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
	IL6002026	A. BUILDING: ______ B. WING ______	C 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE CENTER	4314 SOUTH WABASH AVENUE CHICAGO, IL 60653

(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 Facility Reported Incident of July 12, 2020/IL125018	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010d) 300.1010e) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies d) All residents, or their guardians, shall be permitted their choice of a physician.	S9999		

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e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)

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. (B)

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be

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made by nursing staff and recorded in the resident's medical record.

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 interview and record review, the facility failed to ensure a resident exhibiting aggressive and self-inflicting behaviors was provided medical psychiatric services at the facility to promote well-being. This failure affected one resident (R1) out of 3 (R1, R2 and R3) reviewed for quality of care. This failure resulted in R1 hanging himself.

Findings include:

R1 is a 36 years old male with diagnosis of: Type 2 Diabetes, Hyperkalemia, Acute Kidney Failure, Covid- 19, Schizophrenia, Hypertension, GERD, Peptic Ulcer and Cognitive Communication Deficit.

On 7/13/20 at 10:41 am, V1 (Administrator) stated, V3 (Certified Nursing Assistant) was doing rounds on 7/12/20 around 5 am and noticed R1 was not in his room. V1 stated the search was initiated of the building, however, V3 came back to R1's room and found the resident in the closet. R1 committed suicide by hanging using 2 plastic hangers. V1 further stated, R1 kneeled, placed his neck between the hangers and leaned forward to cut off his airflow. V1 further stated, R1 removed the closet metal rod from the bracket, placed 2 plastic hangers on the rod than

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attached the metal rod back to the bracket and used the plastic part of the hangers to commit suicide.

On 7/13/20 at 11:07 am, V8 (Licensed Practical Nurse) stated she worked with R1 on 7/10/20, the resident looked fine, he smiled, however . he had behaviors in the past, would talk to self, sing out loud and displayed some aggression like yelling and would jump off furniture. V8 also stated, R1 was more quiet last year, however this year he was more loud and had behaviors.

On 7/13/20 at 11:11 am, V9 (Certified Nursing Assistant) stated she was off the weekend. She recalled once the resident had a behavior, he got on top of the dresser, hit his head and was sent to the hospital for observation.

On 7/13/20 at 2:09 pm V10 (Psychosocial Rehabilitative Services Director) stated R1 has been in the facility since last year, on one occasion R1 was aggressive where he broke the television in his room.

On 7/14/20 at 10:50 am, V13 (Licensed Practical Nurse) stated, "we make rounds every two hours and it is recorded in the communication book or in the residents' chart."

On 7/14/20 at 2:39 pm V7 (Social Services) stated, on 7/2/20 he heard loud yelling and he rushed to R1's room. V7 observed R1 hitting his head against the wall, so right away R7 intervened to stop any self-harm. R1 was yelling, "The police cannot do anything to me". V7 said at the time there was a demonstration outside with many police cars

On 7/14/20 at 4:10 pm, V14 (Medical Doctor)

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stated R1 was going back and forth to the hospital due to behaviors. V14 said, he is not surprised the resident committed suicide, he was confined to his room due to Covid-19. V14 stated the plan of care for R1 was to keep monitoring the resident and he had medications in place.

On 7/15/20 at 1:29 pm V15 (Psychiatrist) stated the last time he saw R1 was in February 2020. R1 had no symptoms of depression, no suicidal ideation. V15 also stated, R1 was transferred at some point under V16 (Psychiatrist) care however he was not sure when.

On 7/16/20 at 9:52 am V16 (Psychiatrist) stated, R1 was never assigned to her in the facility. V16 stated she never saw R1 because he never came up on her list of residents to see. Even during covid-19 times, she was seeing residents via zoom video. V15 was seeing R1 from October 2019 to February 2020 per progress note documentation. R1 never came on our list of residents to see in the facility. In order for residents to change doctor, they have to sign consent for a doctor change and then the nursing home will assign the resident to the doctor. The facility called me for orders in May 2020 for the resident, she gave them orders. V16 stated she never saw him in the facility. V16 further stated," If you look on the resident's face-sheet, V15 is assigned as a psychiatrist for the resident. The facility used to have a psychiatric nurs, however, she is no longer working there, and things are disorganized."

