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
	IL6002075	A. BUILDING: _____ B. WING _____	C 03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	5336 NORTH WESTERN AVENUE CHICAGO, IL 60625

(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 Complaint Investigation 1681088/IL86389 1681090/IL83693 An extended partial survey was conducted on the federal side of this survey. STATEMENT OF LICENSURE VIOLATION:	S 000		
S9999	Final Observations 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. b) The facility shall 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 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. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) This requirement is not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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Based on observation, interview, and record review the facility failed to implement adequate resident monitoring and observation per physician orders, failed to follow their fifteen-minute monitoring policy, and failed to identify suspicious behaviors for five of five residents (R1, R2, R3, R4 and R5) reviewed for supervision in the sample of five and the facility failed to ensure residents were provided with psychosocial services to address the identified substance abuse needs for 5 of 5 sampled residents (R1, R2, R3, R4, R5), identified with a history of substance abuse.
The facility's failures lack of supervision and monitoring on 2/27/16, between 2:30pm and 3:10pm, when five residents (R1,R2,R3,R4,R5) were found unresponsive on the second floor of the facility and were sent to the hospital where heroin overdose was confirmed. The facility also failed to consistently implement 15-minute monitoring per doctor's order and facility policy, when four of the five residents (R2, R3, R4 and R5) returned to the facility in the evening of 2/27/16. As a result, R5 had access to and ingested heroin for the second time on 2/28/16 between 9:05am and 10:09am.

Findings include:
Facility's incident reports dated 2/27/16 of five residents (R1, R2, R3, R4 and R5) document that the five residents were found unresponsive on the second floor of the facility within the duration of approximately 40-minute period. The five residents were sent to the hospital where heroin overdose was confirmed. Upon return to the facility of the four residents (R2, R3, R4 and R5) on 2/27/16, the facility failed to provide supervision and monitoring that resulted in R5's subsequent heroin overdose on 2/28/16.
1. Face Sheet documents R5 is a 46-year old

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resident admitted to the facility on 12/31/15 with the diagnoses of bipolar disorder and schizoaffective disorder. Hospital Transfer form dated 12/31/15 documents a history of substance abuse. (MDS) Minimum Data Set dated 1/7/16 Section C- Cognitive Patterns scores R5 as "15" indicating no cognitive impairment or signs of delirium; Section G Functional Status documents R5 is independent with activities of daily living and ambulation. Interview for Substance Abuse Disorder dated 1/7/16 documents R5 has used heroin in the past. Physician Order Sheet dated 2/28/16 documents R5 is on 15 minute monitoring.
Hospital Record dated 2/27/16 documents the reason for emergency room visit is heroin overdose, 2/28/16 documents the reason for emergency room visit is probable heroin overdose.
R5's care plan for substance abuse/chemical dependency dated 1/23/16 does not have evidence that it was updated with additional or new interventions to address the heroin overdose on 2/27/16 or 2/28/16.
Progress Note 2/27/16, 6:47pm, R5 was found unresponsive in R6's room, along with R4. Upon their arrival, paramedics administered Narcan to R5; R5 started to wake up and R5 was transferred to the hospital. Ambulance Run Sheet dated 2/27/16, 3:05pm, documents R5's symptoms were overdose, confusion, vomiting; R5 received two doses of Narcan to treat a suspected opiate overdose. Progress Note 2/27/16, R5 returned from the hospital.
Progress Note 2/28/16, 11:23am, documents a second episode of non-responsiveness within 12 hours from returning from the hospital on 2/27/16. R5 was found unresponsive on the floor in R4's room. Upon arrival, paramedics administered Narcan and R5 began to wake up. Ambulance

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Run Sheet 2/28/16 10:17am documents R5 was given Narcan for a suspected opiate overdose; Impression is documented as heroin overdose.
On 3/2/16 at 9am, by phone, Z3 (Police Detective) stated that on both 2/27/16 and 2/28/16, R5 was found with rolled up paper money next to her, which is used as a way to inhale heroin through the nose.
Plan of Care 2/28/16, documents 15-minute monitoring started 2/28/16 at 8:28am; On 2/29/16 at 3:45pm, E2(Director of Nursing) stated in the Daily Status Meeting that all documents regarding 15-minute monitoring of R5 have been presented. Medical record presented by the facility staff does not show evidence that R5 was being monitored every 15 minutes as stated. R5 was not available to interview during the survey.
On 3/2/16 from 11am-12pm, video recorded footage from the second floor was reviewed. The video recording shows staff walking through the entire second floor, checking in each room from 2am - 2:10am on 2/28/16. This staff activity was repeated again at 5:05am, three hours later. In between 2:10am and 5:05am, staff intermittently walked up and down the halls, but did not go into R5 ' s room in regular 15-minute intervals.
Video footage 2/28/16, at 9:05am shows R5 walking from the dining room into R4's room; 9:42am E21(Nurse Aide) walks to R4's doorway (unable to determine if E21 goes into the room); at 10:09am, E21 walks into R4's room, then comes out of the room, staff at the nurse's station get up and go to R4's room; at 10:12am, the emergency crash cart is brought down to R4's room; at 10:13am, R3 walks out of R4's room.
On 2/28/16 at 10:30am, R3 stated R4 and R5 "got high again this morning (2/28/16)." R3 stated that R3 knew this because R3 was in the room with them (R4 and R5). R3 stated R5 was taken back to the hospital because she (R5) was

