STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016216	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VISTA BURR RIDGE	6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60521

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S 000	Initial Comments Annual Health Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)1 300.1210d)2 300.1210d)5 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat	S9999		

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S9999	Continued From page 1	S9999		

pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that medications were present for a resident with recurrent diarrhea and to notify the Physician about the medications, failed to ensure lab testing was completed in a timely manner for the resident, and failed to ensure staff responded to the resident's stool incontinence in a timely manner. These delays in treatment resulted the addition of a third medication, and the resident experiencing increased weakness and skin irritation.

This applies to 1 of 4 residents (R14) reviewed for nursing cares in a sample of 26.

Findings include:

R14 was admitted to the facility on 1/29/24. R 14 has diagnoses that includes congestive heart failure, muscle weakness, and enterocolitis due to clostridium difficile. R114's MDS (Minimum Data Set) shows he is cognitively intact and requires staff assistance for mobility using a walker. R14's care plan dated 2/11/24 includes actual impaired skin integrity, MASD

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S9999	Continued From page 2	S9999		

(Moisture-Associated Skin Damage) to buttocks with risk for further skin breakdown including skin tears, bruising and /or pressure related to decreased mobility.

On 4/18/24 at 10:05 AM, the call light computer display showed R14's call light had been unanswered since 8:56 am (one hour and nine minutes).

On 4/18/24 at 10:19 AM, V12 (Family Member) stated R14 has recurrent C diff (Clostridium Difficile) infections. V12 stated R14 had been having diarrhea stools since Saturday 4/13/24 (five days). V12 stated, on Tuesday, 4/16/24 R14 was seen by the NP (Nurse Practitioner) at which time fidaxomicin and metronidazole were ordered. V12 stated she told the NP, V4 (RN), and another staff member she would pay out of pocket and retrieve the prescriptions if necessary. V12 stated staff never told her R14 had not been started on the medications and R14 seemed weaker since she saw him on Saturday. V12 also stated she had put the call light on at around 9am for stool incontinence. V12 stated V4 came in the room but did not provide incontinence care, and that R14 had a second stool incontinence episode since and still had not been cleaned.

On 4/18/24 10:25 AM, V3 ADON (Assistant Director of Nursing) was asked by the Surveyor to have staff provide incontinence care for R14. V14 CNA (Certified Nursing Assistant) was sent to room to provide incontinence care.

On 4/18/24 10:30 AM, V5 (Physician) stated he saw R14 on Tuesday, 4/16/24 and had ordered labs, IV (Intravenous) fluids, and called the ID (Infectious Diseases) Practitioner to see R14. V5 stated ID was at the bedside within an hour of his

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call and ordered fidaxomicin and metronidazole. V5 stated the fidaxomicin and metronidazole had still not been administered, and the ID called the facility Nurse Manager on 4/17/24 to follow up about the two medications. V5 stated the NP is now adding Vancomycin. V5 stated the C diff and urine labs he ordered two days earlier still had not been collected. V5 stated R14 seems weaker since he saw him on 4/16/24 but they were trying not to send him to the hospital. V5 stated the delay in treatment definitely had a negative impact on R14.

On 4/18/24 10:45 AM, Surveyor in hallway heard R14 calling for assistance from his closed bathroom door. Surveyor requested V3 ADON and another staff member sitting at nursing station to aid R14. R14 buttocks were observed while he was in the bathroom with V3. The toilet seat was covered with liquid brown stool and the area between R14's rectum and buttocks to his upper thighs was fiery red and excoriated.

On 4/18/24 at 5:05 PM, V2 DON (Director of Nursing) stated she did not have documentation of stool and urine specimens being sent for R14. V2 stated, the first dose of metronidazole ordered on 4/16/24 was administered 4/18/24 at 11:12 AM. There was no documentation of administration for the fidaxomicin ordered on 4/16/24, and V2 verified there was no nursing documentation showing the physician was notified that the fidaxomicin was not available. V2 stated the medication order should have been sent to the pharmacy and delivered by 10pm the same day or on the next delivery the following day after it was ordered and the physician should have been notified about the medication delay.

(B)

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