STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004352	A. BUILDING: _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457

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S 000	Initial Comments Complaint Investigation #2092147/IL121211	S 000		
S9999	Final Observations Statement of LicensureViolations: 300.610a) 300.1210a) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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. These requirements were not meet as evidenced by: Based on interview and record review, the facility failed to provide monitoring and supervision per facility policy for a resident with a known history of suicidal ideation and self-harm by not having effective interventions in place to monitor the resident and by failing to intervene promptly to maintain resident safety. This failure applied to one (R1) of five residents reviewed for supervision and resulted in R1 being able to leave	S9999		

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S9999	Continued From page 3 01/27/2020, R1 was observed by staff outside of the facility walking toward the facility, upon entering the facility resident noted to have a cup of coffee. She was re-educated that she does not have independent pass privileges at this time and that she's not to go out of the facility without permission or a staff escort. She states, "I know that I am not supposed to go out, but I needed some air." DON (Director of Nursing), administrator, nurse practitioner (V8) aware, will refer to social services to f/u. no apparent s/s of distress noted. 2/09/2020, R1 came to the nurse station and told staff that she swallowed 20 batteries and that she was suicidal. MD was made aware order to send resident to hospital for medical/psych with petition. Resident placed on 1:1 monitor while waiting for ambulance to transport to hospital. Resident was admitted with diagnosis of foreign body of alimentary tract and suicidal ideation. Per hospital record, resident stated that she swallowed the batteries because facility staff did not believe her when she told them that she was suicidal. CT scan of the abdomen conducted at the hospital showed multiple foreign bodies identified at the gastric lumen consistent with batteries. Resident underwent upper endoscopy with removal of foreign body at the hospital. 10/28/2020 at 11:06AM, V5 (RN) stated that the facility is aware that R1 is suicidal, including about 6 other residents, everyone gets the same level of supervision unless one expresses thoughts of suicide, then they will be placed on a 1:1 monitoring pending transportation to the hospital. V5 also added that the facility does not have alarms on the doors but have monitors located at the front office and the nursing station. V5 was asked if there is a designated staff for	S9999		

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monitoring the cameras and he said no, if someone is not at the nursing station or around the camera at a particular time, it is possible for a resident to walk out without being seen.

Behavior care plan for R1, dated 10/22/2019, states (R1) experiences auditory hallucinations AEB (as evidenced by) hearing voices telling her to eat batteries. Goals state that resident will show a decrease in episodes of auditory hallucinations by staff redirecting conversation. Interventions include to document in the progress notes the intensity, duration or frequency of behavior. Provide redirection or distraction to minimize frequency or duration of behavior.

R1 has an SMI (Serious Mental Illness) care plan dated 12/18/2019 and Suicidal Ideation care plan dated 12/05/2019, state that resident has a history of SELF-HARMFUL behavior AEB resident digesting batteries, Evidence of severe mental illness (i.e., active psychosis, major depression, lack of sound judgment, poor contact with reality), Poor impulse control, Attention seeking Problems/needs are manifested by, Voicing threats of self-harm. Additional risk factors include previous self-harmful behavior, Substance abuse history, etc.

During the course of this survey, there were no care plans provided that documented any changes to R1's plan of care or required level of supervision.

10/27/2020 at 10:30AM, V4 (Social Worker/PRSC) said that she was the assigned social worker for R1; per V4, (R1) was pleasant, provides a lot of insight to her past and had a good relationship with co-peers. V4 added that R1 had a history of suicidal ideation, and had

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been to the hospital several times for that. When she returns from the hospital, the social worker will do a one to one counseling, and do a room sweep for 72 hours. Then they will do a random room check on a daily basis and document it in resident's medical record. She added that she is aware that R1 is a high risk for suicide. R1 was not placed on a one to one supervision with an assigned staff because the facility does not provide that level of monitoring. Per V4, if a resident requires that level of care, they are usually sent to the hospital. V4 added that R1's room was searched the day that she swallowed 20 AAA batteries. During the course of this survey, surveyor asked for documentation that R1's plan of care was followed by searching R1's room but it was not provided.

10/28/2020 at 11:20AM, interviewed V6 (Psychiatrist) stated that he does not recall the resident but was reminded of resident's documented behavior and suicidal attempts by the surveyor. V6 stated that it is very difficult to manage residents with self-injurious behavior but that someone with this type of history could have been monitored better, she should not be able to go out and get a cup of coffee. V6 continued to state that he does not decide where people go; he only manage their health and medications, it is up to the social worker at the hospital and the facility to determine appropriate placement for the resident; sometimes the facility will state that they don't have the capability to handle a particular resident and placement arrangement will be made.

10/27/2020 at 3:08PM, V8 (Nurse Practitioner) stated that she is very familiar with resident, she is aware that she is suicidal but said that she also has a history of swallowing batteries. She added

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that R1 is not considered a high risk once they come back from a psych hospital because they have completed their psychotherapy. V8 was not sure how the resident got the batteries she swallowed but said that R1 told her that she paid another resident to purchase the batteries for her.

10/28/2020 at 11:49AM, V2 (DON) stated that the suicidal residents in the facility are monitored by a daily checks conducted by social services and that they all have individualized care plans. V2 was asked if R1 was supposed to be an independent smoker with her history of suicidal ideation and ingestion of foreign bodies. When asked, V2 stated that it is possible for a suicidal resident to pick up anything while smoking independently and that no one knows where R1 got the batteries she swallowed.

Facility policy titled, Resident Behavior Watch (undated), reads: Objective; It is the facility policy to assess, evaluate and investigate statements voiced or otherwise communicated by residents that may be threatening to themselves or others. The facility will provide appropriate follow-up intervention based upon the individual's need. The document goes further to identify persons who are considered at greater risk including persons with a history of previous suicide attempt, history of psychiatric problems and / or a personality disorder diagnosis, etc. Under procedure, the document states that follow-up intervention and evaluation will be provided based upon each individual's need. Item 5 of the procedure states that care plan approaches and interventions may include suicide warning signs. Staff should look for warning signs and promptly report any change in behavior, and intervene accordingly to promote resident's safety.

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