| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING: _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 1 | S9999 | | |

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

This requirement is not met as evidenced by:

Based on interview, and record review the facility failed to document and report to the State Agency, three elopements, and failed to transcribe and administer the proper dosage of a medication, and failed to notify the physician of the medication error and change of condition for one resident of five, (R3) reviewed for accidents and incidents, in a sample of five.

Findings include:

The facility's Abuse Prevention Program Facility Procedures, dated 9/2106, documents "Internal Investigation: All incidents will be documented,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING: _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 2 | S9999 | | |

whether or not abuse, neglect, mistreatment or misappropriation of resident property occurred, was alleged or suspected.

The facility's Reporting of Unusual Occurrences, dated 1/17, documents "All occurrences will be recorded on the designated occurrence form and tracked. This includes occurrences to residents staff and visitors...Occurrence Forms are completed for all...occurrences where there is an injury or the potential to result in injury...The Health Care Provider as well as the family is notified of the incident."

The facility's Medication Error Documentation Policy, dated 1/17, documents "An event/med error from is completed for all Medication errors. The DON (Director of Nursing) reviews medications errors and reports them as appropriate. All medication errors are reported to the Health Care Provider. Upon discovering the error, a consumer observation is completed by the nurse. Documentation of the consumer observation is placed in the progress notes, as well as any follow-up documentation required. A root cause analysis is completed by the DON or designee to determine the cause of the error"

R3's Nurses Notes, dated 11/17/16 documents that R3 was admitted to the facility with a diagnosis of Schizoaffective Disorder.

R3's Nurses Notes, dated 11/18/16 documents that R3 was packing R3's clothing, to leave the facility. R3 stated "I can do anything I want don't try to change it." R3 then left the facility AMA (against medical advice). This same form documents that Z1 (R3's Mother) and the local police department were notified. R3 returned to the facility at 7:30am on 11/19/16.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING: _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 3 | S9999 | | |

R3's Nurses Notes, dated 11/20/16 at 12:30pm, documents that R3 ran out of the facility. This same form documents that R3 returned to the facility at 6:00pm. R3 was then transferred to the local Psychiatric Hospital for evaluation and treatment.

R3's Social Service Notes documents that R3 left the facility at 11:30pm on 11/18/16, then returned at 7:30am on 11/19/16. R3 left the building AMA again on 11/20/16 at 1:18pm, then returned and was discharged to the local hospital. R3 was readmitted to the facility on 12/21/16, then left the facility AMA on 12/24/16. R3 was then discharged to the local hospital.

R3's Nurses Notes, dated 12/21/16, documents that R3 was readmitted to the facility. This same form documents that R3 is alert and oriented to person, place, and time.

R3's Discharge Instructions, dated 12/21/16, documents the following medication orders:
1.Clozapine (antipsychotic) 200mg (Milligrams) take one tablet together with 3 tablets of 25mg Clozapine for a total daily dose of 275mg.
2.Clozapine 25mg take 3 tablets by mouth nightly together with 200mg of Clozapine for total nightly dose of 275mg. R3's complete blood count labs were sent with his discharge papers, so that there would be no delay in R3 receiving the medication.

R3's Medication Administration Form, dated 12/21/16 through 12/31/16, documents to give Clozapine 200mg every night. There is no documentation of giving the other 75mg of Clozapine. This same form has no documentation of R3 receiving the medication on the night of admission, 12/21/16.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 4 | S9999 | | |

R3's Nurses Notes, dated 12/24/16 at 8:05am, documents that staff reported that R3 left the building. R3 returned to the facility at 4:55pm, R3 was sent to a Psychiatric Hospital for an evaluation and treatment, due to R3 expressing that he is hearing voices, the voice told R3 to go to Navy Peer.

On 1/9/17 at 1:50pm, E7, Licensed Practical Nurse, verified that E7 completed R3's admission on 12/21/16. E7 verified that E7 did not transcribe R3's admission medication orders properly. E7 stated that R3 did not receive his nightly medications, because the medication was not in from the pharmacy. E7 also stated that E7 faxed the proper lab work to the pharmacy, so there would not be a hold up on him getting the medication. E7 stated that the next pharmacy delivery would be between 5:00am and 6:00am. E7 stated that Clozapine is not a drug that is supplied in the medication convince box. E7 also verified that R3 was alert and oriented to person, place, and time at the time of his admission. E7 that Z1 (R3's Mother) had called several times that day to make sure all of R3's medications would be in and given.

On 1/9/17 at 10:11am, Z1 (R3's Mother) verified that Z1 called the facility several times on 12/21/16, to make sure that all of R3's medication would be given that evening. Z1 stated Z1 even enquired about R3's lab work, to make sure it was up to date, so there would not be a delay in R3 receiving his medication. Z1 stated that E2, DON, and E3, SSD, (Social Service Director) ensured Z1 that all of R3's orders have been received, and would be taken care of prior to R3's admission. Z1 stated that Z1 even spoke with E7 on the evening of 12/21/16 to make sure R3 was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING: _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 5 | S9999 | | |

going to receive his evening medication. Z1 stated that E7 did verify the R3 would get his medications as ordered. Z1 stated that she found out that R3 was receiving the wrong dose of Clozapine, when he was admitted to the hospital on 12/24/16.

On 1/9/17, E2, DON (Director of Nursing) verified that there were no incident or accident reports concerning R3's elopements. E2 also stated that the only time R3's physician was notified of the elopements was when R3 was sent to the hospital. E2 stated that the State Agency was never notified of any of R3's elopements. E2 verified that R3's medications were transcribed wrong, and this is a medication error. E2 stated that R3's physicians were not notified, nor was a medication error form filled out, as it is in the facility policy. E2 also stated that Z1 was not notified of the medication error. E2 also stated that R3 would not have received his nightly dose of Clozapine, because it is not a medication that is kept in stock. E2 verified that the pharmacy delivers two times a day, around 5:00am and 5:00pm. E2 stated that E2 was not aware of R3's medication error until State Agency pointed it out.

On 1/9/17 at 2:00pm, E1, Administrator, verified that there were no incident or accident reports filed, concerning R3's elopements, nor was the State Agency notified. E2 also stated R3's physician should of been notified of the incidents. E1 verified that Z2 (Psychiatrist) should of have notified of R3 not receiving the Clozapine on the night of his admission, and also not receiving the proper dosage. Z2 should have also been notified of R3's increase in agitation, and hallucinations.

On 12/24/16, E3, Social Service Director, verified that R3 had eloped from the facility again on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ILL6006290 | A. BUILDING: _____ B. WING _____ | C 01/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE PAV HLTH/TREATMENT CTR | 1400 WEST MONROE STREET CHICAGO, IL 60607 |

| (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 6<br>12/24/16. E3 stated that there were no incident and accidents reports filed for R3's elopements, nor was the State Agency's notified. E3 stated that the physicians were notified only when R3 was transferred to the local hospital.<br><br>(B) | S9999 | | |