

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/04/2017
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NAME OF PROVIDER OR SUPPLIER VERACARE BURBANK	STREET ADDRESS, CITY, STATE, ZIP CODE 5400 WEST 87TH STREET BURBANK, IL 60459
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S 000	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>1791455/IL92429 - Refer to 300.3300y)</p> <p>1791788/IL92799 - Refer to 300.690a)c)</p> <p>1791825/IL92834 - Refer to 300.690a)c)</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.690 a) c)</p> <p>Section 300.690 Incidents and Accidents</p> <p>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.</p> <p>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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

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

TITLE

(X6) DATE

04/28/17

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Based on interview and record review the facility failed to report to the state agency and write an incident report for an elopement for one resident (R1) out of four reviewed for elopement.</p> <p>Findings Include:</p> <p>R1 was admitted to the facility on 1/27/17.</p> <p>R1's face sheet diagnoses include alcohol liver disease, nicotine dependence, diabetes mellitus, hypertension and bipolar disorder. R1's Minimum Data Set (MDS) dated 2/3/17 indicates that R1 had a Brief Interview for Mental Status of 11; R1's functional status for locomotion off the unit indicates that R1 required limited assistance from one person.</p> <p>On 3/23/17 at 11:58 am E10 Licensed Practical Nurse (LPN) stated that R1's elopement risk assessment was initiated on 2/6/17 because R1 left the facility without notifying facility staff.</p> <p>R1's nursing note dated 2/2/17 indicates that Z2 (R1's Physician) gave a standing order for R1 to go out on pass with family.</p> <p>R1's nursing note dated 2/6/17 at 10:10 am indicates: R1 was noted ambulating to neighboring bank independently; two nurses were able to re-direct R1 back to the facility.</p> <p>R1's nursing note dated 2/6/17 at 10:32 am</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>indicates the following: per Administrator R1 is alert and oriented times 3; does not need an electronic elopement device; is encouraged to ask staff for assistance when he wants to go outside; R1 will continued to be monitored.</p> <p>R1's Elopement care plan initiated 1/30/2017 indicates that R1 is an elopement risk/wanderer related to disoriented to place, impaired safety awareness.</p> <p>R1's elopement care plan revised 2/6/17 indicates that R1 is not a wanderer/elopement risk per Administrator.</p> <p>R1's nursing note dated 2/14/17 at 3:30 pm indicates: writer was alerted that R1 was not in his room or inside building after searching entirely throughout; code white was announced and search put into effect; called R1's cell phone and R1 stated that he was at work on his job; R1 stated that the cab was on its way to pick him up; after talking for several more minutes R1 stated that he was not in his right mind at this moment and the he was on 80th; with more conversation R1 stated that he was at a local fast food restaurant and that a family member was on the way; R1 was picked up by staff and returned to the facility.</p> <p>On 3/23/17 E8 Social Services stated that he had R1 sign the behavioral contract after R1 left the facility without notifying staff. E8 stated that R1 had periods when he was alert and oriented and other periods when he was not oriented.</p> <p>On 3/27/17 at 10:26 am E13 Licensed Practical Nurse (LPN) stated that R1 left the facility without informing the staff. E13 stated that R1's cell phone was called and when he answered he</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>stated that he was meeting his wife at a local restaurant. E13 stated that staff brought R1 back to the facility; the rules for leaving the facility were explained to R1; R1 was placed on close monitoring and the staff was in-serviced.</p> <p>R1's nursing note dated 2/18/17 indicates that: at 3:00 pm R1 was agitated and left the facility, stating he wanted to leave and go home; started walking west on a main street; unable to re-direct back to facility; called police for assistance; police was able to convince R1 to return call to family; family made aware of incident.</p> <p>R1's nursing note dated 2/19/17 at 6:51 am indicates: 2:00 am R1 was agitated again and attempted to leave facility, stating that he wants to buy a cigar; R1 started walking toward main door; Certified Nursing Assistant (CNA) called nurse to assist and local police was called; police able to convince R1 to calm down unit morning; message left for family and Director of Nursing (DON) gave order to transfer R1 to hospital in the morning.</p> <p>R1's nursing notes dated 2/19/17 at 7:45am indicates that upon rounds R1 was not in room or unit; code white (missing person per DON) in progress; room to room search throughout building; cannot locate R1; local police called missing person report made out. R1's nursing note dated 2/19/17 at 9:15 am indicates that R1 remains sitting outside in police car.