STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009872	A. BUILDING: _____ B. WING _____	C 03/24/2016

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

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S 000	Initial Comments Complaint investigation # 1671424 / IL 84073	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.625k)o) 300.626c) 300.626d)2)3) 300.690a)b)c) 300.1210b) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.625 Identified Offenders k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) o) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.
Section 300.626 Discharge Planning for Identified Offenders
c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department.
d) A facility that admits or retains an identified offender shall have in place policies and procedures for the discharge of an identified offender for reasons related to the individual's status as an identified offender, including, but not limited to:
2) The facility's inability to provide the security measures necessary to protect facility residents, staff and visitors; or
3) The physical safety of the resident, other residents, the facility staff, or facility visitors.
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.

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S9999	Continued From page 2 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 summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care 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. 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) These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to identify, assess and prevent resident behavior of illegal drug use in the	S9999		

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facility. This failure resulted in two residents overdosing on opioid narcotics which required emergency 911 services and the administration of narcan (an opioid antidote) to prevent respiratory arrest and death.

This applies to two of five (R2 and R3) residents reviewed for behaviors involving substance abuse in a total sample of eight residents.

The findings include:

According to a Fire Department ambulance run report dated March 8, 2016, the fire department arrived at the facility for two people showing signs of a drug overdose. The report shows both residents were unconscious with slow respiratory rates and pinpoint pupils.

1. According to the Hospital Emergency Department notes dated March 8, 2016, R3 had diagnosis of heroin use. The ED (Emergency Department) Records shows EMS (Emergency Medical Services) was called to the facility where R3 was unresponsive with snoring respirations. EMS had given Narcan 2 mg(milligrams) intranasally and R3 responded. An ED note at 7:17pm shows R3 admitted to snorting heroin.

On March 23 2016 at 9:55am R3 said he did one line of heroin but "the heroin (he inhaled) must have been a bad batch, it may have been cut with fentanyl" on March 8, 2016. R3 stated he almost died on March 8, 2016 but admits to snorting one or two lines of heroin once or twice a week for the past six to seven months while a resident in the facility. R3 stated he would take the heroin with R2 and R5 and it was always in R5's room. R3 said R5 had gotten the heroin. R3 said Friday night was considered party night.

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On March 23, 2016 at 9:15am Z2 (Emergency Department Doctor) stated R3 had admitted to snorting heroin when he had been brought into the ED with another resident from the same facility. He said R3 had responded to the administration of Narcan. Z2 said when a person has an overdose of heroin the person could go into respiratory arrest and eventual death if Narcan was not given.

According to the March 2016 POS (Physician Order Sheet) R3 had diagnoses including schizoaffective disorder, morbid obesity and depressive disorder. The MDS (Minimum Data Set) dated January 20, 2016 shows R3 is cognitively intact and does not need ambulation assistance from staff. A Substance Abuse Assessment dated January 20, 2016 shows R3 had previously used alcohol, marijuana and cocaine. R3 did not have a care plan for behaviors of substance abuse until March 8, 2016.

2. According to the ED records dated March 8, 2016 R2 had a diagnoses of intentional drug overdose. The notes show R2 said he took an undisclosed amount of Norco (A combination medication of acetaminophen and hydrocodone. Hydrocodone is an opioid pain medication). The notes show R2's laboratory studies are not consistent with any sort of acetaminophen overdose and based on presentation to the ED, heroin is more likely the cause.

The fire department run report dated March 8, 2016 at 6:27pm R2 had a labored, irregular respiratory rate of 10 breaths per minute, bilateral decreased breath sounds and two millimeter constricted pupils bilaterally with a sluggish

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response. Narcan two milligrams was given via nasal atomizer at 6:29pm with improved respirations. Another dose of Narcan two milligrams was given at 6:31pm with an improved level of consciousness.

According to the March 2016 POS R2 had diagnoses including bipolar disorder, obesity, psychotic disorder with delusional conditions, sedative abuse and cocaine abuse. The POS also showed an order for (Norco) hydrocodone 5mg/acetaminophen 325mg tablet every six hours as needed for pain. Review of the February and March 2016 MAR (Medication Administration Record) shows R2 had only received this medication twice on January 11, 2016; once on January 22, 2016; once on January 28, 2016; and none in February.

A substance abuse care plan showed R2 had been sent to the hospital for intake of heroin on April 8, 2015 and an episode of drinking on July 20, 2015 while a resident in the facility. R2 also had a history of aggressive behavior manifested by ineffective coping mechanisms care plan.

