STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001598	A. BUILDING _____ B. WING _____	C 05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL PLAZA RESIDENTIAL HOME	321 27 NORTH CENTRAL CHICAGO, IL 60644

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Z 000	COMMENTS Investigation of Complaint Number 1281035/IL57029 (no findings); 1281291/IL57318;(no findings) 1281297/IL57326-(no findings) Incident Report Investigation of 4/11/12 (IL57482)-300.1210a)b)6 Incident Report Investigation of 4/06/12 (IL57508)-300.1210a)b)6	Z 000		
Z9999	FINDINGS Licensure Violations: 300.1210a) 300.1210b)6) 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 psychosocial well-being of the resident. Adequate and properly supervised nursing care shall be provided to each resident. b) 6) All necessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate resident's to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	Z9999		

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Z9999	Continued From page 1 resident. (A, B) (Section 2-107 of the Act) This requirement is not met as evidenced by: Based upon observations, record review and interviews 2 of 8 sampled residents (R4, R5) did not receive adequate supervision to prevent resident's injuries. As a result of this failure R4 was discovered dead on an unlocked patio, and R5 jumped from the window causing a Acute Lumbar Spine (L1) Fracture. Findings include: 1. R4 is a 31 year old male with a diagnosis including Schizoaffective Disorder per face sheet. R4 according to the documentation by E1 (administrator) located on the nurses' notes and dated 4/11/12-7:30am depicts in part the following: " approximately 6:40 a.m. security went to the patio and observed R4 on the ground...security called resident (R4) name and asked R4 to get up. Getting no response, immediately called nursing....observed resident face to be cyanotic. his body felt cold and rigid to touch. Unable to obtain pulse and respiration....911 paramedics called. arrived, and after assessing body pronounced him (R4) deceased." During the onsite visit, E1 (administrator) identified E8 (security guard) as the first one to discover the body of R4. E8 (security) was interviewed on 4/12/12-1:00pm . E8 stated," Another resident, (R7) came and got me. I had just walked in and said someone on the patio sleeping. I went to the patio and saw	Z9999		

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Z9999	Continued From page 2 R4 was on the ground, I called R4 name, no answer, walked toward R4, was bluish and gray color. I went to get nurse working 11/7 shift, called ambulance, 911 they came." R7 was interviewed on 4/12/12-2:21pm and stated," I was going to get fresh air and saw R4, and I told security. But R8 saw R4 before I did, but did not tell anyone." R8 was interviewed 4/12/12-2:30pm, stating, " I was scared when I saw R4, R4 did too much dope." R4's was assigned to E5 (certified nurse aide/CNA). E5 was interviewed on 4/18/12-11:45am and stated," I was looking for my residents, R4 is usually visible. I couldn't find him, this was about 11:30pm. I started looking at 12 midnight, could not find R4. I told nurses, they told me to do all search, all call. That means we do all search on the floors, all CNA's. Receptionist make a page to ask all CNA's on their floors, I asked security to check. I did not check outside or the patio. I checked lobby and smoke room....usually security check patio and usually locked, I didn't check that. I did know R4 used drugs, R4 was high on my floor, came drinking, I never told anyone, another CNA told me." E6 (nurse) for the 11/7 shift was interviewed, and in part on 4/18/12 at 11:25 am stated,"E5 (CNA) told me , R4 was missing from his room. I told them to start a search, I looked on the immediate 1st. floor, not the patio. I thought patio was always locked." Z#2 (R4's physician) was interviewed and stated," we suspect R4 OD (overdosed), R4 had used	Z9999		

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Z9999	Continued From page 3 before in the past. R4 got hold of some money, circuit breaker check came, we think R4 purchased drugs." The facility Missing Resident policy reviewed on 4/12/12 and denotes in part," Upon orders a search includes bedrooms, bathrooms, closets, office and common areas. E1 (administrator) and surveyor on 4/12/12 -11:00am observed the patio door where R4 was discovered and revealed the patio door does not have a lock capability. E3 (director of security) was interviewed on 4/12/12-11:30am , and stated," security was to check all areas of the building, all house search, each dept." E1 (administrator) and Z1 (Imperial Surveillance Company) toured the facility on 4/12/12 where the camera's were located in the administrator office. The camera located in the administrator office was not able to monitor the patio area. In addition, E1 (administrator), and surveyor toured the receptionist area and the nursing station where the camera's were located, and the patio where R4 was found was not visible on the camera. Z1 stated," not able to fix the camera's today. I am here to give a quote." 2) R5 is a 48 year old male with a diagnosis including Schizoaffective Disorder per face sheet. R5 was not in the building during the 4/16/12 on-site visit. E1 (administrator) was interviewed on 4/16/12 at 11:30am, regarding R5 and stated," R5 removed	Z9999		

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Z9999	Continued From page 4 window frame and jumped out of his room window, and climbed over the wall, we sent R5 to hospital. R5 had a fracture but able to walk." Review of R5's below nurse notes: " dated 4/06/12-10:30pm in part depicts the following: "Upon assessment of situation observed frame in room 325 broken out and on roof. Res (R5) was observed by staff sitting on ground in front of facility alert and aware. Witness in the front of facility stated, " heard something break and when looked didn't see anything. Few seconds later heard another noise and saw res climbing off roof....." "4/6/12-10:40pm-..... ambulance arrived and resident escorted to ..... hospital." "4/8/12-10am-staff nurse reported to writer that when checking on status of resident, ...was informed that resident had evidence of lumbar compression." "4/9/12-9:40am-...checked on status of resident ....cast scan was completed and was transferred to .....hospital with dx (diagnosis) of lumbar fracture." "4/11/12-3:45pm-call to check on status of resident. Nurse reported resident had decompression fusion surgery..." The review of R5's social service progress notes in part denotes the following: "During the 1:1, PRSC and resident discussed reports that R5 left facility early this morning out	Z9999		

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Z9999	Continued From page 5	Z9999		

the side emergency exit of the facility (around 3am and returned around 3:15 am) smelling of alcohol per staff report. R5 has also been displaying an increase in paranoia, irritability, and there have been a recent increase in reports of resident using ETOH (alcohol) this month..... will discuss R5 recent increases and should R5 substance abuse issues remain a significant problem, a more intensive programming for substance abuse, and additional approaches will be employed."

"4/6/12-R5 reported he wanted to leave the facility because he was "stir crazy". It is also pertinent to note approximately 1 hour earlier. R5 had asked to leave the facility via the front door, upon such security easily redirected."

The facility policy on 1:1 Monitoring in part denotes the following:

"It is recognized that a resident condition (whether medical or psychiatric) may periodically necessitate continued monitoring. A physician, the RSD (Resident Service Director); DON (director of nursing) and/or ADON (assistant director of nursing) must be consulted prior to an individual being placed on 1:1 monitoring."

E2 (director of nursing) interviewed on 4/16/12-1:30pm regarding the above documentation via social service department and stated," I was not informed of R5 condition."

The review of the hospital record dated 4/7/12 - CT lumbar spine without contrast Impression depicts:

"1- Anterior wedge compression deformity involving the L1 vertebral body with approximately

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Z9999	Continued From page 6 50% loss of height, small joint avulsion fracture of the anterior/superior portion of the L1 vertebral body." "2- 3mm thickening of the posterior longitudinal ligament extending from L1 to L3 could be from edema or hemorrhage in the posterior longitudinal ligament however, a small subdural hemorrhage cannot be excluded...." (B)	Z9999		