</p> <p>On 3/23/17 at 9:40 am E11 Licensed Practical Nurse (LPN) stated that when she arrived at the start of her shift on 2/19/17 at 7:45 am she overheard staff stating the R1 had tried to leave the facility. E11 stated that she was assigned to care for R1 and went to do initial rounds</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>immediately and noticed that R1 was not in his room. E11 stated that she immediately notified E12 Registered Nurse (RN) and a code white for missing person was called. E11 stated that she did not see R1 on 2/19/17 because he was already out of the building when her shift started.</p> <p>On 3/23/17 at 10:02 am Z2 (R1's Physician) stated that R1 was allowed to go out on pass with his family. Z2 stated that R1 was not allowed to go out into the community alone because of his diagnosis of dementia. Z2 stated that the times she did a physician visit with R1 he displayed some confusion.</p> <p>On 3/27/17 at 9:33 am Z3 (R1's Family) stated that R1 tried to leave the facility before 2/19/17. Z3 stated that R1's family was in the process of finding appropriate placement for R1 because the facility had difficulty keeping R1 from leaving unsupervised.</p> <p>R1's release of responsibility for leave of absence does not include sign in/sign out for 2/14/17, 2/18/17 or 2/19/17 when R1 left the facility unsupervised.</p> <p>The facility could not provide incident reports for R1's actual and attempted elopements.</p> <p>R1's police report dated 2/18/17 indicates that on 2/18/17 at 3:28 pm the police was dispatched to the facility because R1 had walked away from the facility and was located 6 blocks from the facility. The report indicates that E12 RN indicated that R1 was admitted to the facility for possible onset of dementia. The report indicates that after speaking with Z3 (R1's Family) R1 was taken back to the facility. The report indicates that Z2 (R1's Physician) stated that R1 was suffering</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>from the onset of dementia and alcohol abuse.</p> <p>R1's police report dated 2/19/17 at 7:44 am indicates that the police department received a missing person report from the facility; E11 LPN advised that R1 was last seen at approximately 5:00 am by the midnight shift; upon doing rounds at 7:15 am E11 discovered that R1 was missing. The report indicates that R1 was located (no time provided) at a location approximately 6 miles away from the facility (per MapQuest search). The report indicates that Z3 (R1's family) was notified and signed R1 out of the facility. The report also indicates the following: it should be noted a similar incident occurred on today (2/19/17) at approximately 1:26 am where R1 walked out of the facility and was located several blocks away and escorted back.</p> <p>On 3/27/17 at 3:30 pm E1 Administrator stated that R1 leaving the facility was not an elopement but a behavior and therefore was not reported to the state agency.</p> <p>The facility's Resident Elopement policy revised August 2012 indicates: the Administrator, Director of Nursing or a designee will: notify the state agency, if required; complete and file an incident/accident report.</p> <p>(B)</p> <p>300.3300 3) 4) 5) f) g) y)</p> <p>Section 300.3300 Transfer or Discharge</p> <p>3) A statement in not less than 12-point type,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>which reads:</p> <p>"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below." (Section 3-403(c) of the Act)</p> <p>4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)</p> <p>5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)</p> <p>f) A request for a hearing made under subsection (e) of this Section and Section 3-403 of the Act shall stay a transfer pending a hearing or appeal of the decision, unless a condition which would have allowed transfer or discharge in less than 21 days as described under subsections (d) (1) and (2) of this Section develops in the interim. (Section 3-404 of the Act)</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>g) A copy of the notice required by subsection (d)(1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act)</p> <p>y) Any owner of a facility licensed under the Act shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than 10% of the residents. Such notice shall be given to the Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under subsection (u) of this Section. (Section 3-423 of the Act)</p> <p>This requirement is not met as evidence by:</p> <p>Based on interview and record review the facility</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>failed to issue notification for involuntary discharge/transfer with all the required information for 36 of 36 of residents (R2 - R8, R10, R11, R12, and R14 - R39) reviewed for involuntary transfer, in a sample of 39.</p> <p>Findings Include:</p> <p>On 3/22/17 at 12:30 pm E1 (Administrator) stated that the facility is transitioning to provide sub-acute care only. E1 stated that the facility is in the process of finding placement for the long term care residents in the facility. E1 stated that several residents have already been transferred to other long term care facilities.