STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. BUILDING _____ B. WING _____	11/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HOUSE NURSING & REHAB CTR	2320 SOUTH LAWNDALE CHICAGO, IL 60623

(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 371	Continued From page 20 Review of the dietary handwashing policy showed that it did not include proper handwashing in the dishroom, when handling soiled to clean dishes. Surveyor discussed this with E6, who agreed. 8) On 11/9/09 at 12:30 PM, in the second floor dining room, surveyor observed ice machine rusted, and top with burn marks and food splashes. There was a towel on top of the pipe and back of machine. There was a container of sour cream stored on top of the ice inside the machine. There was also an orange insulated cooler sitting on top of the ice machine, spout was dripping water onto the ice machine cover. There was a dirty cloth around the bottom of the ice machine to catch the drips. The cooler was heavily soiled with grayish dried substance all over and peeling plastic. The wall behind the ice machine had chipped paint and holes. On the floor was an old broom and a table leaning up against the wall.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.3240a) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care	F9999		

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F9999	Continued From page 21 and services to attain or maintain the highest practicable physical, mental, and psychosocial 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 presonal 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 prevnet accidents. 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 requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to provide supervision and monitoring for 1 of 22 sampled residents (R17) who was found unresponsive in whirlpool tub by staff and subsequently was pronounced dead on arrival at a local hospital. R17's cause of death was ruled as a drowning. R17's diagnoses included Schizoaffective Disorder, Diabetes Mellitus and Seizure Disorder. R17 was assessed as cognitive impaired. The tub room was unlocked at the time of discovery. R17's	F9999		

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F9999	Continued From page 22 entry was unnoticed. This deficient practice has the potential to effect all 62 residents assessed as being cognitively impaired. This deficient practice of lack of supervision places all 62 residents at risk for possible injury. Findings include the following: On 11/9/09 at 10:35 AM, surveyor responded to a Code Blue to the D wing, announced over the facility overhead call system. Surveyor observed multiple staff outside the whirlpool tub with the emergency crash cart in place, and then observed several staff in the tub room placing R17 on the tub room floor. E2 (DON) was attempting an airway and Cardiopulmonary Resuscitation (CPR) was started while awaiting outside emergency services (911). Surveyor asked staff what happened and was told R17 was found unresponsive in the tub. Review of local fire department (EMS) report dated 11/9/09 denotes the following upon arrival at facility: "CPR in progress upon arrival patient on floor of tub room unknown down time. Patient (R17) straight line upon arrival and remained that way following 3 rounds of epinephrine and atropine. Attempted to pace patient at various energy levels to no avail. When attempting to intubate patient jaw stiff and snapped back into place unable to complete procedure. No sign of trauma. All times for computer only and do not indicate the actual time or sequence of events OK to discontinue per Z5 (telemetry physician). R17 was pronounced dead at the facility." Review of facility initial incident report dated	F9999		

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F9999	Continued From page 23 11/09/09 denotes R17 was found unresponsive in whirlpool, 911 called and CPR done. Ambulance crew continued CPR without success. Called time of death at 11:02 AM. R17's remains were transported to hospital . At 1:00 PM on 11/9/09 local medical examiner and local police department were conducting an investigation as to R17's cause of death. On 11/9/09 at 11:42 AM, surveyor interviewed staff CNA (Certified Nurses Aide) E11 who found R17 in the tub. E11 stated she went down to whirlpool tub room on D wing to see if tub was empty so she could bathe a resident. E11 stated the tub room door was closed and heard water running which was unusual. E11 stated she knocked on door and heard no response and opened door. E11 stated she saw R17 in the tub under water and laying on his side. E11 stated she pulled R17 above water and called out for help. E11 stated R17 was unresponsive and held R17 up above water until other staff came (Code Blue). E11 stated the whirlpool tub was full to top with water. E11 stated R17 never usually took baths and was able to care for self but needed supervision. E11 stated the tub room is usually locked and residents are not allowed to go in unsupervised. E11 stated rounds are done every 2 hours to check on whereabouts of residents. E10 (Head CNA) was assigned to R17 on 11/9/09 on the 7-3 shift. E10 stated in interview on 11/9/09 across from nurses station, he did not know R17 was in the tub room at the time R17 was found. E10 stated R17 was alert and independent in activities of daily living (ADL'S), and stated in later interview the last time he saw R17 was at breakfast. E10 stated the tub room is	F9999		

