STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E392	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 8 R1 with smoking materials (cigarettes and lighter). The smoking assessment dated 3/7/12 in R1's record did not accurately reflect the resident's ability to handle smoking material safely. The facility has no system in place to assess or determine whether residents returning from an emergency psychiatric hospitalization are in remission or need individualized interventions to supervise/monitor them. R1's psychosocial assessment and care plan were reviewed with E5 on 1/31/13. On 12/28/12, R1's readmission, E5 wrote in the psych-rehab notes that R1, " still was very delusional upon return, but redirection/close observation will continued to be rendered." The facility did not determine or specify the extent of close observation needed. This was verified with E5.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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F9999	Continued From page 9 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 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by:	F9999		

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F9999	Continued From page 10	F9999		

Based on observation, interview and record review the facility failed to identify potential safety risks for a resident (R1) with a history of suicide attempts. The facility failed to develop a plan to supervise a resident with worsening behaviors and problems with insight, reasoning and judgement. These failures contributed to R1 enclosing herself in her room sustaining 2nd and 3rd degree burns to 11% of her body (upper torso and bilateral arms, chest and back) from a fire in R1s room. R1 required treatment at a burn unit and will need surgery to treat some of her burns.

This applies to 1 of 4 residents (R1) reviewed for accidents/supervision in the sample of 4.

Findings include:

R1 was admitted to the facility 3/10/09, with diagnoses including Major Depression Disorder, Severe Psychotic features, Schizoaffective disorder (Bipolar type) and history of suicide attempts, as listed on the face sheet. The Pre Admission Screen-Mental Health assessment (PAS/MH Level II Notice of Determination dated 3/10/09 noted R1 to have absent motivation, limited insight and reasoning, delusions, poor judgement and was depressed upon admission.

R1's Minimum Data Set, quarterly assessment (MDS) dated 12/3/12 (completed two days prior to R1 being hospitalized for suicidal ideation) showed the following: The Brief Interview for Mental Status, was not completed. R1 scored a

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F9999	Continued From page 11	F9999		

zero showing the resident was rarely/never understood. The Cognitive Patterns assessment showed short and long term memory problems, moderately impaired daily decision, making poor decisions, with cueing and supervision required. Section D of the MDS (Mood) was left blank and incomplete. The Behavior (section F) assessed R1 to have delusions, verbal threatening behavior to others, screaming and cursing at others daily. The assessment documented R1's behavior has worsened since the prior assessment.

The Screening Assessment for Indicators of Aggressive and Harmful Behavior for R1, was reviewed with E5. E5 scored R1 a ..(zero) for category (1). The problems identified were, general insight, reasoning and judgement. These concerns were identified in R1's PAS upon admission but not scored in the assessment.

On 1/31/13 at 1:45 p.m., E5 (psychosocial rehabilitee counselor) PRSC stated "R1 said during an interview that was documented on 3/15/09 in the initial social service interview, that there were two suicides attempts by R1, to overdose on medications in 1991. The facility did not complete an assessment to indicate the circumstances that precipitated the suicidal behaviors/overdose". E5 stated R1 had not had any other suicidal ideations since that time.

R1 had another episode on 12/5/12. It was documented in the nursing notes by E2 (nurse) and on the involuntary transfer records where R1 voiced comments of, "going to end it all". "...resident attempted to run out of building into traffic...resident attempted to put hands around the staffs neck, yelling and screaming at staff,

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F9999	Continued From page 12	F9999		

increased paranoia".

On 1/31/13 E1, E5 (PRSC) said the facility does not have a policy and procedure for the management of residents who are admitted to the facility with a history of suicidal ideation's or for the residents who demonstrated signs and symptoms of self harm behaviors to themselves. The hospital discharge clinical summary on 12/28/12, shows R1 was admitted, " due to suicidal ideation and risk of harm and aggressive and paranoid behaviors". R1 was hospitalized for twenty three days and returned to the facility.

On 2/1/13, 1:00 p.m., E2 stated she was present when R1 stated, "wanted to end it all". E5 said we always send residents out when they are suicidal. E5 involuntarily transferred R1 to a psychiatric facility. E2 was asked if R1's (PSRC) E5 was notified of the suicidal behavior and the reason for discharge. E2 stated, "No".

