

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6003776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2017
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NAME OF PROVIDER OR SUPPLIER GRASMERE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4621 NORTH SHERIDAN ROAD CHICAGO, IL 60640
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Z 000 COMMENTS

Statement of Licensure Violations

Complaint #1725035/96297 - No deficiencies cited.
 1785186/96468 - No deficiencies cited.
 1785094/96360 -Section 300.610 a) cited
 Section 300.1210 2) cited
 Section 300.1220 b)6) cited
 Section 300.3220
 f)g)1)C)E)i)ii)iii)iv)v)vi)vii)viii)F)G)H)I) cited
 Section 300.4040 A)1)C)1)2)D)
 cited

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Z9999 FINDINGS

Statement of Licensure Violations

Section 300.610 a)
 Section 300.1210 2)
 Section 300.1220 b)6)
 Section 300.3220
 f)g)1)C)E)i)ii)iii)iv)v)vi)vii)viii)F)G)H)I)
 Section 300.4040 A)1)C)1)2)D)

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

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Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Z9999	<p>Continued From page 1 and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.</p> <p>Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) g) Every woman resident of child-bearing age shall receive routine obstetrical and gynecological evaluations as well as necessary prenatal care. (Section 2-104(b) of the Act) In addition, women residents shall be referred immediately for diagnosis whenever pregnancy is suspected. 1) "Routine obstetrical evaluations" and "necessary prenatal care" shall include, at a minimum, the following: C) Identification of factors in the current pregnancy that help to identify the patient at high risk, such as maternal age, vaginal bleeding, edema, urinary infection, exposure to radiation</p>	Z9999		
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Z9999	<p>Continued From page 2</p> <p>and chemicals, ingestion of drugs and alcohol, and use of tobacco;</p> <p>E) The following laboratory tests, as early in pregnancy as possible. Findings obtained from the history and physical examination may determine the need for additional laboratory evaluations:</p> <p>v) Rubella antibody titer measurement;</p> <p>vi) Syphilis screen;</p> <p>vii) Cervical cytology; and</p> <p>viii) Viral hepatitis (HBsAg) testing;</p> <p>F) A risk assessment that, based on the findings of the history and physical examination, should indicate any risk factors that may require special management, such as cardiovascular disease, maternal age more than 35 years, neurologic disorder, or congenital abnormalities;</p> <p>G) Return visits, the frequency of which will be determined by the patient's needs and risk factors. A woman with an uncomplicated pregnancy shall be seen every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter;</p> <p>H) Determinations of blood pressure, measured fundal height, fetal heart rate, and, in later months, fetal presentation, and urinalysis for albumin and glucose. Hemoglobin or hematocrit level shall be measured again early in the third trimester. Glucose screening is recommended for women who are 30 years of age or older;</p> <p>I) Evaluation and monitoring of nutritional status and habits;</p> <p>Section 300.4040 General Requirements for Facilities Subject to Subpart S</p> <p>a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S:</p>	Z9999		
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Z9999	<p>Continued From page 3</p> <p>1) 24 hours of continuous supervision, support and therapeutic interventions;</p> <p>4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance;</p> <p>c) The facility's psychiatric rehabilitation program shall have the following overall goals:</p> <p>1) Encourage the engagement of each resident in his/her recovery and rehabilitation;</p> <p>2) Increase acquisition, performance, and retention of skills to enhance independence and promote community integration;</p> <p>d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for self-management of psychotropic medications and utilization of other supportive mental health services, such as cooperation with prescribed treatment regimen, self-medication, recognition of early symptoms of relapse, and interactive effects with other drugs and alcohol.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to follow their drug test policy and conduct a drug test, failed to carry out a physician's orders regarding care, medications and an appointment with a high risk obstetrician, facility failed to follow their cardiopulmonary resuscitation (CPR) policy and failed to follow standards of care and provide effective CPR, failed to provide psychiatric rehabilitative services, the facility's director of nursing failed to review physician's orders for one of one resident (R1) in a sample of three and</p>	Z9999		