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F9999	Continued From page 24 locked most of the time. E15 (CNA) was assigned to do head count of residents at 10:00 AM on 11/9/09. According to the census shift form E15 signed R17 was in the shower at 10:00 AM. Surveyor reviewed census sheet with E15 on 11/9/09 which revealed E15 signed R17 was in shower at 10:00 AM. E15 stated during her rounds she saw light on in tub room, knocked on door and asked if R17 needed assistance and was told no. E15 stated she left and did not come back. E15 stated tub was 1/2 full at the time. E15 stated R17 is alert and oriented and independent in all ADLs. E15 stated when residents are put in tub, staff is too stay close to the door E12 (Nurse) assigned to R17 on 11/9/09 stated the last time she saw R17 was at 9:00 AM medication pass when he received his medication. E12 stated R17 was alert and oriented. E12 was unaware R17 was in the tub until the Code Blue was called. E12 stated the tub room is usually unlocked. E2 (Director of Nursing) stated he respond to the Code Blue called for R17. When E2 entered tub room he observed 4 staff members holding R17's head up out of the water and attempting to get R17 out of the tub. E2 stated at that time the tub was 1/2 full and the whirlpool was going. E2 stated R17 was placed on floor in tub room and CPR was immediately started. E2 stated R17 was flaccid and unresponsive, R17 had emesis 2-3 times and was suctioned. E2 stated the shower in D wing is left unlocked because all residents on the D wing are alert and oriented. Surveyor informed E2 of observations made on 11/9/09, wandering residents unsupervised	F9999		

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F9999	Continued From page 25 walking up and down the hallway. E2's response was the shower is locked today (11/10/09). E1 (Administrator) stated on 11/10/09, the facility had no prior policy regarding tub rooms being locked. Review of R17's record reveals a diagnosis of Anemia, Seizure Disorder, Diabetes Mellitus. R17's Minimum Data Set of 10/7/09 assessed R17's Cognition as moderately impaired (decisions poor; cues/supervision required. Under bathing (how resident takes full-body/shower, sponge bath, and transfers in/out of tub/shower); R17 was assessed as requires supervision-oversight help provided. Computerized quarterly assessment dated 1/013/09 by E8 (Clinical Director-Social Service) assessed R17's daily decision making as "residents decisions are poor and questionable requiring supervision." R17's current care plan dated 10/12/09 denotes R17 has a problem identified as poor hygiene with approach for R17 to be encouraged to bath on schedule and as necessary. Resident will be allowed to use tub/whirlpool when asked and available independently. Wash entire body and report to staff of bathing/showering. Care plan dated 11/8/09 identifying R17 as a risk for potential injury related to seizure activity, and receives anticonvulsant medications daily, resident receives Depakote 500 milligrams twice a day. On 11/9/09 record review, revealed a phone order obtained by E13 (LPN-care plan) dated	F9999		

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F9999	Continued From page 26 11/8 for Depakote 500mg twice a day. E13 was asked why a new order for Depakote was obtained. E13 stated she was reviewing R17's care plan on 11/8/09 and noted when he came back from hospital he was not on his Depakote for seizures and called Z1 (R17's primary physician). E13 stated R17 was a little confused on making decisions for himself, and always took a shower. Review of copies of hospital record provided by facility reveals R17 was admitted to hospital on 10/15/09 with Pancytopenia. Review of consultant notes dated 10/20/09 denote "resident has been quite confused over the past week according to primary care physician. Current medications: Ability, thiamine, Depakote, Seroquel." Z1 (R17's physician) stated in phone interview on 11/9/09 he was informed of R17's expiration by E2. Z1 stated he couldn't recall why R17 was on Depakote for behaviors or seizures. Z2 (psychiatrist) stated in phone interview R17 had a history of seizure disorder and was taking Depakote for seizures not for behaviors. Z2 stated R17 needed assistance with few ADL's and cognitively was okay, had no depression or suicidal ideation. On 11/10/09 during phone interview with Z3 (medical examiner) Z3 stated R17's death was ruled a drowning but undetermined cause. Z3 stated R17 had a bite mark on the tongue upon exam. Z3 stated toxicology reports are pending. The facility failed to monitor R17 for at least 30 minutes, as a result R17 died from drowning.	F9999		

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F9999	Continued From page 27 (A)	F9999		