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
	IL6009757	A. BUILDING: ______ B. WING ______	C 10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

(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 #2087921/IL127492	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.3240 a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 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.

These regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure safe/secured windows in rooms of one (R4) of three residents who had elopement risks behaviors in a sample of 3 residents reviewed for elopement. This failure resulted in R4 jumping from his bedroom window and being hospitalized for pelvic fracture and facial lacerations.

Findings Included:

R4 was a 70 year old admitted to facility on 3/23/2020 with Diagnoses to include Cocaine Abuse and Dementia. His mental status was mildly impaired as noted in the Brief Interview for Mental Status (BIMS) score of 10 out of 15, dated 3/30/2020. Acording to MDS(Minimum Data Set), dated 6/27/2020, R4 was ambulatory with extensive assistance of staff otherwise he used a manual wheelchair.

Elopement risk assessment, dated 3/23/2020, noted R4 was low or no risk for elopement.

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S9999	Continued From page 2 There was no other elopement risk assessment until 7/17/2020. On 6/3/2020, nursing note documented,"Resident dressed, ambulated to back of corridor attempting to leave the floor and said he was going home." On 6/4/2020, Psychiatry notes documented that R4 was very unhappy and said he did not want to be there. On 6/6/20 Psychiatry notes documented R4 noted with new wandering behaviors especially at nights. Stated his gait was steady. On 6/20/20, Psychiatry notes noted R4 said he wanted to leave and was depressed with interrupted sleep. Incident report for R4 on 7/17/2020 documented R4 allegedly jumped from the second floor unit through the window and was found on the ground outside under his room's window. The fall was unwitnessed. The incident was reported by neighbors in the community according to report. Investigation report by the facility documented one of R4's room mate (No longer there) said on the night of 7/17/2020 he saw R4 doing something at the window, but he thought R4 was turning the heat on or off. On 10/23/2020 at 12:10PM, V11(Nurse for R4) wrote that she saw R4 in the bed at 4:00AM, on the night of the incident. Unable to make contact with V11 during investigation. On 10/22/2020 at 11:00AM, the window in room where R4 resided could open only six inches	S9999		

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S9999	Continued From page 3 high. On 10/22/2020 at 11:20AM, R6 (R4's) roommate said R4 always stated he was leaving the facility and would sometimes pack his belongings and waited at exits. He said he did not see him exit through the window. On 10/22/2020 at 11:40AM, V5(Assistant Director of Nursing/ADON) said R4 was not a risk for elopement. When asked if she was aware that there was psychiatrist documentation that R4 had exit seeking behavior, V5 did not answer. On 10/22/2020 at 10:50AM, V10(Maintenance Director) said after the incident, he checked the window where R4 allegedly jumped out. According to V10, the window could open all the way upwards and the screen was cut which could have allowed someone to through. He said he usually checked the windows at least every two weeks, but could not remember the last time he checked. He said the window was not supposed to be like that. According to V10, the window was supposed to be set so that it could only open about 6 inches and no one could have passed through. On 10/23/2020 at 1:40PM, V13(Certified Nursing Assistant/CNA) said she was the staff who took care of R4 on the night he assumedly went through the window. She said she made rounds at about 4:30AM, and R4 was asleep in the bed. She said she was not aware that R4 was at risk for elopement. Emergency room records for R4 on 7/17/2020 documented, "70 year old s/p fall from 20 feet. Pt jumped out of window in a nursing home. Noted 3centimeter laceration to the right superior gum	S9999		

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S9999	Continued From page 4 line , small abrasion to the posterior head. Clinical impression of Closed bilateral fracture of pubic rami". Facility did not present a policy on Accidents/Elopement. (A)	S9999		