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 _____	03/13/2020

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on interview and record review, the facility failed to follow its Change in a Resident's Condition or Status policy and procedure for one of three residents (R1) reviewed for change of condition. Findings include: R1's laboratory (lab) results of 1-6-2020, document Sodium; Serum level of 155 (High), normal range 131-145 mEq/L and Potassium; Serum level of 3.3 (Low) normal range 3.5-5.1 mEq/L. The specimen was collected on 1-6-2020 and reported to facility on 01.06.2020 at 7:53 PM. V5 (Licensed Practical Nurse) stamped and signed the document four days later when he notified R1's physician of the abnormal lab values. On 03.12.2020 at 10:20 PM, V2 (Director of Nursing) confirmed that V5 was working when the results were received and should have notified R1's physician at that time. On 03.12.2020 at 11:17 AM, V5 said: I can't recall the labs, or if I called the physician. Nursing Progress Notes (01.06.2020-01.08.2020) do not document that R1's physician was notified of abnormal lab results, R1's change in condition or R1's hospital transfer. Facility's Change in a Resident's Condition or Status policy and procedure (undated) documents (under Policy Statement): Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and or status. (Under Policy Interpretation and Implementation) The DON or designee will notify the resident's Attending Physician or On-Call Physician when there has been: d. A significant change in the resident's physical /emotional/mental condition; g. A need to transfer the resident to a hospital /treatment center. 2. A significant change of condition is a decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). 4. Notification will be made as soon as possible (within twenty-four (24) hours of change occurring in the resident's medical/mental condition or status.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform a resident's physician of abnormal laboratory results and change in condition for one of three residents (R1), reviewed for dehydration. This failure resulted in R1 requiring hospitalization for altered mental status due to [MEDICAL CONDITION] (high concentration of sodium in the blood). Findings include: R1's laboratory (lab) results of 01.06.2020, document Sodium; Serum level of 155 (High), normal range 131-145 mEq/L and Potassium; Serum level of 3.3 (Low) normal range 3.5-5.1 mEq/L. The specimen was collected on 01.06.2020 and reported to facility on 01.06.2020 at 7:53 PM. V5 (Licensed Practical Nurse) stamped and signed the document four days later when he notified R1's physician of the abnormal lab values. No documentation was found in R1's Progress Notes regarding physician notification of R1's abnormal lab results or change in condition Emergency Department Progress Notes (01.08.2020) document R1 was admitted to the hospital for [DIAGNOSES REDACTED]. R1's sodium level had increased to 168 mEq/L. On 03.12.2020 2:46 PM, V6 (Nurse Practitioner) said he was asked to see the resident on 01.08.2020 for lethargy; resident wasn't responding to sternal rub, he didn't look good. V6 reviewed copy of lab results dated 01.06.2020 and said those results were in R1's medical record 01.08.2020 when he saw the resident. V6 said had he seen the resident on 01.06.2020, I would have acted on the abnormal labs. If he (resident) was stable, at a minimum I would have ordered oral potassium and IV fluids. I think the labs should have been acted on that day. Those abnormal lab values could possibly cause heart irregularities and poor perfusion. On 03.12.2020 at 10:20 AM, V2 (Director of Nursing) confirmed that V5 was working when the results were received and should have notified R1's physician at that time. On 03.12.2020 at 11:17 AM, V5 said: I can't recall the labs, or if I called the physician. Nurses Progress Notes (01.06.2020-01.08.2020) do not document that R1's physician was notified of abnormal lab results, R1's change in condition or R1's hospital transfer.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement care plan interventions for one of three residents (R3) reviewed for injuries and falls. Findings include: On 03.10.2020 at 2:12 PM, in the 3rd Floor Dining Room, R3 was observed getting up from chair; resident's eyes were partially shut, resident appeared unsteady on her feet. V4 (LPN-Licensed Practical Nurse) who was seated at Nurses Station (located directly in front of Dining Room) saw R3 get up from chair and said She's up, V4 did not re-direct resident to sit down. At 2:15 PM R3 was observed falling backwards onto Dining Room floor. V4 said: She sat down. V3 (LPN) said: She (resident) doesn't know how to stop herself. On 03.11.2020 at 3:00 PM, V2 (Director of Nursing) said staff informed her that the CNA (Certified Nursing Assistant) was called away from the Dining Room; R3 got up and fell . V2 said someone (staff) should have got up to redirect R3. R3's Face Sheet documents [DIAGNOSES REDACTED]. R3's Falls care plan (reviewed/revised 03.05.2020) notes the following interventions: Staff will monitor for behaviors; of placing self on the floor, and redirect her to sit in the chair and Observe frequently.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** Based on interview and record review, the facility failed to implement their Guidelines for Reporting Test Results to Physicians policy and procedure by not reporting abnormal laboratory results to a resident's physician for one of three residents (R1) reviewed for abnormal laboratory results. Findings include: R1's laboratory (lab) results of 01.06.2020 document Sodium; Serum level of 155 (High), normal range 131-145 mEq/L and Potassium; Serum level of 3.3 (Low) normal range 3.5-5.1 mEq/L. The specimen was collected on 01.06.2020 and reported to facility on 01.06.2020 at 7:53 PM. V5 (Licensed Practical Nurse) stamped and signed the document four days later when he notified R1's physician of the abnormal lab values. On 03.12.2020 2:46 PM, V6 (Nurse Practitioner) said he was asked to see the resident on 01.08.2020 for lethargy; resident wasn't responding to sternal rub, he didn't look good. V6 reviewed copy of lab results dated 01.06.2020 and said

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 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) those results were in R1's medical record 01.08.2020 when he saw the resident. V6 said had he seen the resident on 01.06.2020, I would have acted on the abnormal labs. If he (resident) was stable, at a minimum I would have ordered oral potassium and IV fluids. I think the labs should have been acted on that day. Those abnormal lab values could possibly cause heart irregularities and poor perfusion. On 03.12.2020 at 10:20 AM, V2 (Director of Nursing) confirmed that V5 was working when the results were received and should have notified R1's physician at that time. On 03.12.2020 at 11:17 AM, V5 said: I can't recall the labs, or if I called the physician. NuirsesProgress Notes (01.06.2020-01.08.2020) do not document that R1's physician was notified of abnormal lab results, R1's change in condition or R1's hospital transfer. Facility's Guideline for Reporting Test Results to Physicians (undated) documents other abnormal levels including Potassium and Sodium should be reported the next office day.