

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
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NAME OF PROVIDER OR SUPPLIER KENSINGTON PLACE NRSG & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall 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 resident care</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>plan. 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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>d) Pursuant to subsection (a), 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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>review the facility failed to secure room windows, failed to define and implement supervision and monitoring for residents at risk for elopement, failed to identify and document potentially self injurious behaviors, failed to follow elopement policy and procedure and failed to prevent one resident (R24) from falling/jumping from a third story window of three residents reviewed for elopement in the sample of 26 residents. This failure resulted in R24 sustaining wrist, rib, hip and foot fractures from the fall.</p> <p>Findings include:</p> <p>Physicians Order Sheet dated 5/1/14 to 5/31/14 indicates R24 is a 55 year old female who was admitted to the facility 4/11/14 with diagnoses that include schizoaffective disorder and depression. R24 was a resident on the third floor of the facility, the building has three resident floors.</p> <p>Nursing Notes dated 4/14/14 at 9:41pm indicate at 5:00pm R24 was agitated and noted to be ambulating out of her room with all her belongings. Note also indicates R24 was screaming out her window "help" but refused to state what she needed help with when asked.</p> <p>Psychiatric Evaluation dated 4/28/14 indicates R24 had poor impulse control and poor insight. Note also indicates R24 was delusional, denied suicidal and homicidal ideations.</p> <p>Social Service Notes dated 4/15/14 at 5:04pm indicates R24 was observed screaming out of the window.</p> <p>Social Service Note dated 4/18/14 3:07pm indicates R24 had attempted to elope twice from the facility, that R24 is ambulatory and spends the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>majority of her time looking out the window in her room. Note indicates R24 Brief Interview For Mental Status (BIMS) score is 13/15. Note furthers indicates Assessment: Unauthorized Departure/Elopement Risk Assessment score is (2) - Moderate risk and that the R24 has attempted to elope from the facility twice.</p> <p>Unauthorized Departure/Elopement Risk Assessment dated 4/15/14 indicates that on 4/14/14 R24 tried to leave the building and was difficult to redirect and that on 4/15/14 R24 was screaming out of her bedroom window. Assessment indicates risk score of 12 and states that a score of (4) or greater indicates a reasonable departure risk potential and appropriate interdisciplinary interventions.</p> <p>Care Plan Problem: Behavioral Symptoms with problem start date of 4/26/14 indicates (Wandering) R24 with attempts to elope from the facility because she wanted to go wash her clothes. Approach start date of 4/26/14 indicates: Maintain safe environment (secured windows, functioning alarm device, etc.) No documentation of R24 screaming out of her window was found in R24's care plan or description of a second attempt by R24 to elope from the facility.</p> <p>On 5/15/14 at 2:00pm E5, Psychosocial Rehabilitation Services Coordinator (PRSC) stated that on 4/15/14 she was walking by and checking on residents when she observed R24 screaming out of her room window. E5 further stated that the window screen was slightly pushed over at that time but not pushed out.</p> <p>Facility Nursing and Rehabilitation Center</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Elopement Policy (undated) indicates: If a resident attempts to elope from the facility, resident will be put on increased supervision and monitoring in order to ensure knowledge of whereabouts.</p> <p>On 5/15/14 at 2:15pm E12, Psychosocial Rehabilitation Services Director (PRSD) stated that the facility doesn't have any formal supervision or monitoring for residents at risk for elopement, "We just try to eyeball them more." On 5/21/14 at 12:40pm via telephone E12 stated that there is no documentation of how staff are monitoring residents assessed to be at elopement risk. E12 further stated that the facility elopement policy is the same as elopement precautions and there is no documentation of increased monitoring or supervision by social service or nursing staff. E12 identified seven residents currently in the facility who have been identified as being on Elopement precautions.</p> <p>On 5/14/14 at 3:50pm R43, roommate of R24, stated that she last saw (R24) on 5/11/14 at approximately 9:45am. R43 stated "I went out of the room then to go smoke. I wasn't in the room when R24 jumped."</p> <p>On 5/15/14 at 10:45pm E13, Housekeeper stated that on 5/11/14 he was just coming to clean R24's room when he noticed that the window curtain was pulled back, the window was wide open and the window screen was behind the bed. E13 stated he then looked out of the window and saw R24 lying on the ground and was moving on the grass. E13 further stated that he noticed a big suitcase with belongings packed on top of the suitcase placed in front of and below the window. E13 went on to state that he had never seen the</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>window open like that before, that usually the windows are only open about 6-8 inches.