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	14E392	A. BUILDING _____ B. WING _____	C 03/07/2005

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F9999	FINAL OBSERVATIONS STATE LICENSURE FINDINGS: Section 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 35 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 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. 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 prevent accidents. These REGULATIONS are not met as evidenced by: Based on staff interviews and record review, the facility failed to supervise residents with histories of suicide attempts and/or ideations by not: 1. Placing R17 and R2 on the behavior level, consistent with the facility's Resident Incentive and Contingency Management Program for community privileges. 2. Conducting a thorough search for missing persons; by failing to search the entire perimeter of the facility grounds on 10/17/2004 following R 17's failure to appear for her 5:00 PM Medications. 3. Assuring R2 was taking his medication (Restoril). R2 has a history of ETOH (alcohol) abuse and history of non-compliance in taking	F9999		

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F9999	Continued From page 36	F9999		

medications.
4. Developing a plan of care on how the facility will:
a) Monitor and supervise R2's compliance with the facility rules.
b) Monitor and supervise R2's identified problems with alcohol abuse and non-compliance in taking medications.
c) Monitor and supervise R18's compliance with facility rules.
d) Monitor and supervise R18's identified problems with alcohol and non-compliance taking medications.
e) Supervise and monitor R19's behavior of self-injurious behavior with suicidal ideations.
f) Supervise and monitor newly-admitted R20 's identified problems with alcohol and non-compliance in taking medications.

This is for 5 residents in the sample of 21.

The findings include:

A. Review of the resident's clinical record at the facility showed that R17 is a 55 year old with diagnoses including Major Depression, Chronic Obstructive Pulmonary Disease (COPD), and Hypothyroidism. R17 was admitted to the facility on 3/10/04. R17 came to the facility after a hospitalization following a suicide attempt by taking an overdose of benzodiazepine medication .

1) Upon admission to the facility, residents are required to acknowledge that they will comply with the facility's Resident Incentive and Contingency Management Program. This

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F9999	Continued From page 37	F9999		

program classifies residents' compliance with the facility rules into one of 3 levels (0, 1, and 2). One of the Level 2 privileges allows the residents an independent community pass. One of the requisites to have a level 2 pass is to attend programs, groups, and activities as recommended. An activity progress note dated 09/04 (the most current note available at the time of the survey) in R17's record documents that R17 is inconsistent in attending group. The comments section states, "Staff have attempted to involve res in group; however she passively and politely refuses." On 3/2/05 at 12:30 PM while interviewing E6(PRSC), surveyor asked about R17's attendance at activities. E6 stated that she would have E7 (Activity Director) come to speak with the surveyor. E7 failed to come and talk to the surveyor. E6 was then questioned by the surveyor. E6 stated that E7 had told her that R17 never came to any activities. According to the facility's Resident Incentive and Contingency Management Program, attending activities is a required in order to obtain a level 2 pass. Documentation in R17's clinical record (activities) indicates that R17 is isolative, a trait verified through interview with Z3 (physician). There is no documentation that facility staff tried other ways to involve R17 in activities.

2) R17 was on Level 2 at the time of the attempted suicide on 10/17/2004. There is no documentation in the record that shows that R17 was evaluated for being allowed to remain at behavior level 2 after her latest Activity note was placed in the record.

3) Review of a facility incident report dated 10/18 /04, found that R17 failed to show up for her 5:00

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F9999	Continued From page 38 PM medications on 10/17/04. The report further states that a search of the building and grounds was conducted, and facility staff were unable to find R17. The report also documents that, "at 8 PM they did another search. E9 went to a local store to see if (R17) was there and (R17) wasn't able to be located." The facility policy on Elopements presented by E-7 on 11/01/04 states, "Should a thorough search for the resident prove unsuccessful, the Administrator or designee shall make a report of the incident to local law enforcement emergency response system." The incident report indicates that the police were not notified until 9 PM. R17 was found in the bushes in back of the facility at 9:30 PM with both wrists cut from the wrist to the elbow. The police report affirms, "... and brush area of the rear of the (West Chicago) Terrace. At the southwest brush area Z4 (West Chicago Police Officer) located R17 lying in a brush patch semi-conscious with severe lacerations to the bone down and across both wrists and forearms." The report further explains "Z5 (West Chicago Police Officer) located a shaving razor in tall grass where R17 was found. That along with a plastic cup with dissolved pills...". R17 was transported and subsequently admitted to a local area hospital as a result of her condition. On 11/01/04 both E1(Administrator) and E5 (Nurse who searched for R17) verified the accuracy of the facility's incident report. Additionally, E5 told the surveyor that when she did the initial search outside of the facility, she did	F9999		

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F9999	Continued From page 39	F9999		

not walk the entire perimeter of the facility. Surveyor observed the outside area of the facility with E5 who verified the area in which the search was conducted; and noted that in order to see the area where R17 was found, it was necessary to walk the perimeter of the property behind the facility.

