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	145173	A. BUILDING _____ B. WING _____	C 02/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HEALTH CARE CENTER	**15600 SOUTH HONORE STREET HARVEY, IL 60426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 28 a. Identifying and documenting a significant change of condition (SCC); b. Promptly notifying the attending physician of a SCC, and documenting this; c. The above policy revision requiring that when a nurse identifies a SCC, he/she must contact the DON or designee and provide all relevant information; and d. Monitoring and following up on a SCC, including implementation of physician orders, documentation, updating DON, updating attending physician, and updating next nurse on shift. The inservices were completed for the day and evening shifts; A QA/QI monitoring tool was initiated. 3. Actions taken on 2/8/06: The night shift will be inserviced; Staff who are on vacation or otherwise not on duty and new staff, will be inservices on the above before they go on duty; Nurses will be reinserviced quarterly regarding SCC.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a)	F9999		

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F9999	Continued From page 29 300.3240a) 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, in accordance with each resident's comprehensive 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. An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on record review and interviews, the facility failed to ensure that a resident is free of mental and sexual abuse for one resident (R2) who was coerced by staff to have sex with another resident (R1), and promised cigarettes if cooperative with providing sexual favors on 11/5/05. Findings include: R2 is a 42 year old resident with a diagnosis of schizophrenia. The resident is alert and oriented and has no difficulties with memory recall. R2 is ambulatory and has no limitations in range of motion. R2 is independent with all activities of daily living R1 is a 37 year old resident with diagnoses including hypoxic encephalopathy and	F9999		

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schizophrenia. The resident is non-ambulatory and has limitations in range of motion of the bilateral lower and upper extremities. R1 requires extensive staff assistance with all activities of daily living. R1 who is alert and oriented, is nonverbal and uses a communication board.

During an interview on 2/1/06, E3 (nurse) stated that R2 approached her on 11/7/05 and informed her that E9 (certified nursing assistant) gave her two cigarettes after complying with the staff's request to perform sexual acts with a resident (R 1). E3 further stated that she was informed by R 2 that E9 cleaned R1 up and escorted her to the resident's room for the purpose of providing sexual favors. E3 also stated that R2 informed her that she felt pressured to have sex with the resident because she was asked by staff. E3 stated that on 11/7/05, she called the director of nursing (E2) at home and reported the allegation of sexual abuse.

E2 confirmed during an interview on 2/1/06 at approximately 3:50 PM in the conference room, that E3 called her at home to inform her of the alleged resident-to-resident sexual abuse between R1 and R2. E2 stated she called the acting administrator (E10) at home to inform her of the allegation of abuse. E2 stated that an abuse investigation was initiated on 11/8/05.

E2 confirmed that E9 worked on 11/5/05 and was the staff person who was assigned to care for R1. E2 stated that it was determined that the sexual activity took place on 11/5/05 between 10:30 AM and 11:00 AM. E2 stated that she interviewed all of the staff who worked on the morning of 11/5/05

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. E2 stated that all of the staff who worked on 11/ 5/05 were interviewed and denied they witnessed the alleged sexual abuse. E2 stated that some of the staff who were interviewed mentioned that they heard that R1 and R2 had sex and that some of the staff watched. According to E2, none of the staff interviewed identified that they had first hand knowledge of the staff who watched the residents having sex. E9, who was not scheduled to work on 11/7/05, was notified of the allegation of abuse and terminated.

During an interview on 2/1/06 at approximately 12:57 PM in resident room ***, R2 confirmed that E9 gave her cigarettes in exchange for having sex with R1. R2 stated that E9 cleaned the resident up and she was then taken to his room by E9. R2 stated that she was taken to the resident's room for the purpose of "performing sex acts." R2 confirmed that she and R1 had sex on 11/5/05. R2 stated that they had "half and half " (oral sex and intercourse). R2 further stated that when they finished having sex, she left the room to inform E9 that she had provided the resident with sexual favors and wanted the cigarettes that she was promised. R2 stated that E9 then gave her two cigarettes. R2 stated that afterward she was concerned that she may be pregnant. R2 stated that it was unfair for staff to ask her to have sex with another resident and not offer to provide her with condoms. R2 stated, " they have them (condoms) in the nursing station but nobody even gave me one."