</p> <p>Nursing Notes dated 5/11/14 at 11:01am indicates R24 was noted on the ground below her window lying on her left side, at 10:20am emergency department called. Note further indicates R24 was alert and complained of pain to right wrist and on right side of body. Note at 12:44 indicates R24 had a laceration to her left forearm area and was transported to the hospital.</p> <p>Social Service Note dated 5/11/14 at 12:07pm indicates R24 jumped out of the window of her room.</p> <p>Social Service Note dated 5/11/14 at 12:35pm indicates R24 presented with self-injurious behavior as evidenced by jumping out of the window.</p> <p>Hospital Emergency Department/Trauma History and Physical Addendum dated 5/12/14 indicates: R24 was found on the ground outside of an open third story window, purportedly jumped. Left hip fracture, mildly displaced fracture of right fourth and right 5th rib; displaced right 9th and 10th rib fractures, small right hydropneumothorax; right wrist fracture; left 2nd and 3rd toe fractures.</p> <p>On 5/15/14 at 10:55am E14, Maintenance Director stated "Approximately two weeks ago we put two screws in (R24's) window track to keep the window from sliding more than 6 inches because (R24) was sticking her head out the window and screaming." E14 further stated that all windows are checked visually on Mondays but documented only monthly.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 5/15/14 at 11:10am during inspection of third floor windows, it was observed that windows can be lifted entirely out of the frame. E13 acknowledged that he was aware that the sliding window could be entirely removed from the frame which would allow window opening greater than 6 inches. One standard type screw was observed placed into the window track in windows on the second floor to prevent the windows from opening more than six inches, E13 acknowledged that was how the window was in R24's room on the third floor previous to her jumping from the window.</p> <p>On 5/23/14 at 3:15pm E8, Maintenance Supervisor stated that the type of windows used throughout the facility in resident rooms is a thermal pane window with a steel frame. The windows measure 71.5 inches wide and 58.5 inches tall with the opening of the window 35.25 inches if fully opened.</p> <p>On 5/15/14 at 12:00pm E8, Maintenance Supervisor stated that on 5/6/14 he was told by social service staff that R24 was sticking her head out her window and screaming and at times would push the screen aside and throw things from the window. E8 went on to state that he went to R24's room and added an additional screw into the window track next to the original screw to prevent the window from sliding all the way open. E8 further stated that he notified his supervisor E14 after placing the second screw on 5/6/14. E8 stated that he did not follow up to check if the screws were intact after adding the screw on 5/6/14. E8 went on to state that on 5/11/14 after R24 went out the window, that one screw was taken out from R24's window track and one screw was snapped in half.</p> <p>E8 stated that he could not recall who the social service staff were that notified him on 5/6/14.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>No documentation was found or presented regarding R24 sticking her head out of the window on 5/6/14.</p> <p>On 5/23/14 at 3:15pm E8 stated that he believed R24's window was a safety issue and that he is supposed to report safety issues to the maintenance supervisor.</p> <p>On 5/16/14 at 9:30am R24 was interviewed at the hospital where she was recovering from her injuries sustained in the fall.</p> <p>At that time R24 stated that she was just looking over and out the window ledge when she fell out of the window. R24 went on to state that she had pushed the window "up and over" because it wouldn't freely go by itself. R24 went on to state that "normally there is a stopping point when sliding the window so you can't stick your head out - that's when I lifted the window up and over which broke the screws." R24 admitted to taking the screen out and placing it inside by the bed. R24 stated that she did not recall maintenance ever coming in prior to the accident to fix or secure the windows.</p> <p>Monthly Maintenance Inspection Log dated April and May 2014 indicate on 4/18/14 and 5/6/2014 Item: Windows (be sure they cannot be opened more than 6 to 10 inches). Item is marked "No" for good working order with "replaced screws as needed" as the action to correct the issue. Log does not indicate what room or rooms had screws replaced.</p> <p>Monthly Maintenance Inspection Log Policy and Procedure (undated) indicates: 2. Immediately repair any item that poses a hazard to residents or employees.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>On 5/16/14 at 4:15pm via telephone E1, Administrator stated that he was aware that all building windows were initially using the one screw method of stopping windows from sliding all the way open.</p> <p>E1 also stated he was aware that R24 had been screaming out of her window, however was not aware that R24 had been sticking her head out of the window or that E8 placed an additional screw in R24's window on 5/6/14 after R24 was observed sticking her head out of the window and screaming. E1 went on to state that he should've been notified about the incident on 5/6/14 and maintenance's response.</p> <p style="text-align: center;">(A)</p>	S9999		