On 7/16/20 at 10:07 am ,V1 stated, there is overlap between psychiatrists for R1. V16 was his doctor in the sister facility where the resident came from.

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On 7/20/20 at 12:32 pm, V1 said for a resident to change a physician, the facility will have a resident fill out a change of physician form, provide a reason and sign it. V1 was not sure if the facility has a change of physician form for R1. The facility will have to check to verify it.

On 7/20/20 at 1:23 pm V1 said, V17 (Former Director of Nursing) made the psychiatrist switch from V15 to V16 however facility cannot locate the signed change of physician form but will provide a black form for reference.

Review of R1's progress note dated 7/2/20 at 8:56pm by V7 documents, resident displayed physically aggressive and violent self-inflicting behavior as evidenced by him banging his head against the wall and being loudly verbal yelling "the police can't do anything to me". Resident was redirected and provided with one on one counseling to calm him down. R1 was administered Haldol 5 mg/ml injection by the nurse.

Review of R1's progress note dated 7/2/20 at 11:19 pm by V14 documents a preventative visit to address medical conditions to promote on-going stability and prevent avoidable hospitalizations. Assessment - currently at baseline functional status, and medically stable despite episodic behavior issues. Plan- continue present management, maintain fall/safety precautions and encourage compliance.

R1's (6/30/20 at 9:14 pm) progress note by V7 documents resident exhibited physically aggressive behavior as evidenced by him continuously banging his head on the wall by his room entrance. Resident was counseled by V7.

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R1's care plan (2/11/20) documents history of elopement, R1 hangs around facility exits, R1 has the physical ability to leave the building and R1 becomes easily confused. With intervention of-rounds/hourly room checks per facility protocol to monitor resident to assist in minimizing chance of unauthorized leave.

R1's (6/8/20) care plan documents resident exhibited violet physical aggressive behavior.

R1's (6/17/20) care plan documents exhibited aggression and violent physical behavior towards staff.

R1's (6/30/20 and 7/2/20) care plan documents resident exhibited violent physical aggressive and self-inflicting behavior.

R1's behavior care plan (initiated 6/8/20) documents interventions of safe and secure environment with caring professionals, encourage verbalization of issues or concerns, establish a counseling schedule with the resident, provide 1:1 counseling on boundary issues relating to conflict, report any incident of abuse to the administrator, intervene when any inappropriate behavior is observed, provide supportive intervention and refer R1 to a mental health professional. No updated care plan interventions for 6/17/20, 6/30/20 and 7/2/20 incidents of R1's behaviors.

R1's Face-Sheet (printed 7/13/20) documents V15 as the resident's Psychiatrist.

R1's psychiatric progress notes document resident was seen by V15 on 11/21/19 and 2/26/20.

Facility does not have a Change of Physician

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policy, they follow residents' rights.

Facility blank "CHANGE OF MEDICAL DOCTOR/PSYCHIATRIST'S FORM" documents resident and staff have to sign and date the form.

Facility Assessment (5/1/19) documents in part:

Provide person-centered care: Support emotional and mental well-being; support helpful coping mechanisms.
Illinois Department of Aging "Residents' Rights" documents in part:
You have the right to choose your own doctor.

300.610a
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)3)
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 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care

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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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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

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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.

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 provide supervision and failed to identify a hazardous item in a resident's room with self -harming behaviors for one resident (R1) out of 3 (R1, R2, R3) residents reviewed for safety and supervision. This failure resulted in R1 hanging himself.

Findings include:
R1 is a 36 years old male with diagnosis of: Type 2 Diabetes, Hyperkalemia, Acute Kidney Failure, Covid- 19, Schizophrenia, Hypertension, GERD, Peptic Ulcer and Cognitive Communication Deficit.

On 7/13/20 at 10:41 am, V1 (Administrator) stated, V3 (Certified Nursing Assistant) was doing rounds on 7/12/20 around 5 am and noticed R1 was not in his room. V1 stated, a search was initiated of the building however V3 came back to R1's room and found the resident in the closet. R1 committed suicide by hanging using 2 plastic

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hangers. V1 further stated, R1 kneeled, placed his neck between the hangers and leaned forward to cut off his airflow. V1 further stated, R1 removed the closet metal rod from the bracket, placed 2 plastic hangers on the rod then attached the metal rod back to the bracket and used the plastic part of the hangers to commit suicide. Surveyor asked what type of residents reside on the 3rd floor, V1 stated, independent residents with psych problems.

