

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/28/2017
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NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3311 S. MICHIGAN AVE. CHICAGO, IL 60616
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S 000	Initial Comments Complaint Investigations: 1781491/IL92471-No Findings 1781551/IL92534-G conversion 1781625/IL92617-300.615e) f) j) cited 1781653/IL92654-G conversion 1781712/IL92712-G conversion	S 000		
S9999	Final Observations Statement Licensure Violations: 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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. 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: 6) All necessary precautions shall be taken	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violation</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/11/17

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to make sure exit door alarms are</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>functioning to alert staff when a resident left the nursing unit via a stairwell and failed to have individualize care plan interventions for monitoring a resident with a known exit seeking behavior. This applies to one of three residents (R5) reviewed for falls, in a sample of 8. This failure resulted in R5 falling and sustaining an injury (acute displaced trimalleolar fracture right ankle with tibiotalar dislocation-right ankle fracture) consistent with fall down the stairs.</p> <p>Findings include:</p> <p>Review of R5's medical record (Face Sheet) notes diagnoses including but not limited to: Schizoaffective Disorder, Complete Traumatic Amputation of Two or More Left Lesser Toes, Lack of Coordination, Difficulty Walking, Muscle Weakness, Diabetes Mellitus, Hypertension and Heart Failure.</p> <p>R5's MDS (Minimum Data Set, 02/20/2017) notes R5 requires extensive assistance with one person physical assist for locomotion off unit.</p> <p>Progress Notes documented in part: (03/13/2017 at 11:12 AM) Resident c/o (complaining of) right ankle pain. Right ankle observed with swelling. Resident stated he fell but was unable to provide details of how and when (R5) fell. (2:18 PM) Resident admitted to (hospital) with diagnosis of Right ankle fracture(.)Fracture of 9th and 10th Rib and Tibia dislocation. (02/16/2017 at 6:40 AM) Resident needs constant redirections, resident mobility decrease and needs close monitoring to prevent falls, will continue to monitor. (02/14/2017 at 1:27 PM) At times requires assist with ambulation. (2/13/2017 at 6:27 AM) Up and about with</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>unsteady gait. (10/17/2016 at 9:44 AM) Resident frequently states (R5) can not recall where (R5) is going or why (R5) is on floors other than (R5's). Wanders from floor to floor with seemingly no destination. When redirection attempted (R5) can become verbally aggressive. (10/16/2016 at 10:00 PM) Resident amb (ambulating) on unit needs redirection thru out the shift to keep off stairwell d/t (due to) unsteady gait at times. (09/23/2016 at 11:24 AM) Resident frequently states (R5) can not recall where (R5) is going or why (R5) is on floors other than (R5's). (08/25/2016 at 10:20) Writer met with resident after observing (R5) wandering down hallway. (07/17/2016 at 10:18 PM) Resident redirected x3 this shift cont(continues to exit stairwell against staff advice for safety. (07/15/2016 at 12:28 PM) Resident is up and about hard to redirect multiple attempts to exit unit via doors and stairs monitor closely by staff. (07/14/2016 at 2:11 PM) Reported by staff resident was sitting in stairwell, resident stated (R5) fell. Review of R5's "Unauthorized Departure/Elopement Risk Assessment" (02/20/2017) notes in part, "Not responding favorably to staff re-directing when wandering and/or "hanging around" facility exits, elevators, or other inappropriate areas." No care plan to address R5's exit seeking behavior was found.</p> <p>Copies of R5's electronic "Observation Record (s)" for March 2017 were provided. No records are found for 03/01, 03/02, 03/04 and 03/05/2017. No record was found for 03/12/2017, the day R5 fell.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>The record use for nursing monitoring of residents dated 03/06/2017 record documents no checks were completed on the midnight shift. According to E1 (Administrator, 03/28/2017 at 9:25 AM) staff were to complete hourly checks on R5 on the midnight shift.</p> <p>The facility's final incident report (03/19/2017) denotes in part, resident is confused and requires constant redirection. Resident attempted to self-ambulate, fell and sustained injuries due to the fall. Resident's plan of care was being followed and resident was being monitored for safety.</p> <p>The facility's investigation, denotes in part, R5 is oriented to person and place only. Predisposing physiological factors include gait imbalance and impaired memory; predisposing situation factors include active exit seeker, ambulating without assist.</p> <p>R5's hospital record (Emergency Documentation of 03/13/2017) denotes in part, (R5) presents to the emergency department primarily for a right ankle deformity. (R5) states (R5) fell last night. Patient does not recall the events of the fall. Right 9th and 10th rib fracture fracture(s) present on x-ray. Right ankle x-ray consistent with trimalleolar fracture/dislocation. Z3(Physician) said R5's right ankle fracture was not consistent with a fall from a low bed; it was consistent with a fall from higher height or fall down stairs.</p> <p>E2 (DON, 03/26/2017 at 10:23 AM) said in part, R5 always used to walk down stairwell and people would bring R5 back to R5's unit; inservices related to residents no longer allowed to use stairwells were not initiated until IDPH (Illinois Department of Public Health) surveyor</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>began investigation into R5's fall; key codes to stairwells were not working and alarms to stairwells on two floors were not working (thought 4th and 5th floors).