Imposed Plan of Correction

Comments to Licensure Findings.

300.610a)

300.1210b)

300.1210d)6)

300.3240a)

R24 is a 54 y/o female, admitted to the facility on 4-11-2014 with a diagnosis of Depression, Schizophrenia, Schizoaffective Disorder and frostbite to the left foot.

1. R24 was assessed by Social Service and identified as an Elopement Risk. The Elopement Policy and Procedure was followed and she was added to the list of residents at risk for elopement, thereby alerting all staff of the assessment.
 - a. The resident did not receive an unsupervised pass.
 - b. The environment was secure; windows were secured by not allowing them to open more than 6 inches, all exits from the building are alarmed and security is staffed at the front door.
 - c. The attempt to leave the building on 4-14-2014 that the surveyor noted in the residents' documentation was handled immediately. The resident never left the facility (actually never left the floor) and staff was aware to increase monitoring and supervision. Although documentation for this increase of supervision was not in place, all staff are in serviced on the facility's Elopement Policy and Procedure and react accordingly when there is an elopement attempt.
 - d. The 2nd attempt the surveyor noted that was documented in the care plan of 4-26-2014 was an error in documentation. The Social Service staff member had reported to R24's counselor that the resident had been looking for the laundry room, not looking to leave the building. The counselor had misunderstood and documented as an elopement attempt.

2. R24 was assessed by Social Service upon admission to not be at risk for self-harm/suicide.
 - a. The facility had no prior history of self-harm or self-injurious behaviors for R24.
 - b. The facility has no documentation while R24 was there that she displayed any self-harm or self-injurious behavior.
 - c. The resident had a documented behavior of "screaming out the window". At no time did she have a documented behavior of having her head out the window, which would cause concern of her hurting herself or getting hurt because of her behavior.

3. The facility windows were secured.
 - a. Although it was noted on the 2567 that the sliding window can be lifted off the track, the facility had never had such an incident occur. The window is approximately 60-70 pounds and very difficult to lift up off the track. The surveyor did not attempt to lift the window. When the Maintenance Staff attempted to lift the window, the window tilted but it could not be lifted out.

b. E14 could not identify who stated she had her head out the window previously and could easily have misunderstood “screaming out the window” as having had her head out the window. At that point he did ensure the screw was in the frame and reinforced it for extra security.

R24 was assessed accurately, risks were identified, interventions were in place and interventions were monitored for effectiveness and modified when necessary.

Staff intervened appropriately and followed facility policies at all times during R24’s stay at the facility. On 5-11-2014, R24 did not indicate to any staff that she wished to leave the building. She was observed by staff at breakfast, smoke time and on the unit. There was never any indication that R24 would be able to lift the window in the frame and break the security in place.

The facility contends the accident was “unavoidable” and occurred despite the facility’s efforts:

1. To identify resident risk of an accident, including the need for supervision.
2. Evaluate the hazards/risks.
3. Intervention were implemented, including adequate supervision, consistent with the resident’s needs, goals and plan of care, and current standards of practice in order to reduce the risk of an accident.
4. Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.

*Comments
reviewed
6-25-14*