</p> <p>On 3/22/17 the facility census was 79 residents. The facility provided a list indicating that eight residents were transferred to other facilities since 3/1/17 and a list indicating that the facility planned to discharge thirty more residents to long term care facilities.</p> <p>R5's face sheet diagnoses include dementia with behavioral disturbance and schizoaffective disorder bipolar type. R5's face sheet indicates that R5 was transferred to another long term care facility on 3/14/17. R5's nursing notes dated 3/12/17 indicates that R5 was transferred to a local hospital related to behavior episode. R5's nursing notes indicate that R5 was re-admitted to the facility on 3/13/17 and transferred to another facility on 3/14/17. R5's social services note dated 3/14/17 at 11:38 am indicates that R5's family was called by E8 social services to inform of the need to seek alternate placement for R5, with three possible locations for long term placement. R5's note indicates that E8 continued to explain that placement would be honored immediately given the nature of R5's diagnosis</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>and need for increased care related. R5's social service note dated 3/14/17 at 7:22pm documented by E1 Administrator indicates that R5's family stated to the nurse that she was not aware of R5' discharge to a long term care facility today (3/14/17) and stated that she must have misunderstood the conversation with the Administrator and Social Services. R5's note indicates that E1 offered to have R5 return to the facility, if it was felt necessary but R5's family declined and stated let her stay at the new place. R5's nursing notes do not include date, time, resident condition or family notification of transfer.</p> <p>On 3/29/17 at 1:58 pm E8 Social Services stated that R5 was not issued an involuntary notice of transfer or discharge. E8 stated that he spoke to R5's family and gave the name of three facilities that may accept R5 in the long term care facility. E8 stated that once the long term care facility accepted R5 he arranged for transportation to get R5 to the new facility. E8 stated that he verbally informed R5's family of the transfer. E8's social service note dated 3/15/17 indicates that R5's family was notified of the transfer to a long term care facility.</p> <p>On 3/29/17 at 8:32 am Z5 (R5's Family) stated that she did not receive written notice of the plan to discharge or transfer R5 to another facility. Z5 stated that someone from social services called her to inform her that the facility would be sending a request to three facilities to admit R5. Z5 stated that she was not notified that one of the facilities accepted R5 and that R5 had been transferred out to the new facility on the same day that social services informed her of the need to transfer R5. Z5 stated that E1 administrator informed her that the facility was transferring all long term care residents to other facilities.</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>On 3/30/17 at 12:06 pm Z6, Nurse Practitioner stated that R5 was transferred to another facility because the facility is transitioning to sub-acute care. Z6 stated that R5 needs long term care. Z6 stated that R5 was not transferred out due to behaviors because the behaviors were present since admission and the facility was capable of taking care of R5's behaviors.</p> <p>The facility could not provide documentation that R5 and R5's family received written notification of the transfer/discharge to another facility.</p> <p>R10's face sheet diagnosis includes dementia without behavioral disturbance. R10's resident to resident altercation dated 1/8/17 indicates that R10 and R15 had a verbal altercation. The report indicates that R10's guardian agreed to transfer R10 to a different facility that may be able to better address R10 psychological needs and R10 was transferred to another facility the following day. The facility could not provide documentation indicating that R10 and R10's guardian were given a written notice of discharge or transfer to another facility.</p> <p>R14's face sheet diagnosis includes anxiety disorder, major depressive disorder and Parkinson's disease. R14's census indicates that R14 was discharge to another long term care facility on 3/24/17. R14's social services note dated 3/16/17 indicates the following: social services contacted R14's family to discuss discharge to another long term care facility, as this facility is in the process of transitioning into only "sub-acute" care.</p> <p>On 3/30/17 at 12:31 pm Z9 (R14's Physician)</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>stated that he is not aware of R14's transfer to another facility. On 3/30/17 at 12:44 pm Z2 (R14's Physician) stated that she is not sure about R14's discharge. Z2 stated that she is not sure if she was aware of R14's discharge/transfer to a long term care facility. The facility could not provide written documentation that R14 or R14's family were given proper discharge/transfer notification.