On 12/5/12, E2 documented in the nurses notes, "going to end it all and give us, 'staff and others ' what we wanted....attempted to run out of the building into traffic...resident attempted to put hands around the staffs' neck, yelling and screaming at staff, increased paranoia". E5 was asked about this incident. E5 stated, "The reason that R1 was sent out was for medication management and not for suicide". When the nurse's notes were reviewed with E5, E5 acknowledged not being aware of this.

Thirty four days after readmission to the facility a large unwitnessed fire erupted in R1's bedroom on 1/30/13 around 11:30 p.m. R1 was found

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F9999	Continued From page 13	F9999		

alone and a bed was pushed against the door not allowing staff to rescue resident.

On 1/31/13 1:30 p.m., an interview was conducted with E1 (Director of Nursing) This was the morning after the fire in R 1' s' room. E1 said she was told on 1/30/13, by E4 (certified nursing assistant) that she went to the A wing after the fire alarm sounded. E4 said she saw thick black smoke in the hallway and coming from around R1's bedroom door. E4 opened the door and found the room full of thick black smoke. E4 stated, R1 refused to come out of the room after repeated coercing. E4 stated there was a bed in front of the door making it impossible to open the door. E4 stated she tried to push open the door but was unsuccessful while continuing to call out for R1 to come out. E3 (nurse) on duty the night of 1/30/13 verified a written statement from 1/30/13 and was interviewed on 2/8/13. E3 verified a written statement from 1/30/13 and E3 stated, "arriving to R1's room... called out to resident, R1 was talking to me but refused to come out".

Z4 (fire investigator) was present during the initial tour on 1/31/13. Z4 stated that the cause of the fire had not yet been determined, but was told by staff that R1 was caught smoking in her room some time ago. Z4 did not find any cigarettes or cigarettes butts, only a cigarette lighter which was found on the floor between the beds near the night stand of R1.

On 2/1/13 at 10 a.m., Z9 (discharge planner) at the burn unit stated, that R1 was intubated at the emergency room and was sedated for suspected inhalation injury prior to transfer to the Intensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 14	F9999		

Care Burn unit on 1/31/13. Z9 said, R1 breathed in hot air and smoke and could not be interviewed at this time. The Bronchoscopy report from 1/31/13 for R1 while in the Burn unit documented," sustained a Grade I inhalation injury." Z9 stated R1 was assessed to have 11% burns, a mix of 2nd degree and undeterminable burns, some deep, some on the bilateral arms, abdomen, chest and back. Z9 stated after R1 was extubated on 2/1/13, R1 was voicing to the staff that they were trying to kill her and they were out to get her.

On 2/6/13 at 11: 20 a.m., R1 was observed in a room on the burn unit, in bed lying on the left side. Z9 (discharge planner) and Z12 (nurse) were present. There were bandages observed on the right and left arm. R1 was alert and oriented to time, place and person. R1 was asked how she acquires cigarettes. R1 stated she has not had any cigarettes for a while but she gets them from other residents in the facility. R1 said she is allowed to keep her smoking material and never has smoked in her room. R1 said, " I always follow the smoking rules."

On 2/6/13 at 1:15 p.m., Z10 (physician) was interviewed at the burn unit. Z10 stated, "R1 would need to undergo surgery for some of the burns. The burns were partial thickness (second degree burns) on the neck, bilateral arms, and right and left side of chest, upper back and breast area appears to be full thickness (third degree burns)."

The paramedic report from 1/30/13 was reviewed on 2/5/13. The paramedic report read, with Z1 (paramedic)," noticed...patient was wearing a bra,

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F9999	Continued From page 15	F9999		

jeans, and had a blouse hanging from her waist...soot all over hair and face...bra was burned badly on the left breast cup and charred,..burned on the right side of neck up to right ear lobe, upper back on right side, and burns around umbilicus, chest, abdomen and both arms...burns were bright red with yellowish lines through skin...some areas of burns had skin peeling off"...R1 related pain 10/10 and was medicated with a narcotic and stated no relief. Z1 wrote in the report that R1 could state name; however when asked what happened, patient stated, 'I don't know, I don't know, They told me they would get me sooner or later without me knowing, They are out to get me.' When Z1 asked R1, who was out to get her, R1 responded, "They are trying to get me, they are trying to kill me. Z1 stated in the report that R1, during treatment asked, "Where's my lighter? Help me". R1 was transferred to a local community emergency room for injury's/burns to body.

