STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145419	A. BUILDING ______ B. WING ______	C 07/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD CARE	**7733 WEST GRAND AVENUE ELMWOOD PARK, IL 60707**

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F9999	Continued From page 24	F9999		

LICENSURE VIOLATIONS

300.610a)
300.1010h)
300.1210a)
300.1210b)3)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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F9999	Continued From page 25 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following: Based on record review and interview, the facility failed to order and follow-up on a psychiatric consultation for one of one sampled resident (R6) who had verbalized hopelessness and suicidal ideations. The psychiatric consultation was ordered on 5/12/08 and not done. The resident(R6) broke his dialysis perma. cath. (permanent catheter) on 5/16/08 located on his R(right) Jugular vein, and bled to death . Coroner's Report "Immediate Cause of Death" for	F9999		

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F9999	Continued From page 26 R6 on 5/16/08 was exsanguination (meaning drained of all blood from the body). The facility failed to have an established policy/procedure to ensure that residents with suicidal ideations receive a psychiatric consultation in a timely manner. Findings include: R6 is a 53 year old male with diagnoses that include S/P (Status Post) L (Left) BKA (Below Knee Amputation), ESRD (End Stage Renal Disease), DM (Diabetes Mellitus), and Anemia. R6 was admitted to the facility on 5/1/08 for Rehabilitation S/P L BKA (4/2008) and Hemodialysis. Review of POS (Physician's order sheet) dated 5/12/08 includes "Psych consult" (Psychiatric consultation). Review of Psychology and NP (Nurse Practitioner) documentation dated 5/12/08 indicated the following: 1. "States he wants to be dead." 2. Non compliance with treatment. 3. "He (R6) is not amenable to any suggestions and he will not offer any concrete ways we can help him." 4. "Depression" 5. "Will consult psychiatry" Social Service and Restorative Progress notes dated 5/4, 5/5 and 5/13/2008 as written: "He often makes decisions that are not necessarily at his best interest." " Resident (R6) displays sad/worried facial expressions due to illness. His mood is not easily	F9999		

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F9999	Continued From page 27 redirected by staff. He is a new admission to the facility and displayed these behaviors of resisting care upon admission. " During interview of E2 (Director of Nursing) on 5/16/08 regarding the psychiatric consultation on the POS dated 5/12/08 not being done, E2 stated that she did not feel it was an emergent situation. E2 during interview on 5/22/08 told surveyor that R6's "psuedo" Father (Landlord) had visited R6 on 5/15/08, and that R6 had talked about cremation and wanting to wear his Ohio hat. E2 also confirmed during the interview that there was a staffing problem on the 11pm-7am shift on 5/15/08. During interview of Z1(NP - Nurse Practitioner) on 5/22/08, Z1 stated, "I wrote psych. consult that day, I told my student this is beyond our scope. We need Psychiatrist." During interview of E3 (Nurse) on 5/22/08, E3 stated that when she called the Code Blue (Medical Emergency), she heard the dialysis lady (Z2- dialysis technician) state that R6 was going to kill himself. When surveyor asked E3 what Z2 actuallystated, E3 then stated : "Oh my God, he has said that he was going to kill himself and write his will." During interview of E7 (nurse supervisor) on 5/22/08, E7 stated that she was scheduled on 5/16/08 during the 11pm-7am shift, and that she worked as a building supervisor and a nurse on the third floor/Ventilator Unit. E7 confirmed that she was not aware of R6's refusal of all his medications from the 3-11pm shift. E7 confirmed that the refusal of all the medications from the previous shift should have been written on the	F9999		

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F9999	Continued From page 28	F9999		

facility 24 hours report, as it was a significant information.

Interview of CNA'S (certified nurses assistant) on 5/22/08 revealed the following:

E5 confirmed that on the 11pm -7am shift on 5/15/08 she worked on the first floor with E6, and that she worked the opposite hallway from R6's room. E5 during this interview stated that E6 was pulled to the third floor (skilled unit) around 12am-12:30am, and that she made rounds that night only on her side. E5 further told surveyor that she was by herself on the floor until E4 came down around 3:30-4:00am. to help her. E5 indicated that E4 saw everything (suicide incident) and not her.

E6 confirmed that during the 11pm-7am shift on 5/15/08 she worked on the side where R6's room was. E6 recounted that during her first rounds a little after 11:00pm, she observed R6 to be agitated and very unhappy. E6 further described R6's behavior "like he was mad at everybody." E6 went on to state that at 12:00am, before she was pulled to go to the third floor, R6 put on his call light, but during this time R6 was very calm and politely asked her to turn his TV(television) off, and to make sure to close his door before she exited the room. E6 further stated that she could have said something about R6's "obvious attitude change" during her rounds observations, if she had stayed longer on the floor.

E4 confirmed that she found R6 unresponsive and blood everywhere, during her rounds at 10 minutes to 4:00am. The blood was all over on the bed and on the floor and she immediately called the nurse who called the code blue.

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F9999	Continued From page 29 Review of Police Report indicated that E3 and Z2 were interviewed on 5/16/08 and both stated to the officer that R6 made verbal threats of suicide to Z2. Z2 confirmed to the police officer during the interview that on 5/15/08 at approximately 1730 (5:30pm), R6 told her that he wanted to die. Z2 also then told the police officer that she never made a formal report of the death wish. The suicide note that was found by Z2 at the bedside of R6 was reviewed and showed that the letter was addressed to E2, and Z2's name was mentioned in the suicide letter. The first paragraph of the suicide note stated, "I tried to tell you that I did not want to live any longer, on dialysis any more, I just can't stand on shitting or pissing on myself. " Review of Paramedics Fire Department Report indicated that the crew arrived at the scene on 5/16/08 at 4:29am, and found R6 unresponsive, pulseless, breathless and saturated in blood approximately 1000 to 1500cc of blood with coagulation. This report further indicated that a nurse had told them (paramedics) that R6 had refused medications at the last shift (3-11pm shift). (This refusal of medications by R6 on 5/15/08 during the 3-11 shift was also obtained by surveyor's interview with E3. E3 confirmed during the interview that this was the first time R6 had refused all his medications during a shift.) The paramedics report further documented that due to severity of blood loss and lividity (blood pooled to dependent body areas), no resuscitation was attempted. The paramedics report documented R6's condition as follows:	F9999		

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F9999	Continued From page 30 Primary Symptom: Obvious death - Triple Zero Other Associated Symptoms: Bleeding Primary impression: Traumatic Injury Secondary impression: Hypovolemic/Shock (A)	F9999		