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Z9999	<p>Continued From page 4</p> <p>failed to provide prenatal care for 2 of 3 residents (R1 and R11) in a sample of 3 reviewed for pregnancy care.</p> <p>This failure: to assess R1 needs potentially contributed to the fetal demise of R1's unborn child and the overdose of R1; resulted in R1 not receiving prenatal care from 2/21/17 (admission) until 5/31/17; to provide effective CPR has the potential to affect all 178 residents living in the facility.</p> <p>Findings include:</p> <p>Per the Physician's Order Sheet dated 2/21/17 and the Hospital Patient Information Record dated 2/23/17, R1 was admitted to the facility on 2/21/17 with diagnoses of Diabetes Type I and Schizoaffective Disorder. R1 was 8 weeks Pregnant upon admission. R1 had a history of Heroin abuse. R1 had a fetal demise on 7/13/17. R1 died at the facility on 7/30/17. The Certification of Death Record dated 8/22/17 states cause of death combined drug Fentanyl, Heroin and Lorazepam toxicity. Manner was accident, not ruled suicide or homicide.</p> <p>The July 2017 Physician's Order sheet shows, R1 was receiving several psychotropic medications including Seroquel, Buspar, Olanzapine, Clonidine, Ativan. In addition, R1 was receiving Insulin.</p> <p>The Interim Individualized Treatment Plan (IITP) dated 2/22/17 shows, R1 upon admission will meet with the addiction counselor for assessment and support and will be referred to the drug counseling groups.</p> <p>Per facility Consultation Form dated 2/22/17, one day after admission, R1 was admitted to the hospital for benzodiazepine and opioid withdrawal. R1 was discharged and sent back to</p>	Z9999		
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Z9999	<p>Continued From page 5</p> <p>the facility on 2/24/17. The hospital's discharge instructions dated 2/24/17, show opioid withdrawal, insulin treatment for diabetic ketoacidosis and smoking cessation.</p> <p>On 3/15/17 approximately 3 weeks after admission, E3 (Addiction Counselor/Certified Addiction Drug Counselor) completed an initial MISA note. The note states R1 should meet for one on ones once a month. The facility's substance use history document that is part of the assessment was never completed in the 5 months R1 was in the facility per chart review and interview with E3 on 9/13/17 at 2:45pm. E3 failed to complete the assessment at the time of admission per facility policy and failed to meet with R1 as an addiction counselor upon R1's admission.</p> <p>On 9/13/17 at 2:45pm E3 (Addiction Counselor) stated he did not complete an assessment of R1 because she was in and out of the facility. All residents have open access to the community. E3 continued, "I'm the only counselor and I have a bunch of residents. The note substitutes for the assessment." E3 continued to state, R1 was to meet once a week for one on ones, not once a month as indicated in the note. The initial note states R1 did not want to do an assessment/interview. R1 denied any substance use history. No other questions were asked. The assessment asks about drug use, effects of use on family, friends and coworkers and the type of treatment they have had in the past. E3 stated, he never asked R1 any of these questions during her stay at the facility.</p> <p>Review of the facility document of 1:1's show R1 did not have a meeting with the addiction counselor until one month after admission. The</p>	Z9999		
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Z9999	<p>Continued From page 6</p> <p>facility document of 1:1's shows R1 had 13 one on ones with E3 on the following days: 3/23/17, 4/8/17, 5/2/17, 5/9/17, 5/18/17, 5/27/17, 6/9/17, 6/17/17, 6/22/17, 6/27/17, 7/14/17, 7/18/17 and 7/20/17. All 13 one on ones were documented observations by E3, not verbal interactions. E3 never met with R1 for a 1:1 session. The 1:1 documents from March, April, May, June and July 2017 state R1 was observed making a phone call, R1 was observed speaking with peers, R1 was observed running the elevator, R1 had a drug screen and R1 was speaking with the staff at the front desk. E3 did not meet with R1 once a week and thought his observations were a substitute for a 1:1 therapy session as indicated in interview on 9/13/17 at 2:45pm.</p> <p>During R1's stay at the facility no 1:1's sessions with an addiction counselor were done per 1:1 facility documentation for March through July 2017.</p> <p>The facility's group attendance sheet with E3, showed during R1's stay from 2/21/17 through 7/30/17, R1 attended 3 group counseling sessions on 5/24/17, 7/11/17 and 7/19/17.</p> <p>On 9/13/17 at 2:45pm E3 (Addiction Counselor) continued, "one on one is when I see them in the facility and there is nothing unusual. I observe their behavior and they don't seem to be under the influence. I write continue to monitor." E3 continued by saying that some residents feel better doing a 1:1 rather than a group setting. E3 was asked what occurs if a drug screen is positive. E3 responded the resident is talked to and group therapy is recommended and hopefully they follow through, but a lot of times they don't. That's their right not to attend group. If the behavior continues, they are placed on a 30 day</p>	Z9999		
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Z9999	<p>Continued From page 7</p> <p>restriction. The resident is not allowed to go out. They have to attend group, as often as they can come to the group. The administrator makes the determination. Surveyor asked why R1 wasn't placed on a 30 day restriction, E3 responded "ask the administrator."</p> <p>On 9/13/17 at 1:55pm E2 (Case Manager) stated the the addiction counselor is responsible for following up on attendance to group therapy. If a drug screen is positive they are encouraged to attend the addiction group therapy. There is a 30 day behavioral contract. In the 30 day contract period the resident cannot engage in the behavior that got them into the contract. If the behavior continues, the facility has the right to terminate them from the facility. The administrator determines if they are placed on a 30 day contract. E2 continued, the contract is used for repeated offenses with drug use and violence. If a drug screen is positive, they are counseled for drugs, the physician and the addiction counselor are notified. They are strongly encouraged to stay in the facility. If they violate this, they could be hospitalized. The administrator determines who receives a 30 day contract.</p> <p>On 9/15/17 at 2:00pm E2 (Case Manager) was asked what is a one on one therapy session, E2 responded a meeting between the counselor and the resident. We can speak about goals, medications, relationship with family, substance abuse issues, pretty much anything. The counselors like to have it focus on major issues they are having. Whatever the resident wants to bring up can be discussed. We meet with them twice a week. Observing a resident is not a one on one therapy session. E2 was asked why R1 was not placed in detox inpatient therapy, E2 responded "it would have to be the physician</p>	Z9999		