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found on the floor of his (R3) room.
On 3/2/16 at 3:15pm, E21 stated R5 was in R4's room on 2/28/16 when E21 checked on them around 9:30am after breakfast. The door to R4's room was half way closed; R4 and R5 were told to keep the door open. E21 stated that was the last time he saw R4 and R5 until E21 found R5 on the floor of R4's room after 10am.
2. Face sheet documents R3 is a 33-year old resident admitted to the facility on 9/30/15 with the diagnoses of suicidal ideations and psychoactive substance abuse. Hospital Note 9/24/15 documents R3 has a history of opiate abuse, bipolar disorder, poly substance abuse, and suicide attempts. MDS (Minimum Data Set) dated 12/30/15 Section C - Cognitive Patterns scores R3 as "15," indicating no cognitive impairment and no symptoms of delirium; Section G - Functional Status documents R3 is independent or only needs supervision with activities of daily living and ambulation.
Substance Abuse Screen dated 10/14/15 documents R3 "denies using street drugs or a history of drug abuse." Assessment for Suicidal or Self Harm dated 10/7/15 documents R3 has had suicidal thoughts and actions.
Progress Note dated, 2/19/16 10:47pm, R3 came back to the facility late from pass, staff smelled alcohol on R3, R3 denied drinking alcohol. Social Service Progress Note 2/23/16 R3 had a "self-harm incident" on 2/19/16. Progress Note 2/24/16 documents a lab result was positive for "substance abuse". Drug Screen 2/21/16 was positive for amphetamines and marijuana.
Physician Orders 2/27/16 documents an order for 15-minute monitoring.
Progress Note 2/27/16 documents that at approximately 2:40pm, R3 was found on the floor of his room, unresponsive. Upon their arrival, paramedics administered Narcan to R3; R3

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began to wake up, and was sent to the hospital. Ambulance Run Sheet 2/27/16 2:54pm documents Narcan was given to R3 for a suspected opiate overdose; upon waking up R3 stated to paramedics that, "(R3) did a dime bag of heroin."
Hospital Emergency Room Record dated, 2/27/16 documents R3 was diagnosed with a drug overdose; R3 stated, "someone brought heroin into the nursing home, gave him some, and he snorted it." R3 has a past history of heroin and marijuana use. Review of clinical record does not show evidence that R3 received increased supervision to monitor for behaviors when R3 returned from the hospital on 2/27/16.
On 2/28/16 at 10:30am, R3 stated that a few weeks ago R3 tried to kill himself by overdosing on heroin because he (R3) was upset. R3 also stated that his roommate, R4, heard that Z2 (family member) is a heroin user and wants to "get some." Then on 2/27/16 after lunch, R1 and Z2 came into R3's room and gave him (R3) "drugs." R3 stated R1 and Z2 were hoping R3 liked the drugs and would buy more. R3 described the drugs as, "white powder in a small zippered baggie." R3 stated he thought the powder was either cocaine or heroin, he inhaled it through his nose, and stated, "I don't remember much after that until I woke up and saw the paramedics standing over me."
During the same interview, R3 also stated that the facility staff did not check on him (R3) "more often after coming back from the hospital." R3 stated that R4 and R5, "got high again this morning (2/28/16) "
Plan of Care monitoring for R3 starts on 2/27/16 at 9:15pm; the next entry is on 2/28/16 at 3pm.
On 2/29/16 at 2pm, E9 (Nurse) stated R3 was on regular two-hour well-being checks on 2/27/16 for the 7am-3pm shift. E9 stated R3 ate lunch in the

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dining room on 2/27/16 but does not remember when R3 was seen after that.
On 3/2/16 at 2:33pm, E5 (Social Service) stated R3 had a suicide attempt while out in the community on 2/19/16, R3 overdosed on heroin.
On 2/29/16 at 3:45pm, E2 (Director of Nursing) stated in the Daily Status Meeting that all documents regarding 15-minute monitoring of R3 have been presented.
On 3/2/16 from 11am-12pm, video recorded footage from the second floor was reviewed for 2/27/16 11pm through 2/28/16 10:15am. Staff walked through the entire second floor, checking in each room from 2am-2:10am on 2/28/16. This was repeated again at 5:05am, three hours later. In between 2:10am and 5:05am, staff intermittently walked up and down the halls, but did not go into R3's room in regular 15-minute intervals as ordered. After 5:05am, there is no video evidence that staff monitored R3 in regular 15-minute intervals. Video footage 2/28/16, 10:13am, R3 walks out of R4's room.
R3's care plan for substance abuse/chemical dependency dated 1/23/16 does not have evidence that it was updated with additional or new interventions to address the heroin overdose on 2/19/16 or 2/27/16.
On 3/2/16 at 2pm, E2 presented new substance abuse care plans for R2 and R3 dated 2/28/16. E2 stated the care plans were updated after the concern was brought to their attention on 3/1/16 by the surveyor.
3. Face Sheet documents R4 is a 61-year old resident admitted to the facility on 12/26/15 with the diagnoses of suicidal ideations, alcohol abuse, paranoid personality disorder, and hallucinations. Minimum Data Set dated 1/23/16 Section C- Cognitive Patterns scores at "14," indicating no cognitive impairment and no signs of delirium; Section G Functional Status

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documents R4 needs supervision only for activities of daily living and ambulation.
Community Survival Skills Assessment dated 12/29/15 documents R4 has a history of substance abuse.
On 3/2/16 at 3:15 PM, E5 stated that R4 is inconsistent with his attendance in the addiction day group. E5 stated the resident is on a RED pass, which means he is not able to leave the facility. E5 was not able to provide any documentation on why R5 is not attending his addiction group; or what other interventions or approaches the facility had implemented to assist R4 in attending the addiction group.

Interview for Substance Abuse Disorder dated, 1/5/16 documents R4 has used heroin and alcohol in the past; last used heroin three weeks ago, and substance abuse is currently a problem for R4 now.
Progress Note 2/27/16 12:16pm (late entry) documents R4 was noted on the bed, unresponsive. 911 paramedics were called and upon arrival took over the care of R4 and R4 was transported to the hospital.
Ambulance Run Sheet 2/27/16 3:10pm documents suspected substance abuse, impression heroin overdose. In this report, R4 "admits to drinking vodka and doing heroin."
Physician Orders dated 2/27/16 is for R4 to have 15-minute monitoring upon return from the hospital 2/27/16.
Plan of Care documentation of 15-minute monitoring starts 2/16/16 and ends 2/25/16. On 2/29/16 at 3:45pm, E2 (Director of Nursing) stated in the Daily Status Meeting that all documents regarding 15- minute monitoring of R4 have been presented. Medical record does not show evidence that R4 was being monitored every 15 minutes as stated upon returning from

