

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145806	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/15/2010
NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645		
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F 323	Continued From page 18 are admitted, will be assessed for self harm/suicide behavior by the social service department. The assessments will be completed annually or more often as needed. Any resident assessed at risk will be referred to their psychiatrist and IDT (Interdisciplinary Team) for a plan of treatment. The plan of treatment will be monitored and will be updated as indicated based on the outcome by the IDT. The assessment will be completed annually or more often as indicated. The Social Service Director will monitor for effectiveness. The Administrator will do spot checks weekly to determine compliance. 11. On 7/13/10, the social service consultant will hold an inservice for the Social Service staff on the correct documentation and possible interventions for residents with acute psychiatric episodes.	F 323			
F9999	Final completion date: July 20, 2010. 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	F9999			

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F9999	<p>Continued From page 19</p> <p>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.</p> <p>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</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</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>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>These requirements are not met as evidenced by:</p> <p>Based on record review, policy review, interview and observation, the facility failed to:</p> <ul style="list-style-type: none"> -prevent accidents by leaving a tub room unlocked and unattended so that any resident had access to this area at any time without supervision, -have policies and procedures on the use of the tub room and supervision of residents while using the tub for bathing, -have a complete and informative incident report regarding the 7/4/10 incident in which a resident (R1) expired, -report the incident within 24 hours to the Regional Health Department Office, -have a complete investigation done of the incident before sending it to the Regional Health Department, -reassess, intervene and have a monitoring system in place (upon return to the facility) for 1 resident (R1) who expressed suicidal ideations three times and was hospitalized twice prior to 7/4/10 because of them. 	F9999			

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F9999	<p>Continued From page 21</p> <p>These failures resulted in R1 being found on 7/4/10 at 8:31pm lying in the tub naked with the water running on her face. The resident expired at the hospital at 9:14pm.</p> <p>These failures have potential to impact those 31 residents who have been assessed by the facility as independent to perform their own bathing, and pose a potential hazard to those 77 residents with mental illness whom may go into the tub rooms unsupervised, as well as those who may have a history of or may experience suicidal ideations.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on 3/11/10 with diagnoses that included Bi-Polar Disorder, Suicidal Ideation, and Chronic Obstructive Pulmonary Disease. R1 resided on the first floor of the facility in room 115.</p> <p>An incident report dated 7/4/10 at 8:31pm states only the following: "Observed in tub with water." No other information was given on the report. This incident was not sent to the Regional Health Department office until 7/6/10 at 1:06pm</p> <p>Nursing notes state that a "Code Blue" was called 7/4/10 at 8:31pm. When the nurse entered the tub room, CNA's (Certified Nursing Assistants) were performing CPR (Cardio Pulmonary Resuscitation); "emesis X 3 of water and undigested food." The resident had been removed from the tub and placed on the floor.</p> <p>Notations attached to the investigation sheet by E7 (nurse) state that the paramedics arrived at</p>	F9999			

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F9999	<p>Continued From page 22</p> <p>8:40pm and took over CPR and took the resident to the local hospital. The resident expired at the hospital at 9:14pm. Two local policemen arrived and interviewed staff, and a detective came in later to interview staff also.</p> <p>E6 (CNA) stated on 7/7/10 at 3:45pm that on 7/4/10 when she came on duty at 3:00pm, she made rounds, changed residents and got them up. At around 5:00pm she had to shower R4 (R1's roommate) because she had soiled herself. R1 was out on the patio smoking at that time. R1 did not eat much and went and laid down. When the patio opened again at 6:00pm, R1 went back out to smoke. At around 7:00pm, R1 told the E7 (nurse) that she was not feeling well and E7 told her to go and lay down and put on her oxygen. R1 did this, and when E6 went in to change R5 (R1's other roommate) around 7:15pm, the resident was lying down with her oxygen on.</p> <p>At around 7:30pm, E7 went to give R5 medications and R1 was not in the room. E7 was upset and told E6 to go look for R1. E6 went room to room looking for R1, the front desk paged for R1 also. She noticed that the tub room door was closed (and it is never closed) and heard the water running "full blast."</p> <p>E6 entered the room and saw the clothes on the floor neatly folded and R1 was in the tub, naked with feces in the water, and her head back and water running in her mouth. "She had her eyes open and was very pale." E6 yelled for help and E5 and E11 (CNA's) came to assist. They removed R1 from the tub and began CPR. E7 came and called 911 and asked them to move the resident into room 120 because they needed the space to continue CPR. The resident was</p>	F9999			