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Z9999	<p>Continued From page 8</p> <p>(who decides)." E2 continued to state, 1:1's can be 10-15 minutes or up to an hour, but twice a week. E2 tries to have a schedule with the residents, but it's usually when they are available and want to talk.</p> <p>On 9/13/17 at 3:00pm E1 (Administrator) stated, a 30 day contract is specific to the resident and the behavior they are exhibiting. Their activity is restricted. R1 signed a contract regarding obeying the rules of the facility about drug and alcohol abuse. R1 did not have restricted activity because she would become violent. All staff are certified in crisis prevention intervention (CPI) to handle situations of resident aggression and violence. E1 continued, R1 would have walked out if restrictions were applied. We couldn't throw her on the street.</p> <p>At that time, E1 was asked who ensures that residents attend drug addiction therapy sessions. E2 stated case managers and the drug addiction counselor. If the residents do not attend their group or their one on ones it is reported to E16 (Social Service Director) and a new approach is added to try to get them to attend therapy. E1 was asked what is a one on one. E1 responded it is based on motivational interviewing it is drawing attention to what the resident is doing. The residents think through the role drugs had in their life and the damage it has caused them. E1 continued, observing a resident is not a one on one therapy session.</p> <p>E3 never reported poor attendance to his sessions to E16, because E3 used his observations as a substitute for one on one's/individual therapy.</p> <p>The Facility's Daily Census Report dated 9/13/17</p>	Z9999		
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Z9999	<p>Continued From page 9</p> <p>shows there are 178 residents in the facility, 75 have a history of drug and alcohol abuse. There is one drug addiction counselor for the entire facility.</p> <p>The facility's policy "Alcohol and Drug Abuse Policy" dated 5/19/15 states "I. Policy Upon admission to the facility all residents will be assessed by the MISA (Substance Abuse Counselor) counselor as part of their initial assessment."</p> <p>The Cambridge Dictionary defines a one on one as an activity involving two people talking directly, usually with one teaching or giving information to the other.</p> <p>On 9/19/17 at 10:10am E12 (Medical Record Clerk) stated, on 3/2/2017 Z3 (Internal Medicine) wrote an order for an obstetrics and gynecology consult as soon as possible. Z3 was called to find out what physician he wanted R1 to be sent to for the consult, but Z3 was no longer taking care of R1 because she was high risk. E12 called Z1 (Medical Director) who instructed her to send R1 to Z5 (Obstetrician) for the consult. E12 called Z5 for the appointment on 3/9/17.</p> <p>Per facility Consultation Form dated 3/15/17, R1 had a consult with Z5 (Obstetrician) on 3/15/17. Z5 made a recommendation to stop all R1's depression and psychiatric medication. The facility Consultation Form shows the recommendation was not followed. Z8 (Psychiatrist) wanted the depression and psychiatric medications to remain the same. Z5 wrote in his recommendation for changes in insulin. Z5 wanted the following new insulin to be started: 26 units of NPH and 14 units of Regular Insulin in the AM and 10 units of NPH and 10 unit</p>	Z9999		
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Z9999	<p>Continued From page 10</p> <p>of Regular Insulin at dinner. The recommendations for Insulin changes were not followed per E11 (Director of Nursing) on 9/19/17 at 9:00am. In addition, Z5 wrote in his recommendations that none of the prenatal labs were drawn and made a referral for R1 to see Z6 (High Risk Obstetrician). On 9/19/17 at 4:32pm Z5stated Z6 does not follow patients, only makes recommendations.</p> <p>Review of the medication administration record for March 2017 does not show the changes in medication Z5 made in his recommendation.</p> <p>Per the Obstetric Ultrasound Report dated 3/21/17, R1 had a consult with Z6 and an ultrasound was done on 3/21/17. The results of the ultrasound "demonstrated appropriately growing fetus, normal location of the placenta, normal amount of amniotic fluid volume, and no evidence of early markers of aneuploidy." Z6 made a recommendation to the facility as follows: "The patient is a candidate to be hospitalized as soon as possible to receive intense insulin therapy to improve her glycemic control. She also should be evaluated for end-organ damage by this long-standing uncontrolled diabetes, including renal and cardiovascular systems. The patient's prenatal care, as pregnancy continues should only be conducted in a tertiary or university hospital were multiple resources and ancillary services are readily available."</p> <p>On 9/19/17 at 9:00am E11 (Director of Nursing) stated, "she wasn't sent to the hospital. I don't see it in the nurses' notes. I do look at the orders when they return and (E12) makes the appointments and the nurses look at them. Sometimes her insurance doesn't take them. They should have sent her to the hospital, the</p>	Z9999		