On 1/31/13 at 1:45 p.m. Interview with E1, E5 and E7 showed that facility does not have a policy and procedure for the management of residents who are admitted to the facility with a history of suicidal ideation's or for the residents who demonstrated signs and symptoms of self harm behaviors to themselves or how the facility plans to supervise and monitor residents.

R1's psychosocial assessment and care plan were reviewed with E5 on 1/31/13 at 1:45 p.m. On 12/28/12 when R1 was readmitted to the facility E5 wrote in the psych-rehab notes that R1, "still very delusional upon return, but redirection/close observation will continue to be rendered." The facility did not determine or

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F9999	Continued From page 16	F9999		

specify the extent of close observation needed. This was verified with E5. A care plan for redirection/close observation was not developed for R1 by the facility.

The care plan was reviewed with E5. The review found the interventions in the care plan to be generalized and not specific to R1's suicidal behaviors/problems that occurred on 12/5/12. The contributing factors underlying the cause/effect of R1's behaviors were not assessed nor were interventions developed to prevent such behaviors from reoccurring. The interventions did not address how the facility will supervise and monitor R1 for the behaviors that sent R1 to the hospital.

The facility assessed R1 to be able to smoke independently said E5 (psychosocial case manager) on 1/31/13 at 1:45 p.m. (which allowed R1 to keep cigarettes and lighter). The Smoking Safety Risk Assessment dated 3/7/12 completed by E5 was reviewed on 1/31/13 with E5 . R1 had a total score of 2 which notes (follows rules/may independently be able to handle smoking materials) (score 0-2). E5 written comment was, "There has been no recent behavior of smoking in undesignated areas... Proceed to care plan".

E5 was asked whether R1 had violated the facility's rules for smoking in an unauthorized area. E5 stated, "yes", was told this had happened, but was awhile ago. E5 was asked when this occurred. E5 was unable to state when. R1's medical record was reviewed for this information. There was no information regarding when this occurred. E5 was asked how often the

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F9999	Continued From page 17	F9999		

residents are reassessed for smoking risk. E5 stated there were no specific guidelines that he was aware of.

E1, E5 and E7 (psychosocial director) on 1/31/13 were asked to describe the procedure the staff would follow to document and monitor behaviors. E1 stated the psychosocial department had the policy and procedures. E1 and E7, were for the written facility policy's or procedures for the facility to follow monitoring and documenting behaviors, E5 and E7 stated their were none.

The smoking safety risk assessment tool dated 3/7/12 completed by E5 for R1 was inaccurate and did not include R1's history in violating the facility's smoking rules. Interviews with E1 on 1/31/13 and review of the written Fire Protection report (1/31/13), the Police report 2/8/13 and interview with E4 (2/13/12), indicated that R1 had been caught smoking in her bedroom before.

The care plan was reviewed on 1/31/13. The facility did not have a care plan developed for R1's unsupervised smoking or the supervision of R1 with smoking materials (cigarettes and lighter). The smoking assessment dated 3/7/12 in R1's record did not accurately reflect the resident's ability to handle smoking material safely.

The facility has no system in place to assess or determine whether residents returning from an emergency psychiatric hospitalization are in remission or need individualized interventions to supervise/monitor them.

R1's psychosocial assessment and care plan

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	14E392	A. BUILDING _____ B. WING _____	C 02/21/2013

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WEST CHICAGO TERRACE NH	**928 JOLIET ROAD WEST CHICAGO, IL 60185**

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F9999	Continued From page 18 were reviewed with E5 on 1/31/13. On 12/28/12, R1's readmission, E5 wrote in the psych-rehab notes that R1, " still was very delusional upon return, but redirection/close observation will continued to be rendered." The facility did not determine or specify the extent of close observation needed. This was verified with E5. (B)	F9999		