusive). R2's (June 2020) TAR affirms Venelex was not documented on 6/3, 6/5, 6/11, 6/19, 6/25, 6/26, 6/27, and 6/30. (Daily skin assessments are not inclusive). On 7/30/20 at 2:31pm, surveyor inquired about concerns regarding R2's (5/27/20) Venelex order V4 (Nurse Consultant) responded The order says apply to their affected area but the location is not exact. Surveyor inquired what the blank spaces indicate on R2's (May/June 2020) TAR for daily Venelex and weekly skin assessments V4 stated Possibly it wasn't done. __ R2's (6/17/20) progress notes state in part; assessed patient and found open wound with red wound base on Right buttock, Stage II wound noted to site (1.5 x 1.0). Medical Doctor notified, new treatment order entered into EMAR (Electronic Medication Administration Record). R2's (July 2020) MAR and TAR affirm that there were no (right buttock) treatment orders entered on or about 6/17/20. On 8/3/20 at approximately 11:00am, V4 stated Generally if there's a wound they'll call the Physician to get orders and have the Wound Care Physician see the patient. R2 was not assessed by the wound care physician until one month after the (6/17/20) stage II (right buttock) wound was identified. R2's (7/17/20) initial (Physician) wound evaluation includes 3 wounds; 1) Sacrum: unstageable wound 2 x 2cm (centimeters) x not measurable. Thick adherent devitalized necrotic tissue 100%. Moderate purulent exudate, odor. Etiology: pressure. Surgical excisional debridement performed. treatment plan: [REDACTED]. Cover with gauze. 2) Right Foot: arterial wound 10 x 10cm x not measurable. Thick adherent necrotic tissue 100%. treatment plan: [REDACTED]. 3) Right heel arterial wound 4 x 4 x 0.5cm. Moderate purulent exudate. Thick adherent devitalized necrotic tissue 50%. Surgical excisional debridement performed. treatment plan: [REDACTED]. Cover with gauze. Recommend [MEDICATION NAME] (Antibiotic) 875/125 BID (twice daily) x 10 days. R2's (July 2020) POS affirms the following orders were entered on (7/20/20) Left foot: cleanse with NS (Normal Saline), apply [MEDICATION NAME] gauze, cover with dry dressing every other day and PRN (as needed). Sacrum: cleanse with NS, skin prep peri wound, apply Dakin's soaked gauze, cover with dry dressing daily and PRN (as needed). ([MEDICATION NAME], right foot and/or right heel treatment orders are not inclusive). On 7/30/20 at 2:35pm, surveyor inquired about treatment orders for R2's right foot and right heel as recommended on 7/17/20 by the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Wound Care Physician V4 reviewed her (July 2020) TAR and stated All they have is the left foot. R2's (July 2020) treatment administration documentation was requested V4 stated We do not have wound care documentation for July. R2's (July 2020) TAR affirms daily skin assessments, left foot treatments and sacrum treatments are not documented (all entries are blank). __ R2's (7/22/20) weekly skin assessment includes only the sacrum. The following was documented; Sacrum: moderate drainage (25-75% of dressing). Exudate: purulent. Indicate what referrals may be appropriate: no referrals necessary. On 8/3/20 at 9:58am, surveyor inquired about R2's (7/22/20) wound assessment documented by V8 (Licensed Practical Nurse). V8 stated The wound nurse enters the wound assessments but I was designated that day to do it. When I assessed the wound there was dark, it was pink, and there was no drainage. Surveyor inquired if R2 had any other wounds V8 replied I think it was one on her foot. On 8/3/20 at 11:29am, surveyor requested R2's weekly wound assessments from 5/26/20 through 7/22/20. V4 presented only one assessment (dated 7/22/20) and stated There was a process but it was not in place so we don't have them. On 8/3/20 at 3:53pm, surveyor relayed concerns regarding care and services provided to R2 wounds V4 (Nurse Consultant) stated For change in condition we notify the physician to obtain orders and notify the appropriate members like wound care. __ R2's medical records affirm she incurred significant weight loss of 12.32% (within 6 weeks) while residing at the facility. On 8/4/20 at 12:44pm, surveyor inquired if V11 (Nurse Practitioner) was aware that R2 had wounds V11 responded I was not. Surveyor inquired about the potential harm to R2 if she had wounds and significant weight loss V11 stated It depends on how vigilant they are with the wound care but it would be slow wound healing I would imagine. On 8/5/20 at 2:02pm, V12 (Medical Director) stated They have to notify the attending physician or nurse practitioner for change in condition. When they don't find them they call me and I give orders what to do. For wound care recommendations they send them (in writing) to the attending physician to approve or disapprove. When the wound is purulent you're supposed to get an order to culture it and treat it. Surveyor inquired about potential harm to R2 if antibiotic and/or treatment orders were not received and/or carried out V12 responded The wound just continues to deteriorate. Surveyor inquired if he was aware of R2's significant weight loss, declining wounds and/or [MEDICATION NAME] recommendations for an infected wound V12 responded The attending is in charge of the patient. The DON (Director of Nursing) did not tell me about this patient, I did not get any calls. R2's 7/23/20 hospital history and physical states; presenting with failure to thrive, left foot with dry gangrene, and tunneling sacral wound. Presentation [MEDICAL CONDITION]. Initial labs notable for leukocytosis (increased white blood cells) 23.1. Given the extent of the gangrene, non-salvageable left foot. The (January 2017) prevention of pressure wounds policy states; routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.