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the hospital on 2/27/16 after a heroin overdose.
On 2/28/16 at 11:30am, R4 sat in the conference room for an interview. R4 had slurred speech and the conversation was incoherent at times. R4 would fall asleep sitting at the table, wake up and not know where he was or where the conversation was going. R4 stated that on 2/27/16, he spoke with Z2 (family member of R1) about drugs. R4 said Z2 could, "get some good s**t" for R4, so R4 paid Z2 $25 "for drugs." R4 told Z2 that if the drugs were good, R4 could triple Z2's money in three days at the facility. R4 stated he (R4) controlled the drugs "both times" so R5 would not "overdose again". R4 was not able to specify what that meant.
During the same interview, R4 stated the staff " is not watching " him more closely since coming back from the hospital on 2/27/16. At the time of this interview, R5 was already transferred to the hospital but R4 was not aware of this fact.
R4's interview is validated with Z3 (Police Detective)'s interview, review of the video, portions of R3's interview, and ambulance run sheet documentation.
On 3/2/16 from 11am-12pm, video recorded footage from the second floor was reviewed. Staff walked through the entire second floor, checking in each room from 2am-2:10am on 2/28/16. This was repeated again at 5:05am, three hours later. In between 2:10am and 5:05am, staff intermittently walked up and down the halls, but did not go into R4's room in regular 15-minute intervals as ordered.
Substance Abuse care plan does not document any new or updated interventions upon R4's return from the hospital after the heroin overdose on 2/27/16.
On 3/2/16 at 2pm, E2 presented new substance abuse care plans for R2 and R3 dated 2/28/16. E2 stated the care plans were updated after the

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concern was brought to their attention on 3/1/16. R4's care plan was not updated because he is no longer in the facility.
4. Face Sheet documents R2 is a 58-year old resident admitted to the facility on 8/12/15 with the diagnoses of suicidal and homicidal ideations, major depression, opioid dependency, and poisoning by heroin. Minimum Data Set dated 2/12/16 Section C- Cognitive Patterns score is "15," indicating R2 is cognitively intact and without signs of delirium; Section G - Functional Status R2 requires supervision with activities of daily living.
Facility document titled Indicators of Aggressive and/or Harmful Behaviors 1/22/16 documents R2 has a history of substance abuse with recent relapse (unknown date). Interview for Substance Abuse Disorder dated 8/19/15 documents R2 has used heroin and marijuana, last using heroin on 4/11/15.
Social service note dated 3/1/16 addresses "the incident of 2/27/16".
Nurse Progress Note dated 2/27/16 2:50pm (late entry) documents R2 was found on the floor in the room behind the door. Nurse Progress Note 2/27/16 10:33pm, R2 returned from the hospital with the diagnosis of heroin overdose. Physician Order Sheet dated 2/27/16 documents 15-minute monitoring for R2.
Plan of Care documentation starts on 2/27/16 at 9:27pm; the next entry is 2/28/16 at 8:13am.
Ambulance Run Sheet dated 2/27/16, 3:01pm, documents present history is substance abuse, overdose, and pinpoint pupils; R2 admits to using heroin this day; Narcan is administered at 3:24pm for the indication of opiate overdose. Impression is "overdose". Hospital Record 2/27/16 documents R2's diagnosis in the emergency room is heroin overdose.
R2's Social Service Interview for SMI/Substance

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S9999	Continued From page 11 Abuse Disorder dated 8/19/15 documents use of street and prescription drugs, such as, marijuana and heroin. It was documented that the resident used heroin daily. R2 also admitted to being convicted of substance possession. R2's admission social service note dated 8/12/15 documents R2 having a history of heroin and marijuana abuse, and suicide ideation. R2 stated that he checked himself into the hospital prior to his nursing home admission due to being homeless and overwhelmed with his situation. R2's 2/12/16 care plan documents substance abuse/chemical dependency. The approaches/intervention included:to establish a verbal or written behavioral contract specifying what is or is not allowed. Implement increasingly restrictive interventions in effort to break the addictive cycle. Interventions may include: supervision while in the community, restrictive independent pass privileges, implementation of money guidance and budget control to reduce/prevent access to substances. The clinical record lacked documentation that R2 was provided with any substance abuse programs. R2's hospital noted dated 2/27/16 documented R2 admitted he used heroin while in the facility. The hospital record indicated the resident was being treated for a heroin overdose. There was no toxicology lab required, as the resident admitted to the use of heroin. On 2/28/16 at 10:20am, R2 stated that after lunch on 2/27/16 he found a baggie of white powder in the corridor, "snorted it," and doesn't remember anything after that until the paramedics woke him. R2 stated that he (R2) knew it was cocaine or heroin. R2 also stated no one checked on him	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 12 (R2) more often after coming back from hospital on 2/27/16. On 2/29/16 at 3:45pm, E2 (Director of Nursing) stated in the Daily Status Meeting that all documents regarding 15-minute monitoring of R2 have been presented. On 3/2/16 from 11am-12pm, video recorded footage from the second floor was reviewed with E1 (Administrator) and E2 for 2/27/16 11pm through 2/28/16 10:15am. The video shows the facility staff walked through the entire 2nd floor, checking in each room from 2am-2:10am on 2/28/16. This was repeated again at 5:05am, three (3) hours later; Staff did not go into R2's room. From 3:44am to 7:28am, the door to R2 ' s room remained closed and no one entered the room to perform 15-minute checks on R2. R2's care plan for substance abuse/chemical dependency 2/12/16 does not have evidence that it was updated with additional or new interventions regarding the heroin overdose on 2/27/16. On 3/2/16 at 2pm, E2 presented new substance abuse care plans for R2 and R3 dated 2/28/16. E2 stated the care plans were updated after the concern was brought to their attention on 3/1/16. 5. Face Sheet documents R1 is a 53-year old resident admitted to the facility on 2/16/16 with the diagnoses of schizophrenia and major depression. Hospital records dated 2/10/16 documents that R2 has a history of alcohol and recreational drug use. Minimum Data Set dated 2/23/16 Section C - Cognitive Patterns documents R1 is cognitively intact, scores 14 out of 15 on the Brief Interview for Mental Status, and does not have any signs of delirium; Section G - Functional Status R1 is independent with walking in the halls and using the bathroom. Community Survival Skills Assessment dated 2/17/16	S9999	Attachment A Statement of Licensure Violations	