B) Review of the Nurses Notes dated 11-16-04 showed, " 8:50 PM, CNA called me to see R2,;he vomited on the floor. At 9:30 PM, he was cyanotic with gurgling breathing sounds. At 9:35 PM, breathing stopped. Initiated Rescue Breathing with Ambu bag. 9:40 PM, Paramedics responded, and R2 was transported to the Hospital. After search of the the room, liquor bottles were found. Review of the facility investigation report dated 11-16-04 read " a 5th of Brandy was found in the corner of the room wrapped in R2's jacket."

Interview with the Maintenance Staff (E3) on 12-06-04 at approximately 2:35PM. E3 stated "3 empty alcohol bottles were found in R2's chest drawer. One Vodka, a Bourbon, I can't remember the 3rd one. I don't know how he gets it in." The Administrator (E1) stated they don't know how and where he got the liquor. E1 stated R2 overdosed on sleeping pills and is on a vent (Ventilator)."

Review of the Medical History and Admission Examination dated 5-21-04 found that R2 had Admission Diagnoses of Suicidal Ideation and Depression. Recommendations for Routine Care

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F9999	Continued From page 40 showed ETOH Abuse. Admission Information on Advance Directives and Self Administration of Medications dated 5-21-04 disclosed that R2 had marked, "I would like the Nurse to administer my medication." Review of hospital records showed that R2 was admitted on 11-16-04 with Principal Diagnosis: Alcohol/ ETOH Intoxication, Secondary Diagnosis of Respiratory Failure. The Pre-hospital Patient Care Report dated 11-16-04 documented that R2 "was noted to have ETOH on breath, cyanotic, not breathing and unconscious, was intubated." Per staff, R2 had consumed unknown amounts of alcohol. Hospital Discharge Summary/History showed "found unresponsive at the Nursing Home after bouts of drinking with a partner. Found hypoxic/cyanotic." Hospital Psychological Evaluation Consultation dated 11-17-04 showed a history disclosing, " according to the staff, he had been ingesting alcohol, quantity unknown." Reason for Evaluation showed, "the patient was admitted following respiratory failure, associated with overdose of alcohol and benzodiazepines in an apparent suicide attempt. He claims today that he had been trying to wean himself off the sleepers; hence has not been taking his Temazepam and accumulating that drug. He took "7" of the 30 mg. tablets or 210 mg, in conjunction with considerable alcohol and was thereafter rendered comatose with substantial respiratory depression." Review of R2's Physician Order Sheet disclosed that R2 was prescribed with Tamazepam (Restoril) 30 mg. one capsule at 9:00PM since 08-	F9999		

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F9999	Continued From page 41	F9999		

19-04. There were no consent found for the use of the Hypnotic (Restoril).

Hospital Social Work Progress Notes dated 11-19-04 read, "patient says he hid 7 sleeping pills and took them because he did not care if he lives . He stated he had brandy to drink and took pills. No one at the Nursing Home had any knowledge of patient's hiding pills or thinking of suicide."

A Phone interview was done with the Hospital Social Worker (Z1) on 1-04-05 at 1:40 PM. Z1 stated " I talked to him. He said he was drinking in the nursing home and somehow stored his sleeping pills and took it with alcohol." At approximately 2:15 PM via phone interview, the Hospital Doctor (Z2) stated "he OD'd (overdosed) on alcohol and Benzodiazepines. He further confirmed it to us that he took 7 Restoril at the same time."

On 1-13-05 at approximately 10:35 AM, R6 came to the nursing station asking for her 9:00 AM pills. E5 gave R6 medications and turned around. E5 did not wait and observe
if R6 swallowed her pills. E5 stated "I don't go to rooms; they need to come and get it here."
E4 and E5 were also observed in the nursing station pre and post signing the Medication Administration Records (MAR).

Review of the PAS/MH, Notice of Determination dated 5-19-04 showed that R2 needs 24 hour supervision, medication monitoring, and substance abuse programming.

During the daily status meeting held on 3-03-05

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F9999	Continued From page 42 at approximately 3:45 PM, the Administrator and the DON stated "we agree about the seven sleeping pills, but we were told his Alcohol level was zero." C. Review of the resident's clinical record at the facility showed that R18 is a 40 year old female admitted to the facility on 8/9/04 with diagnoses including Bipolar; Schizoaffective disorder with recent history of 2 suicide attempts. Comprehensive integrated RAP (resident assessment protocol) summary form (A) documents R18 is erratic and is formed by manipulative behaviors that are demanding and aggressively explosive. R18 displays poor impulse control, flight of ideas at times, and must be in control of all situations. R18 is assigned and attended the following groups: 1. Anger management -attendance sheets show R18 attending groups 4 times in September 2004 , 6 times in October 2004. No other participation or progress notes documented. 2. Coping with Psych symptoms -attendance sheets show R18 attending 1 time in September 2004, 2 times in October, and 1 time in November. No other participation or progress notes documented. 3. Assertiveness skills/Social Skills -attendance sheets show R18 attending 1 time in September 2004, 2 times in September. No other participation or progress notes documented. Review of the nursing notes shows:	F9999		