On 1/31/06, R1 was interviewed regarding the arranged sexual encounter with R2. R1 used his communication board and made hand gestures to respond to questions asked. When the

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F9999	Continued From page 32 resident was asked if he had ever had sex with any female residents in the facility, he smiled and gave the "thumbs up" sign. R1 spelled out on his communication, "I wish they would." When R1 was asked if he had ever had sex with R2, he continued to give the "thumbs up" sign and smile. E3 stated during an interview on 2/1/06, that she interviewed R1 and R2 on 11/7/05. E3 stated that both residents confirmed that they had sex with each other and that it was arranged by E9. Facility staff failed to ensure that residents are free from abuse and coercion. On 11/5/05, R2 was coerced by staff to have sex with another resident in the facility. Facility staff who allegedly watched the residents having sex would not come forward and did not report the sexual abuse to the administrative staff. On 11/7/05, R2 reported the abuse to staff (E3) who called E2 at home. E2 then called the acting administrator at home to notify her of the allegation of abuse. E2 stated that the abuse investigation was initiated on 11/8/05. Facility staff failed to immediately investigate the allegation of abuse; and failed to implement additional measures during the investigation process to determine and identify all of the staff who watched the residents having sex. The facility failed to immediately investigate the allegation of abuse in an effort to ensure the safety of residents in the facility. In addition, the facility failed to ensure that residents are free from abuse and/or coercion. (A) 300.1210a)	F9999		

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F9999	Continued From page 33 300.1210b)3) 300.3240a) 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, in accordance with each resident's comprehensive 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. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on record review and interviews, the facility neglected to notify the physician of a resident's change in condition and failed to inform the physician of the daily use of medications ordered "as needed (PRN)", for one resident (R3) who received daily PRN doses of antipsychotic and antianxiety medications for a period of 11 consecutive days. R3 became increasingly sedated over the 11 day period and failure to assess and inform the physician resulted in neglect of the resident who did not receive proper	F9999		

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F9999	Continued From page 34 care for 11 days. R3 expired in the facility. Findings include: R3 was a 51 year old resident who was admitted to the facility on 9/14/05 with diagnoses including seizure disorder, cirrhosis of the liver and schizophrenia. According to the most recent resident assessment dated 12/28/05, R3 was alert with moderately impaired cognitive skills for decision making. The resident was ambulatory and had no limitations in range of motion; and independent with all activities of daily living. R3 had no identified mood or behavior indicators. On review of the nursing notes dated from 12/22/05 to 1/7/06, it was documented that facility staff were having difficulties managing R3's behaviors. It was documented that R3 was upset with mild agitation and that the resident was restless. R3 was unable to sleep during the night and had periods on some days where he was screaming, yelling and demanding. Staff documented that R 3 was walking down the hallway naked. R3 was not able to follow redirection and did not respond well to staff 1:1 monitoring. Facility staff administered standing doses of Haldol 10 mg four times daily and Ativan 0.5 mg three times daily, as well as PRN doses of these medication, to attempt to manage the resident's behaviors. On review of the Medication Hold/Treatment Notes, it was documented that R3 received PRN Haldol and Ativan daily from 12/29/05 to 1/8/06. R3 received these medications for eleven consecutive days. During the eleven day period, R3 received 33 doses of Haldol 5 mg and 33 doses of Ativan 2 mg.	F9999		

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Starting on 1/8/06, R3 became increasingly sedated. It was documented in the nurse's notes that R3 was calm and quiet and that he did not have any further behaviors. R3 slept most of the day on 1/8/06. However, the resident was still given PRN injections of Haldol and Ativan to manage his behaviors.

