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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E204	A. BUILDING ______ B. WING ______	C 08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD CARE	1406 CHICAGO AVENUE EVANSTON, IL 60202

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F 323	Continued From page 5 Rounds Sheets". The results from this worksheets will be discussed at quarterly QA meetings throughout the next two quarters. All residents that do not always comply with facility curfew policy have been identified and their care plans updated as needed. All residents with suicidal attempts/ or ideations have been identified and their care plans updated as needed. The "Daily Maintenance QA Sheet" has been revised to ensure that window restrictors are in place and properly maintained at all times. The results of these QA sheets will be discussed at the quarterly quality assurance meetings throughout the next two quarters. An emergency QA meeting was held on May 23, 2007 to discuss the investigation regarding the resident as well as procedural issues regarding the incident. Floor coverage policy and procedure was reviewed and revised regarding floor coverage during CNA breaks and lunches.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 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 psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised	F9999		

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F9999	Continued From page 6 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: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) 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. 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. Section 300.1220 Supervision of Nursing Services a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse. b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's	F9999		

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comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
7) Coordinating the care and services provided to residents in the nursing facility.
9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group.
10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available.

These Requirements are not met As Evidenced by:

Based on interviews and record review, the facility failed to monitor and supervise one resident with a recent attempt at suicide. R6 had stabbed his throat and required hospitalization prior to transfer to the nursing home. The staff member responsible for bedchecks at night improperly filled out the bedcheck sheet, failed to observe and note a window out in the dayroom, and failed to monitor this resident's whereabouts during the 4:00am check on the fourth floor. R6 jumped out the fourth floor dayroom window in a suicide attempt and was found by police on patrol approximately 4 :07am on 5/23/07 . The facility at had not been aware of any resident missing when

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this information was brought to nursing home staff attention by the police.

Findings include:

R6 was admitted to facility on 4/23/07 from acute care hospital where he was admitted after suicide attempt on 3/24/07 by stabbing the left side of the neck. Psychiatric evaluation from hospital dated 4/9/07 indicates previous suicide attempts in 1990, 1991, 1994, and "one year ago" (2006). R6 is diagnosed with major depression, bipolar disorder, and close monitoring is recommended in this report. Further hospital records located on the nursing home chart and available to the nursing home staff indicate R6 remained unchanged and to maintain all precautions as late as 4/16/07, and also that he becomes severely agitated at night due to his medication Geodon which was continued in the facility.

There is a PASSR screen dated same day, 4/16/07, that indicates resident no longer needs inpatient psychiatric care, and recommends nursing facility.

The facility obtained a contract dated 4/18/07 before admission whereby R6 agrees to take all medication determined to have contributed to suicide ideation, and not harm himself, and tell staff if he feels like harming himself.

R6 was admitted 4/23/07 with schizoaffective disorder but does have a care plan that addresses depression, hallucinations, anxiety. The goal to decrease suicide ideation is to take meds regularly, talk to staff, one to one with PRSC at least once per day, depression management group, and socializing with others.

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Per interviews with E1 (Administrator), E3 (Nurse), E4 (CNA), E5 (PRSC), and E6 (nurse), all indicate there was no suicidal ideation or attempts in the facility by R6, and no behavior that would warn or alarm the staff of present suicide ideation. All staff state he was adjusting well to facility and taking his meds. Record review confirms above information.

The nurses notes document that at 4:25am on 5/23/07, police called the facility wanting to know if any resident was missing. Facility then started a search floor by floor called by E6, and then staff went outside to identify the resident as R6 from 4th floor. R6's body was found directly outside the 4th floor window of the dayroom.

The police report states that the 4th floor dayroom had open window with screen torn, and two sandals were on the floor.

The 4th floor dayroom pictures taken by the facility and attached to survey showed a window frame bottom right pulled out of frame and placed on floor. Glass was cracked right side and locking mechanism cracked as well as window restrictor bent. Loose screws were lying on the frame. The window screen was separated from frame. R6 was 5'10 and 171 lbs.

E4 was the CNA responsible for bedchecks on the 4th floor. During interview on 6/12/07, E4 told surveyor that 4th floor is her usual assignment. E4 noted R6 sleeping on both the 12:00 and 2:00am rounds. E4 then went off the floor to heat up lunch and was gone approximately 15 minutes between 2:45 to 3:00am. No other staff covered the floor in her absence that night. E4 stated

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nurse usually covers, but E6 denied going to floor. The 4th floor layout is simple and compact. There is one long corridor with resident rooms on both sides, an elevator on the south end, and a very small nursing area/desk in center, south end. The dining room is at the southwest end and there is a chair where E4 stated she usually sits which affords a view of the dayroom

E4 stated that she had already done 4:00am check and did not find R6 in room. Roommate told her R6 went out to dayroom. E4 assumed he may also have gone to 1st floor. E4 marked the 4:00am slot as "A" awake without determining where he was or actually observing him. R3 was R6's roommate and was interviewed by surveyor on 6/11, and remembered his roommate getting up and stating he "was hot" and leaving the room, but did not remember any time that this conversation took place. Facility investigation indicated that R3 said it was "20 minutes before police came" which would have made it 4:00am. E4 recalled that the police and nurse came to floor and said to check all residents about 4:20am. When questioned about why the bedchecks were signed both for the 4:00am and the 6:00am observation, E4 responded that she assumed resident up so marked "A" for awake and did same for 6am and changed it to "D" when she found out from police that R6 was the expired resident.

E6 was the nurse in the building and stated that E4 had not told her prior to arriving on the floor with the police that one resident was missing . The identification of the resident was made outside at police prompting.

Based on the interview of E4 who admitted she

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F9999	Continued From page 11 was back on the floor about 3:00am, did bedcheck at 4:00am and found R6 gone; and the interview from the roommate R3 who stated R6 went out of room about 4:00am; E4 was present on the floor and should have noted R6 in the single corridor and been alerted to activity and noise in dayroom while resident removed window, pushed out screen, and squeezed his person through the relatively small window, landing by the dumpster and garbage cans in the alley outside 4th floor dayroom window. E4 when she discovered R6 missing, should have confirmed location of this resident with his previous history of suicide ideation, and because older bedcheck sheets do not indicate that R6's pattern was to get up at 4:00am as evidenced by review of other bedcheck sheets. (A)	F9999		