On 7/13/20 at 11:00 am, R1's closet was observed with V1. R1's closet was on the right end of a three, side by side unit closet, the rod was not in place, it had been removed. The bracket on the right side was shaped like a half-moon, making the right end of the closet bracket able to be lifted up. Left side of closet bracket was secured to the wall and not able to be moved.

On 7/13/20 at approximately 11:57 am, removable metal closet rods were identified with V9 (Certified Nursing Assistant) in rooms 302, 306, 307, 313 and 315.

On 7/13/20 at approximately 12:16 pm, removable metal closet rods were identified with V8 (Licensed Practical Nurse) in rooms 319, 323, 324 and 328.

On 7/13/20 at 11:07 am, V8 (Licensed Practical Nurse) stated, she worked with R1 on 7/10/20, the resident looked fine, he smiled however, he had behaviors in the past, would talk to self, sing out loud and displayed some aggression like yelling and would jump off the furniture.

On 7/13/20 at 11:11 am, V9 (Certified Nursing Assistant) stated she was off the weekend

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however one time, the resident had a behavior, he got on top of the dresser, hit his head and was sent to the hospital for observation.

On 7/13/20 at 12:54 pm, V12 (Maintenance Director) stated, the closet rods in the facility are mostly plastic however some were still metal.

On 7/13/20 at 1:43 pm, V2 (Assistant Director of Nursing) stated resident rounds are made at the beginning of the shift and after that every hour. V2 also stated, resident rounds are documented only in the progress notes in the electronic medical chart.

On 7/13/20 at 2:09 pm V10 (Psychosocial Rehabilitative Services Director) stated R1 has been in the facility since last year. In general, he was quiet, however he would often wander. R1 would try to elope the facility in the past. V10 also stated, R1 on one occasion was aggressive where he broke the television in his room.

On 7/13/20 at 3:04 pm, V12 stated, the closet rods should not be removable, they need to be bolted down.

On 7/14/20 at 10:00 am V4 (Licensed Practical Nurse) stated, she worked the night shift 11p-7 am on 7/11/20. She came on the unit, did rounds and observed R1 in bed around 11:15 pm. R1 was found by V3 (Certified Nursing Assistant) approximately 5:00 am. V4 said, she walked in the room because V3 alerted her and saw R1 in the closet in sitting position, 2 hangers around his neck, he was on his knees. V4 further stated, last time she saw R1 it was around the 11 pm hour. He was asleep, she called his name and he responded. V4 also stated, rounding on residents is done every 2 hours, and Certified Nursing

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Assistants do it also every 2 hours. V4 further stated, we do not have a rounding chart, we do not have to check off a list.

On 7/14/20 at 10:18 am, V3 (Certified Nursing Assistant) stated, the last time she saw R1 alive was around 11 pm when she was doing rounds at the beginning of her shift. V3 further stated, she walked in to R1's room around 5:25 am and did not see him. V3 looked under the bed, checked the bathroom and as she was about to leave the room opened the closet. V3 stated, she screamed, she called out for the nurse. V3 said, R1 was found in the closet. He was balled up in there, 2 plastic hangers around his neck, and he was on his knees facing forward. V3 said, we make rounds every 2 hours. Rounds insist of checks on every resident to see if they need anything and if they are breathing. Surveyor asked V3 for resident rounding documentation. V3 stated, we do not have a rounding chart.

On 7/14/20 at 10:50 am, V13 (Licensed Practical Nurse) stated, we make rounds every two hours and it is recorded in the communication book or in the residents' chart.

On 7/14/20 at 2:03 pm V1 stated, he saw R1's body in the closet after 5 am on 7/12/20 because he was notified by the facility staff about the incident. R1 was kneeling forward and his head was in between the plastic hangers. V1 further stated, the plastic hangers were looped on the removable closet rod.