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Z9999	<p>Continued From page 11</p> <p>nurses." E11 and E12 did not follow through with any of the recommendations that were given. E12 did not schedule an appointment for R1 with a university hospital that was recommended and E11 did not follow up on any of the recommendations that were given. E11 continued to state none of the recommendations made by Z5 on 3/15/17 and Z6 on 3/21/17 were followed. E11 continued to state the nurses should have followed the recommendations and sent R1 to the hospital.</p> <p>Per facility Consultation Form dated 4/4/17, R1 returned for her follow-up appointment with Z5 on 4/4/17. Z5 recommended R1 go to a university for prenatal care. Per facility Consultation Form dated 4/4/17 and interview with Z5 on 9/20/17 at 4:25pm, Z5 wrote "patient would not be sent back to our office for further care." Z5 did not want to see R1 as a patient because she was high risk and needed to be seen in a university setting, per the recommendations of Z6 (High Risk Obstetrician).</p> <p>On 9/19/17 at 9:00am E11 (Director of Nursing) stated she did not call the university hospital that was recommended. E11 was asked if R1 should have gone to the university hospital for high risk sooner, E11 responded "In my opinion with (R1) we did what we could for her, I'm not going to throw her in the street."</p> <p>On 9/19/17 at 9:00am E11 (Director of Nursing) and on 9/19/17 at 10:10am E12 (Medical Records Clerk) stated the recommendation that was made on 4/4/17 to send R1 to a university hospital was not followed.</p> <p>On 9/20/17 at 4:25pm Z5 stated, on 3/15/17 at the appointment, R1 denied drug use and</p>	Z9999		