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F9999	Continued From page 43 1. 9/12/04 at 9:00 p.m. R18 came from pass smelling of alcohol, very drunk and unsteady. 2. 9/13/04 at 12: 15 p.m. Swearing at nurses and smelling of alcohol. 3. 9/14/04 at 5:00 p.m. Attempted to leave the facility. Had plan to kill herself involving a rope which was found in residents room by Psych-social worker along with Butane lighter fluid. 4. 9/28/04 at 5:30 p.m. urine obtained for drug screening. 5. 10/14/04 at 10:00 p.m. Refused meds. 6. 10/21/04 at 10:00 p.m. Refused meds. 7. 11/4/04 at 12:50 pm Resident arguing with another and tried to choke her. 8. 12/5/04 at 7:20 p.m. Resident came to nursing station with complaint of burning bilateral hand. Left hand and right hand. During an observation on 3/2/05 at approximately 11:00 a.m, R18 had dark, brown scarring on top of left hand. R18 stated when asked by surveyor what happened, "I had a hot plate in my room because the facility would not make coffee or hot water for me so I was boiling my own water. I accidentally spilled hot water on my hand." Review of the physician's order sheets show one to two Vicodin every 4-6 hours as needed x 72 hours and apply silvadene twice a day to hands for burn. Interview with E2 on 3/2/05 at approximately 3:45 p.m., E 2 (DON) stated, " R18 had a hot plate locked in her room. I was on duty the night she burned her hand. I removed the hot plate from her room and counseled her. I did not document that I counseled her. She knows she should not have the hot plate; it is against the rules."	F9999		

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F9999	Continued From page 44 R18 was on Level 2 at the time of the attempted suicide on 9/14/04. There is no documentation in the record that shows that R18 was evaluated for remaining at behavior Level 2 after this nursing note was placed in the record. D. Review of the resident's clinical record at the facility showed that R19 is a 45 year old female admitted to the facility on 6/24/04 with diagnoses including Major Depression, gastritis, GERD, seizure disorder. Review of R19's RAP (resident assessment protocol) summary form dated 7/6/04 in mood state and psychosocial areas documents R19 was experiencing suicidal ideation, will proceed to care plan. There is no care plan identifying suicidal ideations. R19 is assigned and attended the following groups: 1. Anger management/ depression. 2. Symptoms Management. 3. Substance Abuse. There is no documentation in the record or progress notes that show that R19 attended the above groups. Record review of a facility incident report dated 2/27/05 showed R19 was leaving the facility. E1(Administrator) and 3 unidentified staff followed R 19 out of building when R19 took a white disposable razor out of her purse and scratched her left wrist.	F9999		

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F9999	Continued From page 45 Review of the nursing notes dated 2/27/05 at 8: 30 a.m.: R19 banging on nurses station demanding her medication. Staff asked resident to calm down; no other intervention documented. At 9:25 a.m. R19 ran out of side door. R19 went down path in front of a house, stopped by the porch, asked to speak to social worker at the facility. R19 went into her purse and pulled out a razor that did not belong to the facility. R19 cut her wrist and then was transferred to hospital. On 3/1/05 at 3:30 p.m. nursing notes show " Faxed 30 day notice to resident at hospital." Resident is on Level 0 according to the sign-out sheets but there is no documentation in the progress notes to determine appropriateness of the level of community access based on R19's Level of behavior. Interview with E1 at approximately 4:00 p.m. on 3 /2/05, E1 stated, "We knew it was not a razor from the facility because it was the wrong color. We do not know how she obtained the razor." E. Review of the resident's clinical record at the facility showed that R20 is a 27 year old male admitted to the facility on 1/22/05 with diagnosis of Bipolar. Review of R20's Psychosocial History summary form dated 1/26/05 showed resident has a diagnosis of bipolar with history of stopping meds so he could drink (alcohol). Review of R 20's Social History and Assessment dated 1/22/ 05 showed Past history of aggression, paranoia. Attempted suicide 3 years ago by hanging himself-auditory hallucination commanded him to harm himself. There is no documentation in the record or progress notes showing R20's Level of	F9999		

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F9999	Continued From page 46 behavior or plan of care relating to suicidal ideation. Record review of a facility incident report dated 1/27/05 showed "Resident (R20) was not seen in his room by E12 when making rounds at 11:30 p. m. on 1/27/05. The nurse (E13) with E9 immediately did a search of the entire building and grounds and resident wasn't found. Staff also went to local store and resident wasn't seen there. The DON and Administrator were called. Attempted to notify family but number was incorrect. The hospital was called, and the nurse at the hospital said he came in for pain and then left at around 12:00 a.m. Police were notified and were given a picture of the resident. At 5:45 a.m. police arrived and stated that resident is in police custody. Police stated that resident attempted to steal a car from a restaurant near the hospital. Later that afternoon administrator called the jail and was told that there wasn't a bond hearing yet, but the judge will most probably not give bond and he will be there awhile. As of 2/4/05 the resident was still in custody. Upon search of the resident's room it was noted that the window screen was damaged and this was possibly how he left the facility. Maintenance replaced the screen and checked the windows throughout the building to ensure that all screens were in proper working condition. R20's court date was pushed off until 2/28/05." No documentation showing R20 was being monitored, attended groups, or progress notes had been written since 1/26/05.	F9999		