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documents it cannot be determined if R1 can refrain from alcohol and drug use in the community. Interview for Substance Abuse Disorder dated 2/17/16 documents that R1 used alcohol every day, with the last drink being three months ago, and denies the desire to use alcohol at this time.
Physician Order Sheet does not document any orders for monitoring or observing R1 prior to 2/27/16. The facility did not present a policy regarding the routine monitoring of residents on the second floor even after surveyor's request.
Substance Abuse Care Plan dated 2/17/16 documents that R1's history of alcohol abuse and drug seeking behaviors, no interventions are documented for the history of recreational drug use as documented in the hospital records 2/10/16 prior to admission into the facility.
Progress Notes dated 2/27/16, 2:45pm R1 was found unresponsive in the common bathroom on the second floor. The facility called 911; staff started cardiopulmonary resuscitation on R1. Paramedics arrived and administered Narcan (to counteract heroin) to R1, and R1 began to wake up.
Ambulance Run Sheet dated 2/27/16, 2:31pm documents R1 was unresponsive in the bathroom, Narcan was administered at 2:40pm for a suspected opiate overdose, and R1 began to respond. Impression is documented as "overdose".
Both the facility Progress Note 2/27/16, 11:32pm and the hospital drug screen 2/27/16 document R1 is positive for opiates and benzodiazepines.
Hospital History dated 2/27/16, documents that R1, "denies taking drugs in her life. There are other residents here with similar symptoms. Supposedly, there was or were individuals passing out heroin at the nursing home. "
Progress Note dated 2/27/16, 9:39pm, R1 signed

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out of the hospital AMA (against medical advice) and returned to the facility. R1's physician was notified and R1 was petitioned out to the psychiatric hospital.
On 2/29/16 at 10:20am, E9 (Nurse) stated R1 was introducing Z2 (R1's daugther) to all of the residents on 2/27/16 before lunch. R4 asked R1 for Z2's phone number and R1 gave it to him. E9 stated R1 is "drug-seeking and has a history of substance abuse." R1 was asking for more medications during the day on 2/27/16. E9 did not have any information regarding R4's behaviors on 2/27/16.
On 2/28/16 at 9:45am, E1 (Administrator) stated five Emergency Code Blues were called within 40 minutes on 2/27/16 involving R1-R5. The facility knows that Z2 brought in a substance which is unconfirmed as heroin.
On 2/29/16 at 10:45am, E10 (Nurse Aide) stated R1 and Z2 were speaking with R4, and E9 said she, "didn't like what was going on" between them. R4 and R5 went into R1's room with Z2 after lunchtime on 2/27/16. E10 stated she saw R2 "begging" R1 for Z2's phone number. E10 did not tell anyone or other members of the staff about this encounter.
On 2/29/16 at 11am, R6 stated he found R4 and R5 in his (R6) room and doesn't know how they (R4, R5) got there. R4 was asleep on the bed and R5 was asleep on the floor. R6 did not tell anyone that he couldn't wake up R4 and R5 to get them out of his room. R6 stated that he heard "some people were doing drugs" on 2/27/16, but does not know where R4 and R5 got the drugs.
On 2/29/16 at 11:50am, E11 (Nurse) stated R1 has a history of drug abuse and E11 only saw R1 with Z2. After the code blues on 2/27/16, E9 and E10 told E11 that R1 was acting suspicious with Z2 and they both went into a resident room with R4 and R5.

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S9999	Continued From page 15 On review of the Substance Abuse/Chemical Dependency care plan dated 2/17/16, facility staff documented that R1 had a history of self-medicating and alcohol abuse, failure to take responsibility for her actions, use of manipulation and confabulation to continue the substance abuse habit. The care plan approaches/intervention: to establish a verbal or written behavioral contract specifying what is or is not allowed. Implement increasingly restrictive interventions in effort to break the addictive cycle. Interventions may include: supervision while in the community, restrictive independent pass privileges, implementation of money guidance and budget control to reduce/prevent access to substances. The clinical record lacked documentation that R1 was provided with any substance abuse programs On 2/29/16 at 3:15pm, E2 (Director of Nursing) stated R2, R3, R4, and R5 were all on 15-minute monitoring when they returned from the hospital on 2/27/16. On 3/1/16 at 11:05am, E17 (Nurse Aide) stated he saw R1 introduce Z2 to R4 in the 2nd floor hallway. On 3/2/16 at 2:20pm, E19(Nurse) stated that on 2/28/16, the night shift (unknown nurse) told her that R5 was on 15-minute monitoring due to a heroin overdose 2/27/16. E19 last saw R5 between 8-9am on 2/27/16. E21 reported to E19 that R5 was nonresponsive on the floor on 2/28/16 around 10am. Per 11/25/11 facility policy titled, "fifteen-minute monitoring," the facility uses "this guideline to emphasize a proactive intervention promoting enhance physical and psychosocial well-being." The procedures documents in part, "(2) a staff member that has been assigned to care for the resident will visualize the resident every 15	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 16 minutes, (4) if the resident cannot be guided or redirected during the 15minute monitoring, one to one monitoring will be instituted, (5) The physician/psychiatrist will be notified for further evaluation and treatment. " The facility does not have a policy for standard two (2)-hour monitoring of residents. 300.4050a)5 Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S a) The facility shall develop and implement a psychiatric rehabilitation program. A facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are met and subsection (c) (4) is met. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following: 5) Substance dependence and abuse management services, including toxicological screens, psychopharmacology, alcohol and drug education, group interventions, recovery programs (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Mentally Ill Substance Abusers (MISA)), and harm reduction. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to implement and assist with Psychosocial Services regarding substance abuse for 5 of 5 (R1, R2, R3, R4, R5) residents identified with a history of substance abuse in the sample of 5	S9999	Attachment A Statement of Licensure Violations	

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residents. This failure resulted in 5 (R1, R2, R3, R4, R5) residents overdosing on heroin within the facility.

