

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

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14E390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>BAYSIDE TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 SOUTH LEWIS AVENUE</b> <b>WAUKEGAN, IL 60085</b>		
(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 000	INITIAL COMMENTS	F 000			
F 323 SS=D	<p>Complaint Investigations: #1270235/IL56063 and #1270375/IL56243 -F323</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, 1 of 1 residents (R2) in the sample, and facility staff failed to; provide adequate monitoring prior to injury, failed to call a physician immediately after injury occurred, and failed to send resident to hospital emergency room after self injury.</p> <p>Findings include:</p> <p>R2 who has a diagnosis of Major Depression, Bipolar with psychotic features, anxiety and a history of suicidal ideations and self injuries. On interview of E3, it was found that on 1/23/12 R2 complained to E3 that her "depression had worsened and she wanted to go to the drug store, buy a razor and cut her stomach". R2 was placed on 1:1 supervision until 1/24/12, and no physician was notified of her suicidal ideations. On interview of E3, she stated she removed the</p>	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>1:1 supervision for R2 on 1/24/12, after speaking to R2 who reassured her "she feels no urge to hurt herself". No staff conference or notification was made to a physician.</p> <p>On interview of E1 and E2, both stated it is facility policy and procedure for staff to notify a physician of a resident who is expressing, or who has attempted suicide/self harm.</p> <p>On interview of E3 and R2 it was found on 1/25/12, R2 went to the drug store and bought herself some razor blades as she had threatened staff to do on 1/23/12, and R2 cut her abdomen. R2 was sent to the hospital on 1/25/12 after nursing staff informed the psychologist of R2's suicidal ideations and her infliction of self injury.</p> <p>In addition to the staff not calling the physician to notify of R2's self injury on 1/24/12, and failing to continue supervision of R2 until seen by a physician on 1/23/12 and 1/24/12. Facility staff did not send R2 to the emergency room promptly after self injury, and nursing staff provided treatment to R2's wound without physicians orders.</p>	F 323			