</p> <p>R11's face sheet diagnoses include dementia with behavioral disturbances, anxiety disorder, diabetes, and atrial fibrillation. R11's census report indicates that R11 transferred to a long term care facility on 3/16/17.</p> <p>On 3/30/17 at 11:44 am Z7 (R11's Physician) stated that R11 was transferred because he was told that R11 needed long term care. R11 stated that he does not decide who is admitted and discharged but the decision is based on the recommendations of therapy and administration. The facility could not provide written documentation that R11 or R11's family were given proper discharge/transfer notification.</p> <p>R12's face sheet diagnoses include respiratory failure, dependence on respirator, tracheostomy, and gastrostomy and anxiety disorder. R12's face sheet indicates that R12 was discharged transferred to a long term care facility on 3/17/17. The facility could not provide written documentation that R12 or R12's family were given proper written discharge/transfer notification.</p> <p>The facility provided a list indicating that a letter of transition from long term care to sub-acute were given or sent to the families of the following residents. R6, R7, R15, R16, R17, R18 and R19.</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER VERACARE BURBANK	STREET ADDRESS, CITY, STATE, ZIP CODE 5400 WEST 87TH STREET BURBANK, IL 60459
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(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	<p>Continued From page 12</p> <p>The facility provided letter of transition that was given to the above mentioned residents read as follows:</p> <p>Dear Family and Friends,</p> <p>On March 1, 2017, (name of facility) was purchased by (new owner of facility). Along with the purchase a lot of significant changes are going to occur very rapidly.</p> <p>To begin, our new name is (new name). We have established a new nursing management team, admissions department, therapy contractors and reception team. We are quickly transitioning into a sub-acute care only facility. This means that we will no longer offer long term care, and need to transition our current long term clientele into other locations in the next 30 days. In fact, several of our special needs clients have already transitioned elsewhere. Due to the limited number of preferred placements locally, I would encourage you to contact social services, as soon as possible, to choose what locations you would prefer for us to refer to, and avoid the last-minute rush.</p> <p>We have treasured the trust you have shown us in the past, in allowing us to care for you loved one. We will be contacting you soon to help move your loved one to the next step in their journey.</p> <p>Respectfully,</p> <p>E1 Administrator</p> <p>The above letter is dated 3/17/17; however, 6 residents (R5, R8 - R12) transferred to another facility between 3/3/17 - 3/17/17.</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>On 3/28/17 at 9:45 am E15 Social Services stated that there were no thirty day involuntary discharge letters given because there was not an issue of payment and none of the long term care residents refused to be discharged or transferred from the facility. E15 stated that families were contacted by telephone to inform them of the transition of care to sub-acute and the need to find placement for the resident. E15 stated that some notification letters were sent out to families.</p> <p>The facility's list of residents who were given or whose families were sent a letter to inform of the facility ' s transition of care from long term to sub-acute indicates that R6 and R7 received the letters personally.</p> <p>On 3/28/17 at 1:20 pm R7 stated that he has not received a letter indicating that the facility was changing the type of residents that will be cared for. R7 stated that he is not aware of any changes that the facility is making.</p> <p>On 3/28/17 at 1:30 pm R6 stated that he was not given a letter explaining what is happening with changes in the facility. R6 stated that he knows about the changes because he heard a visitor for another resident discussing the changes and he (R6) inquired more about the changes and is currently working with social services to find placement.</p> <p>The facility provided a list of patients to be transferred to other long term care facilities which included R2, R3, R4, R6, R7 and R15 - R39. On 3/28/17 at 9:45 am E15 Social Services stated that no written involuntary discharge/transfer notices were given to the residents.</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>The facility's policy for Notice of a Transfer and/or Discharge revised April 2011 indicates the facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30) day written notice of an impending transfer or discharge. The policy indicates the resident and/or representative (sponsor) will be provided with the following information: the reason for the transfer or discharge; the effective date of the transfer or discharge; the location which the resident is being transferred or discharged; the name, address and telephone number of the state long term care ombudsman; the name, address and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.</p> <p>(B)</p>	S9999		