On 7/14/20 at 2:22 pm, V2 stated, safety precautions that are put in place is close monitoring with all the residents. Frequent rounds, and when residents are admitted, staff check all their personal belongings for any

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COMMUNITY CARE CENTER	4314 SOUTH WABASH AVENUE CHICAGO, IL 60653

(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 13 hazardous items, and they remove it from the room. On 7/14/20 at 2:39 pm V7 (Social Services) stated, on 7/2/20 he heard loud yelling and he rushed to R1's room. V7 observed R1 hitting his head against the wall, so right away R7 intervened to stop any self-harm. R1 was yelling, "The police cannot do anything to me". V7 said there was a demonstration outside with many police cars. On 7/14/20 at 4:10 pm, V14 (Physician) stated R1 was going back and forth to the hospital due to behaviors. V14 stated, "I am not surprised the resident committed suicide, he was confined to his room due to Covid-19." V14 stated, the plan of care for R1 was to keep monitoring the resident and he had medications in place. On 7/20/20 at 9:15 am, V12 stated, he had no answer to why the closet rods were removable and not bolted down . For some reason they were this way on the third floor. Review of R1's progress note, V4 documents on 7/11/20 at 11:17pm , R1 was noted in bed, easily aroused. No distress and no behaviors noted at this time. Will continue to monitor. R1's (7/2/20 at 8:56pm) progress note by V7 documents, resident displayed physically aggressive and violent self-inflicting behavior as evidenced by him banging his head against the wall and being loudly verbal yelling "the police can't do anything to me". Resident was redirected and provided with one on one counseling to calm him down. R1 was administered Haldol 5 mg/ml medication by the nurse.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 R1's (7/2/20 at 11:19 pm) progress note by V14 documents a preventative visit to address medical conditions to promote on-going stability and prevent avoidable hospitalizations. Assessment - currently at baseline functional status, and medically stable despite episodic behavior issues. Plan- continue present management, maintain fall/safety precautions and encourage compliance. R1's (6/30/20 at 9:14 pm) progress note by V7 documents resident exhibited physically aggressive behavior as evidenced by him continuously banging his head on the wall by his room entrance. Resident was counseled by V7. R1's care plan (2/11/20) documents history of elopement, R1 hangs around facility exits, R1 has the physical ability to leave the building and R1 becomes easily confused. With intervention of-rounds/hourly room checks per facility protocol to monitor resident to assist in minimizing chance of unauthorized leave. R1's (6/8/20) care plan documents resident exhibited violet physical aggressive behavior. R1's (6/17/20) care plan documents exhibited aggression and violent physical behavior towards staff. R1's (6/30/20 and 7/2/20) care plan documents resident exhibited violent physical aggressive and self-inflicting behavior. R1's behavior care plan (initiated 6/8/20) documents interventions of safe and secure environment with caring professionals, encourage verbalization of issues or concerns, establish a counseling schedule with the resident, provide 1:1	S9999		

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S9999	Continued From page 15	S9999		

counseling on boundary issues relating to conflict, report any incident of abuse to the administrator, intervene when any inappropriate behavior is observed, provide supportive intervention and refer R1 to a mental health professional. Facility unable to provide any documentation of care plans updated after changes in R1's behavior for the following dates: 6/17/20, 6/30/20 and 7/2/20.

Facility's (7/11/20) "Nursing Daily Staffing" documents: V3 and V4 assigned to 3rd floor 11 pm-7 am shift

Facility's "CNA DUTIES/RESPONSIBILITIES/FUNCTION" documents in part:

7. Make on-going rounds on assigned wing(s)/unit(s) no less than every two hours.

Facility's "LPN DUTIES/RESPONSIBILITIES/FUNCTION" documents in part:

3. Closely monitor and supervise all facility residents per facility policies and as warranted by good nursing judgment.
Facility policy (6/13) "ROUTINE RESIDENT CHECKS" documents in part:

1. To ensure the safety and wellbeing of our residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing service personnel.
NOTE: SOME RESIDENTS MIGHT REQUIRE MORE FREQUENT CHECKS.

Facility Assessment (5/1/19) documents in part:

Provide person-centered care:

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S9999	Continued From page 16 Psycho/social/spiritual support: Identify hazards and risks for residents. (A)	S9999		