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F9999	<p>Continued From page 23</p> <p>moved (CPR was done while resident was moved). At around 8:40pm, the paramedics came and took over CPR and removed the resident to the hospital. E6 denied that R1 talked to her about suicide that evening, and she did not notice any unusual behaviors. Residents who want to use the tub come to staff to get their supplies and that is how staff know they are in there; not aware of any policy or procedure.</p> <p>E5 and E11 (CNA's who helped E6) were interviewed on 7/7 and 7/8/10 at 4:05pm and 3:35pm. Both stated that they had heard E6 call for help and assisted with removing the resident from the tub, moving the resident to room 120 and helping with CPR. They also stated that R1 liked to sit on the patio and smoke, and on 7/4/10 they did not notice any unusual behaviors and the resident did not express any suicidal ideations to them. Both also stated that residents who want to use the tub come to staff to get their supplies and that is how the staff know they are in there. Neither was aware of any policy/procedure for use of the tub room.</p> <p>E7 (nurse) stated on 7/4/10 at 3:48pm stated that on 7/4/10 she noticed that R1 was walking around going out to the patio to smoke. This was usual behavior for R1, and she could also make her needs known. E7 went out to the patio to give another resident medication around 8-8:15pm. R1 complained of having difficulty breathing, so she had her come in to take a puff from her inhaler. R1 told E7 that she was going to bed. At around 8:15-8:20pm she went into R1's room to give medication to R5. R1 was not there so she looked in the bathroom and asked E6 to look for her. E7 continued giving medications and heard someone yell "Code</p>	F9999			

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F9999	<p>Continued From page 24</p> <p>Blue." E7 ran to the back and saw the CNA's (E5, 6, and 11) doing CPR in the tub room. E7 called 911 at 8:31pm using her own cell phone. The floor was slippery and the resident was sliding around, so they moved the resident to the floor of room 120. Paramedics came, took over CPR and removed the resident to the hospital.</p> <p>E7 called the physician, family, E1 (Administrator), E2 (Director of Nurses), E4 (Supervisor), E8 (Social Service), and Z1 and Z2 (physicians). Two police came and questioned the staff and stayed back by the tub room; a detective came later and they were all there until around 10:30pm. The resident was compliant with medications and requested PRN's (as needed) medications for her breathing and agitation at times. R1 usually went to bed around 8-8:30pm each night. E7 saw no abnormal behaviors, nor did R1 voice any suicidal ideations that evening to her. The hospital called and told her that the resident had expired. E7 stated that she had filled out the incident report but did not send it to the RHO.</p> <p>When asked about using the tub room for bathing, E7 stated that residents go to the CNA's to get supplies and then use the room. E7 was not aware of any other policy or procedure for residents using the bath tub.</p> <p>E4 (nursing supervisor) was interviewed on 7/7/10 at 1:25pm. E4 stated that she was notified by E7 on 7/4/10 at 8:50pm of the incident with R1, and then E7 called back around 10:50pm to tell her that the resident had expired. E4 came to the facility at around 11:30pm, but did not do anything; "just here to support staff." She called E1 and E2, and talked with them. On 7/5/10, she came and talked with staff and looked to see if</p>	F9999			

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F9999	<p>Continued From page 25</p> <p>the residents were all right. E4 did not write an official report or send anything to the Regional Health Office (RHO) until 7/6/10 because she was waiting for E1 and E2 to sign off on the incident report. E4 had held inservices 7/4 and 7/5/10 with staff regarding HIPPA rules and dealing with grief.</p> <p>E1, E2 and E3 (Owner) were interviewed on 7/7/10 between 1pm and 2:30pm. E1 stated he had been notified on 7/4/10 at around 9:00pm regarding the incident. E4 stated she was coming to the facility to check on the staff and residents. E1 spoke with E4 again on 7/5/10 to check the status of the residents and staff. On 7/6/10 E1 came to the facility, but did not review the incident report or the investigation that E4 had prepared and sent to the RHO. E1 acknowledged that the incident should have been reported within 24 hours, and also said that they had done "a lot of talking" with staff, but no plans had been discussed or put into place yet.</p> <p>E2 stated that she had been notified by E4 on 7/4/10 via voicemail, but did not pick up the message until the afternoon of 7/5/10. E4 called the facility to check on the staff, and came to the facility around 8:00pm on 7/5/10. E2 gave inservices to the staff and the nurses about HIPPA rules and dealing with grief. She told staff to inform the residents (if they asked about the incident) that they were safe, a investigation was taking place and there would be more information later. E4 did the investigation because she was the first to respond to the incident, but usually the investigation is done by herself. E4 did not review the investigation before it was sent to the RHO. E3 had decided to wait until 7/6/10 to develop a plan to move forward.</p>	F9999			

