PRINTED: 12/02/2020 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ IL6008155 B. WING 10/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1512 WEST FARGO ARBOUR HEALTH CARE CENTER CHICAGO, IL 60626 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Annual Certification and Licensure survey S9999 Final Observations S9999 Statement of Licensure Violations: 600.610)a 300.1210)b 300.1210d)6) 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 4 60 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

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Section 300.1210 General Requirements for

by this committee, documented by written, signed

and dated minutes of the meeting.

Nursing and Personal Care

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 10/09/2020 IL6008155 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1512 WEST FARGO ARBOUR HEALTH CARE CENTER CHICAGO, IL 60626 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 Continued From page 1 S9999 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 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. (Section 2-107 of the Act) These requirements were not met evidenced by: Based on observations, interviews, and records reviewed, the facility failed to follow their own policy and care plan interventions to insure the safety of 1 resident (R57) of 3 reviewed for supervision while smoking. This failure resulted in R57 suffering burn wounds to his second and third fingers on 08/19/20.

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Findings include:

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Illinois Department of Public Health

he burned himself.

On 10/8/20 at 12:30 PM surveyor observed V16, Certified Nursing Assistant (CNA), take's R57 to smoke. Surveyor observed R57 holding the cigarette in his right hand between his 2nd and 3rd fingers, where his wounds are. Cigarette

On 10/8/20 at 12:40PM during an interview R16,

burning close to resident's fingers.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008155	B. WING	<u>.</u> .	10/0	9/2020
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ARBOUR	HEALTH CARE CEN	TFR	ST FARGO), IL 60626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 3	S9999			
3	to prevent him from she does not know cigarette holder.	a cigarette holder in the past burning himself. R16 states what happened to R57's				
		2:45PM R57 told surveyor he in while smoking on the				
	interview, V7 (Secu	24PM, during a phone urity Guard) said he did not how to supervise or monitor				
	Social Service Direcigarette holder. Vorder him one. V10 that R57 no longer said R57 is a superfrom burning himse assessment is comadmission and quastaff assigned to sutrained on how to not V10 said she has not staff has been trained evices and supervices.	49PM during an interview V10, actor, said R57 should use a 10 said the facility needs to 0 said she learned on 10/7/20 has a cigarette holder. V10 rvised smoker to prevent him left. V10 said a smoking apleted for residents on arterly. V10 said none of the apervise smokers have been nonitor or supervise smokers. The evidence to present that need on smokers and assistive vision for safe smoking. V10 of the smoking program.		28 28		
	a box containing a	00 pm V10 showed surveyors cigarette holder and said it eceptionist desk (next to exit smoking area).			iti	
	Nursing, in Physica team. R57 said he	AM R57 and V2, Director of al Rehab room with survey burned his fingers in August rned his fingers since then.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008155	B. WING		10/0	9/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ARBOUR	R HEALTH CARE CEN	TER 1512 WES	T FARGO , IL 60626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	ordered Silvadene for burns. V15 said pipe to prevent R57	3 AM V15, Doctor, said he for R57, a treatment he orders the has suggested R57 use a 7 from burning himself. V15 erventions like the cigarette neficial for R57.				
	Administrator, said President, and a sn	during an interview V1, she checked with V14, Vice noking assessment should ed following the report of 9/20.				
	by V2 notes that "R	ed 8/19/20 for R57 completed lesident burnt himself". V2 Services will with follow up	:			
	on 10/6/20 list time responsible for sup	ervising smokers, this includes discourity. R57 is listed as a				
	Judgement related include maintain sa plan indicates he w smoking activities. holder effective dat	ludes a Focus for Impaired to Alzheimer's. Interventions fe environment. R57's care ill be supervised during Resident will use cigarette e 05/20/20. No intervention 19/20 incident report.				
	05/19/20 states if the impaired and 2 or 3 placed on supervision The code is "2" mocausing injury to segunauthorized areas	fety Risk Assessment Dated ne person is cognitively coded the person should be ion or not permitted to smoke. derate problem. Potential for of or others from smoking in cor careless of smoking minimal problem. Potential for				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		OOMII EETED	
		IL6008155	B. WING		10/09/2020	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ARBOUR	R HEALTH CARE CEN	ITCD	ST FARGO), IL 60626			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETE	
S9999	Continued From pa	age 5	S9999			
	coded "3" severe pon managed smok and outcome state handling carrying a Resident is on sup On 08/18/20 Smok was completed. No history of hazardous ustaining burns) of Resident is current resident displays for smoke independent measures for him	a facility safe smoking policy problem. Total score is 5, place ing program. Recommendation is may not be capable of any smoking materials. ervised smoking at this time. A safety Risk Assessment ew assessment category us behavior (examples code "1" minimal problem. Itly in supervised smoking till ull responsibility of being able dently as well as ensure safety and others. Resident to smoke under staff supervision.				
	No smoking safety 8/18/20.	y risk assessment done after				
	Facility policies rel on 10/8/20 and 10	lated to smoking were reviewed 1/9/20.				
	10/6/20. 6 Superv	d Smokers was provided on ised smokers identified on the s "Supervised Smoker".				
	Supervised Smok supervision due to	cy dated 3/2/16 states ers are smokers who require o unsafe smoke practices, and or continue violation of				
	states smokers w their ability to com ability to carry sm requiring supervis	ated Smoking Safety Policy will be evaluated to determine apply with safety rules and their oking materials. Residents sion shall receive this monitoring eir assessment and plan of	g			

care.
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Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING 10/09/2020 IL6008155 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1512 WEST FARGO ARBOUR HEALTH CARE CENTER CHICAGO, IL 60626 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 Continued From page 6 S9999 The facility smoking safety policy dated 4/13/10 further states: Policy Objective: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. The following behaviors and/or conditions will jeopardize and cause revocation of the person's independent privileges: Self-harmful behaviors, such as burning clothing, hands, fingers, face or lips. This category includes residents who are generally "careless" while smoking and may present a significant risk of fire setting. " B"

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TIWQ11