</p> <p>On 03/28/2017 at 9:56 AM, E6 (LPN-Licensed Practical Nurse) and E21 (LPN) were observed exiting the stairwell to the 4th floor. The alarm did not sound. This writer waited for the door to close then exited the stairwell, the alarm did not sound; the key pad was not lit.</p> <p>E1 (Administrator, 03/28/2017 at 9:25 AM) said changing keypad codes was in the works before the surveyor entered on 03/14/2017 (although provided documentation notes inservices on 03/16/2017, one form has no date); some keypads could not be reprogrammed and need to be replaced (documentation provided noting parts on order).</p> <p>E11 (RN-Registered Nurse, 03/24/2017 at 8:54 AM) said in part, R5 did attempt to get out of bed, however was re-directed by staff. E11 said because of the degree of R5's injuries, R5 couldn't have sustained those types of injuries from a fall from a low bed.</p> <p>E9 (CNA-Certified Nursing Assistant, 03/23/2017 at 5:57 PM) and E10 (CNA, 03/23/2017 at 6:08 PM) both said in part, R5 would try to get off the unit via the stairwell.</p> <p>E14 (Security Guard, 03/26/2017 at 4:00 AM) E15 (Security Guard, 03.26.2017 at 4:51 AM) said in part, that E14 heard a resident fell in the stairwell and was sent to the hospital. E15 (Security Guard, 03.26.2017 at 4:51 AM) said in part, that E14 heard a resident fell in the stairwell and was put back to bed by staff. E15</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>said E15 attended an inservice to inform staff that residents are no longer to use the stairwell. E15 said E15 was told by E6 a resident fell and sustained an injury.</p> <p>E7 (LPN, 03/23/2017 at 2:34 PM) said in part, R5 would try to sneak down the stairwell, so staff would monitor more frequently than every two hours; we would go get (R5) before (R5) could get down the stairwell and bring (R5) back to an area where (R5) could be observed more closely.</p> <p>Z7 (Confidential Interview) said in part, Z7 heard a resident fell down a stairwell about 2 weeks ago and that's why residents are no longer allowed to use stairwells.</p> <p>Z8 (Confidential Interview) said in part, Z8 heard a resident fell down a stairwell a few weeks ago.</p> <p>Z9 (Confidential Interview) said in part, we heard a resident fell down stairs approximately 2 weeks ago, that's why residents can't use stairwells.</p> <p>Z10 (Confidential Interview) said residents can no longer use the stairwells because a resident fell in stairwell.</p> <p>Z11 (Confidential Interview) said Z11 heard about a resident falling down the stairs and it was (R5) from the 4th floor.</p> <p>Z12 (Confidential Interview) said Z12 heard a few weeks ago that resident fell down a stairwell.</p> <p>(B)</p> <p>300.615 e) f) j)</p> <p>Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information</p> <p>e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)</p> <p>f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.</p> <p>j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow their abuse policy and procedure and admission contract by failing to complete criminal background checks on one of three residents (R2) reviewed for criminal background checks.</p> <p>Findings include:</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>Review of R2's medical record (Face Sheet) notes R1 was admitted to the facility on 03/07/2012. R2's "Aggression and Violence History and Screening Assessment (effective 03/24/2017) notes in part, "(R2) has a history of aggressive behavior towards peers. Resident had a recent verbal/physical aggressive behavior toward a peer."</p> <p>R2 (03/23/2017 at 11:40 AM) said in part, (R2) was arrested a few times for offenses including disorderly conduct and domestic violence 15 or 16 years ago and served about 4 years in prison for these offenses. R2 also admitted to paying R1 to have sex with (R2). "(R1) told me (R1) needed money. I would give (R1) \$5-\$10 to have sex with me, but not all the time. I paid R1 more than once."</p> <p>R2 is not listed on the "Identified Offenders as of 03/02/2017" provided by the facility.</p> <p>Review of Criminal History Data (03/28/2017) notes in part R2 was convicted of and served time from 1994-1997 for crimes including: "Viol/Order, Knowingly Damage Property, Criminal Damage to Property, Violate Order Protection and Domestic Battery."</p> <p>E1 (Administrator, 03/17/2017 at 12:05 PM) said in part, the facility did not have a criminal history background check for R2.</p> <p>The facility's "Abuse Prevention Program" policy and procedure (08/25/2016, page 1 of 10) states in part: (II Pre-Admission Screening of Potential Residents) "This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will:</p>	S9999		
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S9999	<p>Continued From page 9</p> <ul style="list-style-type: none"> -Request a Criminal History Background Check within 24 hours after admission of a new resident, -Check for the resident's name on the Illinois Sex Offender Registration Website, -Check for the resident's name on Illinois Department of Corrections sex registrant search page, -While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents." <p>The facility's Admission Contract ("Illinois Council on Long Term Care Standardized Admission Packet" 2017) notes in part: (under Resident Criminal History Background Checks Identified Offender Notification Procedures) "It is the policy of this facility to establish a sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background of any resident seeking admission to the facility in order to identify previous criminal convictions."</p> <p>(B)</p>	S9999		
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