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F9999	<p>Continued From page 26</p> <p>E1 stated that she was out of the state on vacation from 6/29-7/6/10. Since she was in a wooded area with poor reception, she did not receive the message on her cell phone until 7/6/10. E1 then called the facility and talked with E3. E1 does not know why the incident was not sent to the RHO until 7/6/10, and also did not review the incident or the investigation that was done prior to E4 sending it..</p> <p>The first floor tub room was observed on 7/6 and 7/7/10, at random times between 9:00am and 4:00pm, to be unlocked and unattended. There was no locking mechanism on the door.</p> <p>E1, E2 and E3 were asked if the facility had a policy and procedure on residents using the tub to bath, or supervision of residents using the tub to bath. They stated that they did not have such policies.</p> <p>Review of the facility policy on Accidents/Incidents/Unusual Occurrences and the facility Abuse Policy both state that the RHO must be notified within 24 hours of any occurrence that results in physical harm or injury. The Accident/Incident/Unusual Occurrence policy states that summary of the occurrence will be sent to the RHO within 7 days after the occurrence. The Abuse policy states an investigation will be sent within 5 days.</p> <p>Review of R1's nursing notes showed the following documentation:</p> <p>On 5/28/10, R1 reported to nurse on duty "I want to kill myself." Resident was place on 1:1 monitoring from 5/28 at 11:00pm, until on 5/30 at</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>4:30am when she was sent out to the hospital. The hospital did not have an available bed until this time.</p> <p>Resident was readmitted on 6/3/10.</p> <p>On 6/10/10 at 9:00pm, R1 told E10 that she had suicidal ideations, and was placed on 1:1 monitoring and given PRN (as needed) Ativan. At 10:30pm she told the staff she no longer had suicidal ideations and wanted to go to bed and the monitoring continued. The local hospital had no bed available, so the resident was never admitted. At 1:30pm, the resident began pacing the hallways, seeking attention, was redirectable and given a PRN. At 2:30pm, the resident stated "I feel better." The documentation stops at this time, so there is no explanation of what condition the resident was in the rest of the day, whether the 1:1 monitoring was stopped, or if Z2 (Psychiatrist) was notified of the resident's condition.</p> <p>On 6/16/10 at 5:50pm, R1 came to the nurse with her entire face and head wet. The resident stated: "I sank my head in the toilet, I was going to drown myself, I want to die." The resident was placed on 1:1 and the physician was notified. R1 was sent out to the hospital at 11:00pm when a bed was available.</p> <p>On 6/18/10 the resident was readmitted to the facility.</p> <p>Social Service notes for these three incidents dated 6/1, 6/10, and 6/17/10 all state the Social Service staff "will monitor resident upon return to the facility." No specifics of what the monitoring will consist of were given.</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>Mood and Behavior notes for 5/28/10, 6/10 and 6/16 when the resident expressed thoughts of suicide show the same interventions tried: "Provide 1:1 support of staff, Encourage to verbalize any thoughts, feelings, concerns, Medicate as ordered per nurse."</p> <p>Documentation also shows that attempts were made to have R1 attend psychosocial groups, but that she would often refuse them.</p> <p>After each of these episodes, no new reassessments were found, and the care plan was not updated with new interventions to be tried to address this increase in frequency of suicidal ideations. No new psychiatric consultations were done.</p> <p>E8 (Social Service Director) stated on 7/8/10 at 9:45am that they had tried outside programs and R1 would go once and then refuse to go again. They tried in-house psychosocial groups and her attendance was sporadic. E8 was made aware of R1's verbalizations of suicide by E10 (PSRC - Psychosocial Rehabilitation Coordinator) and was aware of the resident's attempt to drown herself on 6/16/10. E8 described the resident as quiet, little interaction with peers but would talk with staff, able to make needs known and withdrawn. E8 did not state why after each of these episodes more intervention was not done for R1.</p> <p>E10 (PRSC) stated on 7/8/10 at 1:05pm that R1 was quiet, withdrawn, smoked heavily and had little interaction with peers. R1 had poor insight into her illness but was able to make her needs known. E10 did not notice any overt behaviors</p>	F9999			

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NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645		
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F9999	<p>Continued From page 29</p> <p>with R1, but she would not always attend groups and did not want to go to outside programs. The resident did tell E10 once that she wanted to kill herself. E10 reported it to the nurse and placed the resident on 1:1 monitoring. After the episodes of suicidal ideation on 5/28, 6/10 and 6/16, the resident was monitored, talked to and checked on, but E10 never documented this when she did it. No updates of assessments or care plans were done. On 7/3/10, Z2 (Psychiatrist) saw the resident and did not report to her any concerns/behaviors changes in the resident, and the resident seemed happy that day about her pass status. R1 did not display any unusual behaviors that day.</p> <p>Z1 (Primary MD) stated on 7/12/10 at 10:40am that the resident had multiple medical problems including severe COPD (Chronic Obstructive Pulmonary Disease). He saw her last about a month ago and treated her for cold symptoms. R1 did not voice any suicidal ideations to him at that time and he saw no changes in her behavior.</p> <p>Z2 (Psychiatrist) stated on 7/12/10 at 10:55am that this resident had a long history of psychiatric illness with suicide ideations, but was not sure how many attempts she had made in the past. Z2 saw R1 on 7/3/10 and talked with her about her not having an unescorted pass due to an incident at the grocery store, and she seemed to understand the restriction. He did not observe any unusual behaviors in the resident, nor did she talk about suicide to him. Z2 stated he was aware and had been notified of the other episodes by staff.</p> <p>On 7/12 at 2:30pm, the facility contacted the coroners's office and was told that it would be</p>	F9999			