The findings include:

On 2/28/16 at 10:20 AM, R2 stated that he has been a resident for 5 months in the facility. R2 stated on 2/27/16 he saw a bag on the floor in the hallway, picked it up and took some. R2 stated he has not used since 4/29/15 and says he did a stupid thing because "I was out of it." R2 stated it was white powder that was in the bag and he says he sniffed it . R2 stated he thought it was cocaine or heroin. R2 stated that initially he did not feel anything but then "I must have passed out." R2 stated he gave a urine sample to the nurse in the hospital and does not know what it showed. R2 stated he does not attend any psychosocial programming. R2 stated that he does not know how the drugs got into the facility and does not know R1. R2 stated he has done drugs but won't specify.

On 2/28/16 at 10:30 AM, R3 stated that R4 got wind of Z2 (R1's daughter) being a heroin user. R3 sampled a brownish powder that R1 had brought in and knew it to be heroin. R3 stated he had never done heroin before. R3 stated that Z2 had brought in 13 bags of "JAB" and says it is the first time that he knows of the heroin being brought in to the facility. R3 stated that R4 still has some bags of heroin because R4 wanted to be in control of it. E3 stated that R5 was just sent out again this morning. R3 stated that R4 is in his room and is "not coherent upstairs" because R4 seems high. R3 stated that there is a substance abuse group here but he does not have to go because he does not have a problem with chemical dependency. R3 stated that he tried to

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commit suicide a few weeks ago and the facility let him back in and never did anything about it. R3 would not say how he tried to commit suicide.

On 2/28/16 at 10:45 AM, R4 stated that himself, R1, Z2 and Z2's friend added their money together and came up with $100 on 2/27/16. As R4 is talking, he is falling asleep, being incoherent and changing his story. R4 was asked if he still has any heroin, R4 replied, " that was some good s**t!" which he repeated over and over. R4 added, "I want to sell and triple her money in here." R4 stated he is keeping control of the drug so R5 does not overdose again. R4 asked "this is just between me and you, right?" R4 was asked the whereabouts of R5, R4 responded that she was "up in her room." (R4 was not aware that R5 was not in facility at time of interview.) R4 stated that the staff are not watching him anymore then they did prior to the overdose. R4 stated he does what he wants. R4 stated that Z2 came in on 2/27/16 and gave him 3 to 4 baggies of heroin and stated "it's the good stuff". Prior to obtaining the heroin, R4 stated Z2 came into the facility and talked about getting the heroin and then returned with it. R4 would not answer if he had used the heroin this morning or if he had any heroin left. R4 stated the heroin was snorted with a rolled up (money) bill. Throughout the interview, R4 was extremely lethargic, drifting asleep then the next moment he would be up and pacing. At 11:30 AM, E2 (director of nursing) stated that this was probably due to the heroin residual, not his usual demeanor.

On 2/29/16 at 10:45am, E10(Nurse Aide) stated R1 and Z2 were speaking with R4, and E9 (nurse)said to E10 that she " didn ' t like what was going on " between them. R4 and R5 went into R1 ' s room with Z2 after lunchtime on

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2/27/16. E10 stated she saw R2 " begging " R1 for Z2 ' s phone number. E10 did not tell anyone about this encounter even though it was suspicious behavior.
On 2/29/16 at 11 AM, R6 stated he found R4 and R5 in his room getting high after lunch on 2/27/16. R6 stated he saw bags and some empty bags. R6 tried to get them out of his bed because he is trying to get a community apartment and drugs would ruin his chance. R6 stated he does not know where or from whom R4 and R5 got the drugs. R6 stated that the staff tried to put the blame on him by saying R6 brought in the drugs. R6 stated he did not inform any staff of finding R4 and R5 in his room doing drugs.

On 2/29/16 at 11:50 am, E11(Nurse) stated R1 has a history of drug abuse and E11 only saw R1 with Z2. After the code blues on 2/27/16, E9 and E10 told E11 that R1 was acting suspicious with Z2 and they both went into a resident room with R4 and R5.
On 3/1/16 at 1:25 PM, E3 (Psychiatric Rehabilitation Service Director/PRSD) stated that he came in on 2/27/16 at 3:30 PM to the facility and R1 through R5 were already sent out to the hospital. E3 stated the residents are given choices as to what groups to attend. It is an open format for psych-social groups. The residents are not assigned to groups. E3 stated is the resident's decision to attend groups or not. E3 stated there is not a strong attendance tracking policy because the residents were not required to go to groups. E3 stated if a need is identified to attend a certain groups and the resident does not attend the group, pass privileges are revoked. E3 stated the residents are counseled on the need to attend groups and will try to determine why a resident does not want to attend groups and work with that individual. R3 stated that the residents'

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needs along with their diagnoses are used to establish the type of programming that resident will need. This is done on admission and a quarterly basis. E3 stated that there have been no changes in behaviors for R1 through R5 and is not aware of any current drug abuses by R1 through R5. E3 stated that newly admitted residents with a history of substance abuse are placed on a 30 day wait period for a pass privilege to ensure the resident is clean and sober. E3 stated there are 3 levels of pass privileges. Red pass is no outside pass. Yellow pass is a supervised pass with staff or family and green pass is unsupervised for a set period of time. E3 stated R1, R4, R5 are on Red Pass and R3 is on a green pass. E3 was not sure about R2's pass privileges.

Per the facility's incident report dated 2/27/16, R1, R2, R3, R4 and R5 were found in the facility between 2:30 PM to 3:10 PM unresponsive due to overdose of heroin. When the emergency responders entered the facility, Narcan was administered to all 5 residents and all 5 regained consciousness. All 5 were sent out to the hospital for evaluation and stabilization.

