Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000087	A. BUILDING: _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN NURSING HOME	5448 NORTH BROADWAY STREET CHICAGO, IL 60640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 a) 300.690 b) 300.690 c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

summary of each reportable accident or incident to the Department within seven days after the occurrence.

These regulations were NOT MET as evidenced by:

Based on interview and record review, the facility failed to initiate an investigation and failed to report to the State Agency an incident for one resident (R136) reviewed for closed record. R136 was found unresponsive in bed on 11/20/19.

Findings include:
R136's medical record showed that he was admitted to the facility on 11/11/2019, with diagnoses that includes Bipolar disorder, current episode manic without psychotic features unspecified, Major Depressive disorder, single episode and Pain disorder exclusively related to psychological factors.

R136's medical record progress note, dated 11/19/19 at 2:28pm, showed that R136 went out on community pass with packed medication to return back on 11/23/19.

R136's medical record progress note, dated 11/20/20 at 4:57pm, documented that R136 was found non responsive to verbal\physical stimulus, pale and diaphoretic to the facial area.

On 1/13/20 at 2:12pm, V10, LPN (Licensed Practical Nurse), who was assigned to R136 on 11/19/19 for 3pm to 11pm shift, stated there was no facility out on pass form, and a hand created written pass was initiated and signed by R136 .V10 presented the hand written form, dated 11/19/19, for R136 to be out on pass from 11/19/19 to 11/23/19 at 10pm, with medication

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and instructions.

The facility sign out sheet showed that R136 signed out at 1:40pm on 11/19/19. On 11/20/19, there was no documentation of R136 signing back into the facility. R136's medical record progress note documented that R136 was found non responsive to verbal or physical stimulus, pale and diaphoretic to facial area. R136 was pronounced expired. R136's body was removed by the local police department and transferred to the city morgue for autopsy.

On 1/13/2020 when the surveyor asked V1 (Administrator) whether the State Agency was notified and an investigation initiated and completed, V1 stated there was no investigation initiated and done. V1 could not present any documentation of any investigation done or sent to the State Agency. V1 explained that none of the staff was aware of R136 returning to the facility until found in the bed.

On 1/13/20 at 1:11pm, V9 (Social Services Director) stated, in part, the facility protocol on new admissions before they can have community pass is they have to be assessed and obtain physician order. The residents have to make sure they sign out when leaving, and sign in when they come back to the facility at the security desk. V9 explained that if the resident sign out to get groceries, they need to sign out and be back before curfew at 10:00pm during the week, and 11:00pm on weekends. Anytime they go out on pass they have to sign out and sign in.

On 01/13/20 at 3:00 pm, V15 (Security Monitor staff) stated R136 signed out, but was not aware that he did not sign in. V15 was not aware when R136 came back to the facility. V15 stated

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S9999	Continued From page 3 possibly I was in the washroom or something. The facility policy on Resident Incident, with revised date 1/14, pointed out, in part, the policy is to provide accurate reporting and recording of all resident incidents, the resident incident reports will be completed for each resident. The procedure includes but not limited to determining if an incident has occurred, complete incident report immediately following caring for resident's emergency and safety needs which include the details and specifics. Initiate investigation and complete thoroughly including events as they occurred with medical and potential environment issues that may not have contributed to event. Under reporting the policy indicated that the State Agency must be notified of serious incident or accident (Only) that cause a harm or injury to the resident. The regional office must be within 24 hours of the incident and accident with a final report sent in 5 days to the State Agency. The facility Out on Pass policy pointed out all residents must remain in the facility for 72 hours post admission to allow interdisciplinary assessment. Residents going on overnight pass, must provide the facility with a name address, and telephone number where they will be staying. Documentation of all overnight passes with medication instruction, must be charted in the resident's medical record. (C)	S9999		