On March 22, 2016 at 10:40am E2 DON (Director of Nursing) stated R2 reported he had taken a Norco overdose from medication he had been saving. E2 said she didn't believe R2 could have saved up any Norco because she has seen him take his medication and believes they would have been found during a room search. E2 stated R3 had admitted to her R5 had brought the heroin into the facility. E2 said she had heard R5 had brought in heroin in the past but R5 was never found with any heroin. She said
she had heard a rumor R5 had been suspected of distributing narcotics at his previous facility. E2 stated random room searches had been done

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three times a week prior to the incident on March 8, 2016. When asked, E2 said the facility didn't do an incident report regarding the incident of March 8, 2016 or notify IDPH (Illinois Department of Public Health) because it was a resident behavior and was treated as a behavior. E2 stated this was an unusual occurrence but did not think this behavior resulted in an injury. E2 said R2 and R5 could have died if they hadn't received Narcan and said Narcan administration was more than a first aid treatment.

On March 21, 2016 at 2:15pm E4 PRSD (Psychiatric Rehab Services Director) said both R2 and R3 were known substance abusers. E4 stated the facility had suspicions R5 was bringing heroin into the facility.

On March 23, 2016 at 10:15am E4 stated R5 had the same level of hourly monitoring checks as all the other residents. R5 did not have any increased behavior monitoring.

The facility's Discharge Report show R5 was discharged to home on March 17, 2016 and was no longer in the facility. While R5 was in the facility his room was the last room at the end of the hallway and his roommate was R7.

On March 23, 2016 at 9:45am R7 said R5 always had friends (including R2 and R3) and visitors in the room.

On March 23, 2016 at 9:50am R4 said R5 would have a male visitor several times a week come for short visits lasting approximately 10 minutes. R4 said R5 and the visitor would go to R5's room then leave after a short time.

On March 21, 2016 at 3:05pm E6 LPN (Licensed

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S9999	Continued From page 7	S9999		

Practical Nurse) stated on March 8, 2016 R3 who was unresponsive with a low heart rate. 911 was called. At the same time E6 said R2 had also become unresponsive. E6 said a room search was done after R2 and R3 were taken to the hospital but said he was unsure why the room search was done.

On March 22, 2016 at 9:42am E10 CNA (Certified Nursing Assistant) stated on March 8th at approximately 6:15 or 6:30pm during dinner in the dining room, an unidentified resident said R3 might be drunk. E10 said R3 was in the chair with his head back and looked like he was turning gray. E10 said R2 on the other side of the dining room as if he passed out and was leaning against the vending machine. E10 said 911 was called for both residents. E10 overheard the paramedics state it was definitely opioid use since the residents had responded to the Narcan given.

On March 22, 2016 at 4:15pm E7 (Psych Social Case Manager) stated on March 8 2016 around dinner time, E6 reported two residents "might be high" and 911 was called. E7 said R3 was unresponsive seated in a chair and had turned a dark blue color. E7 noticed R5 had hurriedly left the dining room while staff was responding to R2 and R3. When R2 and R3 had been with the paramedics, a room search was started. E7 said she first went to R5's room to search since he had left the dining room so quickly, he had an incident last year in which he tested positive for drugs. E7 explained R5 was a moderate risk identified offender for drug possession and had been suspected of substance abuse. She said R5's plan of care included weekly meetings but R5's supervision wasn't any different than any other resident. E7 said sometime after Christmas 2015 R5 had a new male cousin who started

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visiting several times a week for short visits. E7 stated R5 was an independent level for privileges and expectations.

On March 22, 2016 at 4:03pm E8 CNA stated residents including R2 and R3 would always go into R5's room. E8 stated she was unaware if R5 had any drug or substance abuse problems. E8 said R5 was monitored the same as all the residents.

On March 22, 2016 at 12:55pm R6 said several weeks ago (thinks it may have been in February 2016) she had opened R5's door and saw R2, R3 and R5 in the room. R6 said there was a white powder substance and thought R2, R3 and R5 might have been doing drugs so R6 closed the door and left. R6 stated she told several of the counselors but couldn't recall who she told.

On March 21, 2016 at 3:30pm E1 (Administrator) said he was the interim administrator from corporate and wasn't here on March 8, 2016 but was aware of the event. E1 stated the facility along with the corporate office felt the incident was considered a behavior, treated as a behavior and didn't feel the incident required an incident report or notification to IDPH.

The facility's policy of Admission of Residents with Severe Persistent Mental Illness, Substance Abuse Disorder and/or a Criminal History (part of the Resident Incentive and Contingency Management Program dated May 2014) shows "The IDT (Interdisciplinary team) is responsible for monitoring the resident for mental health symptoms, including mood state/behavior status changes, changes in level of anxiety, verbalization of threats (towards oneself or others) and any suspected use of alcohol or illicit

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drugs. The psychiatric rehabilitation staff will complete the organization's standardized assessment packet and develop an interim plan of care, as warranted." The program also includes residents must "Abstain from possession or use of alcohol and non-prescribed drugs. Make sure you do not possess any weapons, objects that might be used as weapons, drug paraphernalia or other illegal/contraband items."