On 3/2/16 at 2:33 PM, E5 (Psychiatric Rehabilitation Service Counselor/PRSC) stated she is the assigned PRSC for R1, R2, R3, R4 since her start date of 1/19/16 with the facility. E5 stated E24 (PRSC) use to be their counselor but she only works as needed now. E5 stated R3 was temporarily on a Green Pass so he could attend classes at a local university. E5 stated R3 attends everyday to every other day. When E5 was questioned about the social service entry dated 2/22/16 that documents R3 having thoughts of suicide ideation, E5 stated she did not write that entry. It was written by E6 (PRSC). E5 stated R3

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left the facility on 2/19/16 and attempted suicide by heroin overdose in the community. E5 does not know if a toxicological test was done. E5 stated the hospital probably did a tox screen but she is unable to provide it. E3 stated that drug testing is done when there is suspicion. It is not routinely done.

E5 continued with the interview and stated she returned back to work on 2/22/16 and spoke to R3 about the 2/19/16 incident and informed him to come to her if he has any suicide ideation. E5 stated that upon admission, R3 denied use of drugs. E5 stated the 2/19/16 incident was his first attempt of R3 overdosing and using heroin as far as she knows. E5 stated that R3 informed her that he usually attempts suicide 1 to 2 times a year since he can remember. E5 stated she does not know if or when R3 attends psychosocial groups but knows he sees a psychologist 2 times a week. E5 stated that the over dose on 2/27/16 was not an intended suicide per R3. R3 told E5 that the heroin was dropped in front of him and he was enticed to use it. E5 stated the staff believe R3 snorted it because no needles or devices were found.

On 3/3/16 at 12:16 PM, E2 stated that she looked into the 2/19/16 incident for R3. E2 presented a nurses' note dated 2/19/16 that documents E25 (Licensed Practical Nurse) smelling alcohol on R3 after he came back from being out on pass at 9 PM. R3 denied drinking when asked by E25. E25 asked R3 why he was late returning back from out on pass and R3 claimed his money had been stolen. R3 requested his 9 PM medication which were given. E2 stated that R3 did not report the 2/19/16 suicide ideation to nursing but to the social service department. It is unclear when R3 reported it to social service department and to

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whom. E2 stated that R3 informed staff that he just walked out of the hospital without the hospital staff knowing.

There was no documentation provided or seen to verify this information received by R3. Nor was there a toxicology report provided for the 2/19/16 incident. E2 was able to provide a toxicology report dated 2/22/16 that documents R3 was positive for amphetamines and marijuana, two days after the 2/19/16 incident. This is the only toxicology report the facility had to present for R3 since his admission of 9/30/15.

On 3/2/16 at 3:15 PM, E5 stated that R4 is inconsistent with his addiction day group and is on a RED pass. E5 failed to say and provide documentation on why R5 is not attending his addiction group or what other interventions could be implemented to assist R4 in attending the addiction group.

On 3/2/16 at 3:20 PM, E5 stated that R2 does not receive regular drug testing. E5 stated that R2's psychologist note dated 3/1/16 documents R2 never having any drug rehabilitation except when in the hospital for short term. E5 stated R2 has not been to any addiction group since admission.

On 3/2/16 at 3:50 PM, E5 stated that R1 is very new to the facility. E5 stated that R1 was sent here for depression symptoms. Since R1's admission, E5 stated that R1 has complained of pain and has been drug seeking. E5 stated R1 only reported having a problem with alcohol for 1 year following partner's death and everything going down hill since then, which has been 3 years. E5 stated R1 has not attended any groups. E5 stated she was not aware of R1's diagnosis of schizophrenia because R1 failed to inform E5

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	IL6002075	A. BUILDING: _____ B. WING _____	C 03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	5336 NORTH WESTERN AVENUE CHICAGO, IL 60625

(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
S9999	Continued From page 23 during the intake session. On 3/3/16 at 3:33 PM, E4 (PRSC) stated that she has been employed since 12/21/15. E4 stated that R5 has been on her caseload since mid January 2016. E4 stated that R5 is in the facility due to her substance abuse problem. E4 stated that R5 is to attend Relapse Prevention group but not sure if she does attend. R1's hospital note dated 2/27/16 documents R1 is positive for opioids. This hospital note is after R1 was taken to the hospital after being found unconscious in the facility. R1's initial Minimum Data Set (MDS) dated 2/23/16 documents R1 is a 54 year old ambulatory female, orient times three, and no documented diagnoses. R1's admission date is 2/16/16. R1's hospital face sheet dated 2/10/16 documents R1 was in the psychiatric department for schizophrenia. R1 was evaluated by the emergency department for suicide ideation, delusions and auditory hallucinations. R1 admitted to hearing voices and being depressed. R1 denied alcohol and substance abuse and the hospital tox screen was negative for alcohol. No tox screen for drugs was done. R1 failed to have a Preadmission Screening and Annual Resident Review (PASSAR) done before coming to the facility which would have indicated what psychosocial services are needed for R1. R1's Social Service Interview for SMI (severe mentally ill)/Substance Abuse Disorder dated 2/17/16 documents she has abused alcohol, street drugs and painkillers. R1 stated she has been in treatment for substance abuse in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 24	S9999		

past. R1 claims not to be using at time of interview and has no interest to engage in substance abuse. This assessment done by E5.

R1's 2/17/16 care plan on Substance Abuse/Chemical Dependency documents R1 history of self-medicating and alcohol abuse, failure to take responsibility for her actions, use of manipulation and confabulation to continue the substance abuse habit. The approaches/intervention are to establish a verbal or written behavioral contract specifying what is or is not allowed. Implement increasingly restrictive interventions in effort to break the addictive cycle. Interventions may include: supervision while in the community, restrictive independent pass privileges, implementation of money guidance and budget control to reduce/prevent access to substances.

There was no documentation seen or presented on assisting R1 into a substance abuse program or establishing a behavioral contract.

R2's ambulance run sheet dated 2/27/16 documents R2 admitting to using heroin in the facility and R2 being lethargic with pinpoint pupils. After the Narcan was administered, R2 was alert and orient times three.

R2's quarterly MDS dated 2/12/16 documents a admission date of 8/12/15. The MDS documents R2 as a 58 year old ambulatory male who is orient times three with diagnoses of Depression, Anxiety, Psychotic Disorder, opioid dependence and suicidal/homicidal ideation.