On 1/9/06, R3 was more sedated. Facility staff documented that the resident was "drowsy and very slow to respond." R3 was no longer able to feed himself and was now incontinent of bowel and bladder. According to the nurse's note, the psychiatrist (Z2) was notified , and an order was given to hold all psych medications. During a telephone interview on 2/6/06, Z2 stated that she was never informed that staff were having difficulties managing the resident's behavior earlier, or that PRN medications were administered daily. Z2 further stated, "I would have given orders to send him out to the hospital ."

On 1/10/06, facility staff continued to document that R3 was drowsy. Staff documented that the resident was in bed asleep. Staff further documented that R3 now required staff assistance with turning and repositioning.

On 1/11/06, R3 slept the entire day shift. Staff documented that the resident remained drowsy. Staff continued to document that R3 required staff assistance with turning and repositioning, as he was not moving on his own.

On 1/12/06 at 2:00 AM, E4 (nurse) documented that R3 "remained sleep at this time; attempted to

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arouse with no response at this time." On 1/12/06 at 6:00 AM, E4 documented again that R3 was unresponsive and his "condition unchanged ." E4 further documented that a report was given to the AM nurse. During an interview on 2/1/06, E4 confirmed that she did not call the doctor when she found the resident unresponsive. E4 stated that that she did not call the doctor, as none of the staff on the previous shifts had called either. E4 also stated, "But if you want to know the truth about it, he should have been sent to the hospital earlier on 1/9/06."

On 1/12/06 at 9:05 AM, E3 (nurse) documented that R3 was noted with the following, "jaundice, labor respirations, pulse thready and weak; resident unresponsive to stimuli." E3 further documented that 911 was called and the medical doctor was notified of the resident's condition. On 1/12/06 at 9:10 AM, E3 documented that R3 had stopped breathing and cardiopulmonary resuscitation was initiated. According to the Emergency Medical Services Report Form dated 1/12/6, R3 was assessed at 9:26 AM and it was determined that he had no vitals. R3 was transferred to the emergency room via ambulance. The Nursing Discharge Summary dated 1/12/06 at 9:30 AM, documented that R3 expired.

During an interview on 2/1/06, E3 stated that E11 (nurse) informed her at the start of her shift at 9:00 AM on the morning of 1/12/06, that she should look in on her resident (R3). E3 stated that the resident was unresponsive. E11 who started her shift at 6:00 AM on the morning of 1/12/06, had not notified the physician of the resident's condition. During an interview on 2/1/06, E11

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stated that she assumed that the resident was " just sleeping" and "I felt if he was calm there was no need to call the doctor." E11 stated that the doctor wanted the resident sedated that is why she ordered medications for sedation. During a telephone interview on 2/6/06, Z2 denied that she ever gave facility staff orders to keep the resident sedated.

During a telephone interview on 2/6/06, Z2 (psychiatrist) stated that she was not aware that R 3 was receiving daily PRN doses of Haldol and Ativan. Z2 stated that PRN medications should not be given everyday. Z2 stated that no one informed her of the resident's behavior until 1/9/ 06, when she gave an order to hold all psych meds. Z2 stated that she also gave an order to notify the medical doctor of the resident's condition, as the resident's behaviors could have been related to a decline in his medical condition. Z2 stated that on 1/9/06, staff should have called 911 to transfer the resident to the hospital. Z2 stated during the interview on 2/6/06, that facility staff had not called her to inform her that R3 expired.

R3 had a significant change in status. Facility staff neglected to notify the physician of the resident's change in condition. Staff attempted to manage the resident's behaviors with the excessive use of PRN medications. Again, facility staff failed to notify the physician of the noted change in the resident's behaviors and the use of daily PRN medications. R3 became increasingly sedated after receiving daily doses of Haldol and Ativan. The resident was not sent out to the hospital and expired while in the facility .

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