The facility's undated Substance Abuse Policy includes "The facility reserves the right to protect all residents, staff, and visitors from the negative effects of substance abuse. The facility will take all precautions necessary to prevent residents from using alcohol or illegal substances."

On March 23, 2016 at 10:35am E9 Assistant Administrator, stated the facility was suspicious R5 was involved with bringing heroin into the building on March 8, 2016. E9 said R5 had visitors several times a week but he would usually go outside with them. When asked if any of the multiple short visits were a concern, E9 responded the visitors were suspicious but the facility couldn't prove anything. The facility never found any drugs in R5's possession. E9 stated the police had explained heroin could be in a very small packet which is easy to hide and might not be able to find. R5's room was at the end of the hall with the same hourly observations as the rest of the resident population. When asked if this was an appropriate intervention for an identified offender for substance possession and the facility had suspicions of drug possession, E9 responded R5 "liked his privacy; he was polite, nice, a model resident really." E9 said "It is a fine line to respect someone's privacy or invading it." Regarding R2 and R3's heroin overdose E9 said this was resident behavior and didn't think an

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incident report or notification to IDPH needed to be done. It wasn't considered an emergency.

According to the police report dated March 8, 2016 the staff does not believe (R2) could have been saving the Norco as they conduct random room checks. It continues to include "The staff felt that heroin coming in from the outside was far more likely. They also informed me (R2) often hangs out with another patient who has been caught bringing heroin into the facility in the past."

On March 23, 2016 at 10:32pm Z1 Police Officer stated he had been told by the nursing staff at the facility they had an idea of which resident was bringing it in.

According to the Criminal History Analysis Security Recommendation Report dated April 7, 2015, R5 had Mental Illness/Substance Abuse and was a "Moderate Risk-The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the the level of supervision is sufficient. His compliance with psychiatric treatment and abstinence from alcohol/drug use should be closely monitored. In view of his criminal history and psychiatric history, a moderate risk supervision status is recommended."

R5's Identified Offender care plan shows in intervention to provide closer observation or monitoring than the standard protocol.

Based on the investigation, the facility failed to

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S9999	Continued From page 11 implement any additional interventions for R5 a known Identified Offender for illegal substance possession. They failed to have interventions in place for R3 a resident with history of substance abuse. As a result of these failures, two residents, R2 and R3 sustained a suspected overdose of heroin which required a call to 911 and the immediate use of narcan, an opioid antidote, to avoid death. The facility did not feel this behavior resulted in an injury. The facility did not do an incident report including an investigation or reporting of the incident to IDPH. (A)	S9999		

Imposed Plan of Correction

Facility Name: West Chicago Terrace

Survey Date: March 24, 2016

Complaint : #1671424/IL84073

Violation : A

300.610a)

300.625k)

300.626c)

600.626d)2)3)

300.690a)b)c)

300.1210b)

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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.625 Identified Offenders

k) *The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan.* (Section 2-201.6(f) of the Act)

o) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall identify whether the incident involves substance abuse, aggressive

behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.

Section 300.626 Discharge Planning for Identified Offenders

c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department.

d) A facility that admits or retains an identified offender shall have in place policies and procedures for the discharge of an identified offender for reasons related to the individual's status as an identified offender, including, but not limited to:

2) The facility's inability to provide the security measures necessary to protect facility residents, staff and visitors; or

3) The physical safety of the resident, other residents, the facility staff, or facility visitors

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

Section 300.1210 General Requirements for Nursing and Personal Care

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.

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:

1. A committee consisting of, at a minimum, the Medical Director, the Administrator and the Director of Nursing (DON) will review and revise the policies and procedures regarding Identified Offenders and Abuse and Neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

   A. Recognition of situations that could be interpreted as abusive or neglectful.
   B. Appropriate reporting procedures for staff.
   C. Appropriate and thorough investigations of alleged abuse or neglect.
   D. The facility's responsibilities to prevent further potential abuse while the investigation is in progress.
   E. The facility taking appropriate corrective action when an alleged violation is verified.

2. The facility will conduct mandatory in-services for all staff with 30 days that addresses , at a minimum, the following:
   A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this plan of correction.
   B. The assessment, care planning, appropriate interventions and monitoring of residents who are Identified Offenders, including incorporating Criminal History Analysis Security Recommendation Report.
   C. How to recognize behaviors that may indicate inappropriate behaviors that may require closer and more frequent observation than standard or routine for most residents in an open facility.
   D. Documentation of these in-services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the administrator's office.

3. The following action will be taken to prevent re-occurrence:
   A. The above in-service will be reviewed with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations and incident reporting and follow up are followed.

4. The Administrator and the Director or Nursing will monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Correction.