R2's Hospital Information and Transfer Form dated 8/12/15 documents his major diagnoses to include Suicidal and Homicidal ideation. There

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S9999	Continued From page 25 was no PASSAR presented on psychosocial services needed for R2. R2's Social Service Interview for SMI/Substance Abuse Disorder dated 8/19/15 documents use of street and prescription drugs, such as, marijuana and heroin. Heroin being done daily. R2 also admitted to being convicted of substance possession. R2's admission social service note dated 8/12/15 documents R2 having a history of heroin and marijuana abuse, and suicide ideation. R2 stated that he checked himself into the hospital prior to his nursing home admission due to being homeless and overwhelmed with his situation. R2's 2/12/16 care plan documents substance abuse/chemical dependency with same approaches as R1. There was no documentation presented on how the facility is assisting R2 with substance abuse issues. R3's hospital noted dated 2/27/16 documents R3 admitting he used heroin in the facility and the hospital's impression was heroin overdose. There was no tox lab done on R3. R3's quarterly MDS dated 12/30/15 documents his admission date of 9/30/15 and that R3 is a 33 year old ambulatory male who is orient times three with diagnoses that include Depression, Manic Depression, suicidal ideation, Attention Deficit Hyperactivity Disorder and medication non-compliance. R3's hospital inpatient admission form dated 9/24/15 documents he has depressive disorder.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 26 The hospital initial psychiatric evaluation dated 9/24/15 documents R3 has bipolar disorder along with opioid and marijuana abuse. R3 came to the hospital with complaints of being depressed and having a plan of injecting himself with air to cause "air embolism and kill himself". R3 has been homeless and living on the streets and in shelters. R3 stated he has been self-medicating with cannabis as evidenced by the positive urine drug screen. The drug test also showed R3 being positive for amphetamines . R3 claimed the positive amphetamines results is from his Adderall medication for his attention deficit hyperactivity disorder (ADHD). R3 admitted to severe mood swings, racing thoughts, irritability and vacillating with depressive disorder and crying spells. The evaluation also documents that R3 has been a resident in other mentally ill nursing facilities. R3 reported that he has attempted suicide in the past by overdosing on pills. R3's PASSAR assessment dated 7/27/15 was sent to this facility on 10/6/15 per fax from R3's previous mentally ill nursing home. This is 6 days after R3 was admitted to this facility. This PASSAR documents R3 being hospitalized due to being non-compliant with treatment and a history of suicide attempts. R3 stated he wanted to hang himself and had run out of his medications. The assessment documents R3's anti-social behavior, physical violence toward others, his subsequent arrest and getting probation for aggravated battery and his non-compliance with treatment and his suicide attempts. R3 stated he tried to hang himself while in a nursing home and plans on trying it again. The assessment documents that R3 requires medication monitoring along with stabilization and adjustments, mental health rehabilitation services, incentive program to	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 27 improve participation in treatment and substance use/abuse management. R3's Social Service Interview for SMI/Substance Abuse Disorder dated 10/14/15 documents he denied ever abusing alcohol or street or prescription drugs. R3's substance abuse care plan dated 1/23/16 documents the approaches of implementing increasingly restrictive interventions in effort to break the addictive cycle. Interventions may include: supervision while in the community, restrictive independent pass privileges, implementation of money guidance and budget control to reduce/prevent access to substances. This was not done per lack of documentation. On 3/3/16 at 4 PM, E2 presented a social service note dated 3/3/16 that documents that R3 has not been attending college classes and will postpone classes until next fall. Per E5, the reason R3 has an unsupervised community pass was for him to attend college classes yet he has not been going. The facility's sign out sheet documents R3 has been going outside unsupervised from 10/22/15 for 2 hour increments and then increasing it to 8 hours increments per day on 12/12/15. There are copious (to numerous to count) entries of R3 coming and going from the community. There was no verification by staff that R3 was attending college. The sign in/out sheet has a place to document destination. R3 would document "outside", not where he was going. At times, R3's signature and destination were illegible. The facility did not follow their policy as E3 stated above that newly admitted residents with a history of substance abuse are placed on a 30 day wait period for a pass privilege to ensure the resident	S9999	Attachment A Statement of Licensure Violations	

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is clean and sober. R3 was allowed out of the facility within 22 days of admission.

R3's social service note 2/22/16 by E6 (PRSC) documents that R3 is having thoughts of suicide. R3 was educated on not letting difficult times from his past affect all the progression he has made since his admission. There is no psychosocial programming presented or seen on how R3 is assisted with his issues with the exception of being counseled.

R3's 2/23/16 social service note by E5 documents a self harm incident on Friday (2/19/16). E5 and R3 discussed what triggered the event which was a past trauma from his childhood. It documents that they came up with a "safety plan" which includes regular counseling with E5. There is no documentation to support what the "safety plan" entails. The note documents that E5 will work with R3 on finding forms of leisure to enhance his coping abilities. On 3/2/16 at 2:33 PM, E5 stated the safety plan consists of R3 coming to E5 whenever he feels suicidal.

R4's ambulance run sheet dated 2/27/16 documents R4 admitting to drinking vodka and doing heroin in the facility.

R4's 30 day MDS dated 1/23/16 documents his admission date of 12/26/15 and that R4 is a 61 year old ambulatory male who is orient times three with a diagnoses that includes anxiety, depression, suicidal ideation, alcohol abuse, auditory hallucinations and paranoid personality disorder.

R4's PASARR dated 12/29/15 documents R4 requiring services with mental health rehabilitation activities, illness self management, community

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re-integration and substance use/abuse management. The assessment documents a long history of opiate abuse and being in and out of mental hospitals since age 7.

R4's Social Service Interview for SMI/ Substance Abuse Disorder dated 1/5/16 documents R4 has used heroin and alcohol daily. R4 has been in treatment for substance abuse and still has a dependency on heroin and has used recently.

R4's Patient Information and Transfer Form dated 12/26/15 documents R4 having depression, suicidal ideation, being paranoid and having a history of substance abuse. Along with the transfer sheet, there was a toxicology report on alcohol which was negative. There were no other toxicology reports for R4.

