

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/07/2006
NAME OF PROVIDER OR SUPPLIER WESTSHIRE NURSING & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804		
(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 324 F9999	Continued From page 8 go. Nurses notes of 6-28-2006 through 7-3-2006 documents resident out of the facility. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services	F 324 F9999			

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F9999	<p>Continued From page 9</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>Based on interviews and record review the facility failed to provide psychosocial interventions for one resident (R63) who displayed mental and/or psychosocial adjustment difficulty. This failure resulted in R63 committing self injurious acts and using a razor to cut her neck and wrists.</p> <p>Findings include:</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>Per record review and interview of staff, R63 had multiple episodes of maladaptive behaviors including self harm, verbal abuse and physical abusive (attention seeking behavior) that had not been prevented with a psychosocial plan even when the facility had been aware of R63's history of these behaviors. There had been no planned intervention to prevent R63 and assist her in adjusting to accepted psychosocial well being.</p> <p>Review of R63's closed record documents that R63 was admitted to the facility on 4-17-2006. R63's diagnosis includes: Schizoaffective disorder, unspecified state. R63's Minimum Data Set (MDS) of 5-1-2006 documents R63's mood as persistent anger at placement in nursing home. R63's persistently seeking attention. R63's behaviors of self abusive acts and resisting taking medication were all exhibited the last 7 days.</p> <p>R63's care plan for 5-4-2006 and 6-20-2006 documents R63's need for symptom management using antipsychotic medications.</p> <p>R63's 6-19-2006 Behavior Occurrence Form documents resident wants to sign out Against Medical Advice (AMA), became verbally aggressive when request was not met.</p> <p>On 5-3-2006 resident was observed smoking crack cocaine by staff. There was no intervention provided according to the facility's drug abuse policy. Facility care plan for this issue did not outline any intervention on prevention of drug abuse. Patient has a history of using crack cocaine but did not have any care planning on this until 5-4-2006. Then the interdisciplinary team goal was that the resident will reduce the</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>number of reported incidences of smoking crack cocaine by the next evaluation.</p> <p>Social service entry of 6-20-2006 by E15(PRSC), documents that R63 was involved in a recent physical altercation with peer. Psych services staff met to develop a new care plan focusing on R63's med compliance, verbal aggression and physical aggression. It was also decided that a behavior contract will be developed.</p> <p>Interview with E15, PRSC, on 8-30-2006 9:30 A.M. in the conference room revealed that the behavior contract for R63 was not developed. E15 went on to say that he did not have enough time because R63 moved to another floor. E15 told surveyor that PRSC's do discuss resident needs with each other. However the behavior contract was not done for R63. Interview with E6, Social Service Director, on 8-3-2006 at 3:45 P.M. in the conference room, E6 told surveyor that the behavior contract was a plan of action for R63 but it was not done.</p> <p>Nurse notes document R63's repeatedly refusing the medication from 7-2-2006 though 7-13-2006.</p> <p>7-3-2006 Nurse notes document that R63 continues to approach nurse station for numerous reasons. Still requesting to exit the facility</p> <p>7-16-2006 1 P.M. resident at the nurses station with social service crying she wants to go to the hospital.</p> <p>7-16-2006 5:15 P.M. nurse notes document resident extremely hostile and agitated and anxious, cut left wrist and neck while in the</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>washroom . Patient was supposed to be shaving under her arms. Later stated ,"If you do not send me out and put me in the hospital I'll cut myself again."</p> <p>The 6-20-2006 care plan documents R63's physical aggression toward peers. This behavior is rare and occurs when R63 is not compliant to medication regime.</p> <p>In summery R63 was admitted to the facility on 4-17-2006. R63 was non-compliant with taking medications, demonstrated persistent attention seeking behaviors (self abusive behaviors), consistently requested to be sent to the hospital and became verbally/physically abusive when her requests were not met. R63 was also observed smoking crack cocaine by facility but no interventions were documented by facility staff to decrease or discontinue R63's inappropriate behavior. Per phone discussion with E-1(Administrator), on 9/7/2006, facility staff were aware of R63's behaviors, but R-63's Physician would not discharge R63.</p> <p style="text-align: center;">(A)</p>	F9999			