STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 12/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

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S 000	Initial Comments Complaint# 1797506/IL99068 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b)2) 300.1030a)1)2) 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 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 pain, cardiac failure, or cardiac arrest). 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. Restorative measures shall include, at a minimum, the following procedures: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure medication for the treatment of a resident's congestive heart failure was administered, failed to identify worsening congestive heart failure symptoms and failed to following up on a stat (immediate) chest x-ray results to provide timely care and transfer a resident to hospital for life saving treatment. This applies to one of three residents (R1) reviewed for a change in condition. Facility's failure to identify R1's worsening respiratory condition and congestive heart failure	S9999		

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S9999	Continued From page 2	S9999		

status resulted in R1's transfer to the hospital for acute care of the resident, who died shortly afterward. According to the death certificate the contributing factor for R1's death was congestive heart failure.

Findings include:

Record review on nursing progress note dated on 11/14/17 at 11:13 AM document that R1 was observed with weakness, having hard time verbalizing needs, cough, and congestion and had hard time standing up.

Record review on physician order sheet indicates that V1 (attending physician) ordered immediate (stat) chest X-ray on 11/14/17 at 10:41 AM. Record review on medical diagnostic service document stat X-ray was done at 1:56 PM.

Record review on nursing progress note entered on 11/25/17 at 7:29 AM (Late entry) document that stat X-ray results got delayed and facility received result after 13 hours on 11/15/17 at 3:00 AM.

On 12/26/17 at 2:20 PM V2 (Director of Nursing) stated, "The X-ray results for R1 ordered on 11/14/17 was delayed because of something going on with X-ray company that I had no control over it."

On 12/26/17 at 2:35 PM V1 stated, "Stat X-ray results are expected as soon as possible (ASAP)."

Record review on Diagnostic imaging indicates congestive heart failure and right lung pneumonia. V1 was notified on this diagnostic result and V1 ordered Biaxin 500 milligram (mg)

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S9999	Continued From page 3	S9999		

oral and O2 inhalation 3 litter per minute. No interventions were ordered for congestive heart failure as shown on X-ray.

Record review on physician order sheet document that R1 was not on any diuretic for congestive heart failure.
Record review on nurse's progress note entered on 11/17/17 at 3:16 PM (Late Entry) indicates that R1 noted with crackles upon auscultation and congestion at around 10:30 AM on 11/15/17. V1 was notified again on 11/15/17 at 11:30 AM to update on R1's worsening condition. V1 discontinued Biaxin due to antibiotic reaction and ordered azithromycin 250 mg daily and 500 milliliter (ml) intravenous fluid (D5W) at 60 ml per hour (due to dehydration).

On 11/15/17 at 3 PM, facility contacted V1 again to inform the worsening condition and family's preference to transfer to another hospital. R1 was picked up at 4:15 PM by ambulance to transfer to local hospital.

On 12/29/17 at 8:50 AM, V1 stated, "Yes, yes I did everything from my ethical stand point to save R1. He had weak heart and infection and we treated him with antibiotic. I gave verbal order for Lasix for his fluid overload."

Record review on physician order sheet indicate that there was no physician order for Lasix and medication administration record indicates that no Lasix was given to R1 either on 11/14/17 or 11/15/17.

On 12/29/17 at 9:30 AM V2 stated, "We didn't have any Lasix order from V1. We have many patients with congestion and shortness of breath. R1 didn't have any edema or worsening CHF

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S9999	Continued From page 4 symptoms to send him out to hospital immediately." Facility presented policy on emergency transfer or discharge (dated on 12/2012) policy statement document: Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident. Record review on emergency room (ER) records indicate that R1 had oxygen saturation 81% and chest x-ray indicates severe congestive heart failure and fluid overload. Death certificate indicates that R1 expired on 11/16/17 in the local hospital due to congestive heart failure and ventricular Dysrhythmia. (A)	S9999		