R4's care plan dated 1/23/16 on Substance abuse addresses the same interventions as R1, R2 and R3. Another approach is to place R4 on RED pass to avoid triggers and for R4 to attend addiction group consistently. R4 was not attending his addiction group and there was no documentation seen on how the facility staff were assisting him with his substance abuse.

R5's ambulance run sheet dated 2/27/16 documents suspected opioid overdose with R5 being lethargic with pinpoint pupils. After the Narcan was administered, R5 was alert and looking around and saying nothing.

R5's initial MDS dated 1/7/16 documents an admission date of 12/31/15 and that R5 is a 46 year old ambulatory female who is orient times three with no documented diagnoses.

R5's PASARR dated 12/31/15 documents R5 self

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medicates with drugs (alcohol, heroin, marijuana) to cope with her auditory hallucinations. R5 reported she used heroin a day before the hospital admission. R5's diagnoses include Schizo-Affective Disorder. The assessment also documents recent suicidal ideation. R5 requires services in mental health rehabilitation, self illness management, community re-integration and substance use/abuse management.

R5's Social Service Interview for SMI/Substance Abuse Disorder dated 1/7/16 documents R5 having a heroin problem and used as recent as 3 weeks ago. R5 wants to get sober and not be an addict anymore.

R5's care plan dated 1/8/16 on Substance Abuse/Chemical Dependency documents resident reports use of heroin along with her diagnoses of Bipolar and Schizo-affective disorders. The approaches are the same as R1, R2 and R3. There is no documentation on how the facility is assisting R5 with her addictions.

R1's through R5 's social service progress notes are lacking what area are being addressed, the progress or lack of, details of measurable goals and interventions, the techniques that will be utilized on the maintaining or ensuring their sobriety. The progress notes fail to determine why the residents are not attending and implement interventions that will assist resident in attending addiction groups.

On 3/3/16 at 4:30 PM, E2 (Director of Nursing) stated that it has been a challenge with staffing the psychosocial department. E3 (PRSD) has been here 2 months and the longest employed PRSC is E6 who has been here for 6 months.

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The hire dates for E3, E4, E5, E6 and E7 (all are PRSC with the exception of E3 who is the director) were confirmed per documentation provided by E2. E3 was hired on 12/21/15, E4 hired 12/21/16, E5 hired 1/12/16, E6 hired 6/29/15 and E7 hired 2/10/16.

The facility's policy on Admission/Readmission documents a history and physical must be made within 5 days of potential admit and interview of prospective resident, the facility's ability to care for resident/continuity of care and a determination of need/PASARR screen to be completed prior to admission for appropriateness of the resident to nursing home.

The facility's policy on addressing the drug abuse is that if staff suspect the use of illicit drugs or alcohol the resident will be assessed by the nurse, the physician notified, residents' medications will be withheld if the physician indicates it and the resident will be drug screened either by urine or blood sample. This was not done.

The facility's policy titled "Community Pass Policy" documents random bag checks and/or room checks may be performed when a resident comes back from the community with following reasons : a) If the staff have suspicions that the resident has paraphernalia on their possession that compromise the safety of others and b) If the resident appears intoxicated or under the influence of any type of substance. There is no evidence this was followed for R3's 2/19/16 incident nor the 2/27/16 suspicious behavior between R1 and Z2 with R4 and R5.

The facility's "Program Policy" documents it is the philosophy of this organization to offer mentally ill

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S9999	Continued From page 32 resident consistent and therapeutic intervention designed to help each resident acquire the behaviors necessary to function with as much self-determination as possible in the least restrictive environment. The program centers on 4 main pillars, resident assessment/treatment, environmental control, programming and staff training. The resident assessment/treatment involves point of referral/admission screening, taking a detailed history and formulating a realistic and meaningful care plan. Screening should investigate success or failure in previous environments and history of violence (including substance abuse). The environmental control involves taking steps to create a safe and secure living area. This may include granting pass privileges to persons who demonstrate responsibility. Programming addresses medication compliance, in-house support groups and outside programs and living skills. Staff training involves teaching personnel appropriate psychiatric and mental health interventions. Some topics may include intervention skills, such as, setting and enforcing limits and rules. Persons with concomitant substance abuse disorders are appropriate admission if the person expresses a desire to address their problem, seeks assistance in achieving sobriety and acknowledge the importance of following the rules. The facility failed to follow their own program policy. (A)	S9999	Attachment A Statement of Licensure Violations	

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: CONTINENTAL NURSING AND REHABILITATION CENTER
DATE AND TYPE OF SURVEY: March 11, 2016
COMPLAINT # 1681088/IL86389
COMPLAINT # 1681090/IL83693

300.610a)
300.1210a)
300.1210b)
300.1210d)3)6
300.3240a)

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.

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 and psychosocial needs that are identified in the resident's comprehensive assessment.*

b) The facility shall 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 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.

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.

Attachment B
posed Plan of Correction

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

This will be accomplished by:

I. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident legal representative and family member when there is an accident involving the resident which has the potential for requiring physician intervention; a significant change in the resident condition (physical, mental, or psychosocial status – i.e., deterioration in health, mental, or psychosocial in either life threatening conditions or clinical complications); a need to alter treatment (i.e., need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

II. All nursing staff will be in serviced on the facility's policy for physician and legal representative notification of objective observations of a resident's change of condition, including mental and emotional changes, as a means for analyzing and determining care requirement and the need for further medical evaluation and treatment shall be made and recorded in the resident's chart. Also included in the in servicing shall be a plan to develop the systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning, and assessment

III. The facility will 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 and psychosocial needs that are identified in the resident's comprehensive assessment. In servicing must include processes to identify adequate and properly supervised nursing care be provided to each resident to meet the total nursing and personal care needs of the resident.

IV. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record for compliance weekly for six (6) weeks, then quarterly, and on an as needed basis in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

V. Documentation of in-service training will be maintained by the facility.

Attachment B
Imposed Plan of Correction

VI. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through VI to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this notice.

Attachment B
Imposed Plan of Correction