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Z9999	<p>Continued From page 12</p> <p>complained of abdominal pain. A questionnaire was done. Z5 stated he stopped all her psychotropic medications and put her on insulin for better coverage and told her to see Z6 for a consult. Z5 continued to state, Z6 telephoned him after his consult on 3/21/17 and told him R1 should be seen in a university or level 3 hospital. Z5 continued on 4/4/17 he listened to the baby's heart rate. Z5 stated a pelvic exam was not performed at either appointments. Z5 continued, a pelvic exam is only indicated if a patient has symptoms, pain, bleeding or discharge.</p> <p>On 9/19/17 at 10:10am E12 (Medical Record Clerk) stated she did not contact the university per the recommendation. E12 stated, "I didn't even try to get her in." E12 stated it was difficult to find someone to take R1's insurance. E12 continued, she did not call the university hospital recommended by Z5.</p> <p>Per hospital records dated 4/27/17, R1 had an obstetrics consult with Z7 (Gynecologist) referred by Z1 (Medical Director) on 4/27/17. Per same hospital record, under patient instructions, Z7 referred R1 back to Z5's clinic, for a referral to a high risk Obstetrics university center.</p> <p>On 9/19/17 at 4:01pm Z1 (Medical Director) stated "I sent her to an OB, my friend. He did me a favor." Z1 referred R1 to Z7 who was a gynecologist.</p> <p>On 9/19/17 at 4:32pm Z7 stated, "(R1) needed to be transferred to a super high risk facility due to her psychotic medication and her heroin addiction. I am not high risk. I don't do obstetrics. I told (Z1) I don't do OB and I told the person that brought her to the appointment." Z7 continued to state he called a university hospital</p>	Z9999		
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Z9999	<p>Continued From page 13</p> <p>and they were going to take R1 as a patient. Z7 told R1 he doesn't see pregnant women in his practice anymore. Z7 stated it has been over a year since Z7 did obstetrics and Z1 (Medical Director) who referred R1 knew this information.</p> <p>Z7 (Gynecologist) recommended and secured a placement for R1 at the same university hospital that Z5 (Obstetrician) recommended one month earlier, but the recommendation was not followed up by E11 (Director of Nursing). On 9/19/17 at 4:01pm E11 stated when pressed why the recommendation was not followed, E11 stated "sometimes they don't take insurance." E11 stated the hospital was never contacted to see if they would take R1's insurance. E12 made an appointment and sent R1 to another university hospital.</p> <p>R1 did not get prenatal care until she was seen at a different university hospital on 5/31/17. R1 was approximately 22 weeks at her first visit per hospital records dated 5/31/17. Admission note dated 6-02-17 by Z7 (Physician) shows R1 was admitted at her obstetrics appointment for control of her blood sugars.</p> <p>On 9/19/17 at 10:10am E12 (Medical Record Clerk) stated, the facility had a difficult time finding a facility to take her insurance. E12 stated R1 did not have an obstetrician until she was seen at the university hospital on 5/31/17. R1 was 22 weeks pregnant at her first university appointment on 5/31/17 when she received prenatal care.</p> <p>On 9/19/17 at 4:32pm Z5 (Obstetrician) stated, "my recommendation is an order. Someone should be executing the orders. (R1) is coming from a medical entity." Z5 continued a high risk</p>	Z9999		
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Z9999	<p>Continued From page 14</p> <p>pregnancy should be seen every week and with R1's co-morbidities she will be seen at 20-24 weeks twice a week for prenatal care. Z5 continued, this is why continuity of care is important. Z5 stated he was unaware his orders were not followed.</p> <p>The facility's position titled Medical Records Clerk undated, states "the medical records clerk performs various tasks that include scheduling outpatient medical appts... Major Duties (a.) After orders are received for medical referrals to outside providers and communicated to the medical records clerk. He or she contacts outside providers, sets an appointment time with providers, arranges for transportation to appointment, and is responsible for providing any necessary information on the purpose of the apt or relevant medical history of the consumer."</p> <p>Per facility Consultation Form 4/13/17, R1 was admitted to the hospital on 4/13/17 for detox and admitted to using heroin daily. R1 returned to the facility on 4/20/17. Per laboratory reports dated 4/12/17 and 7/5/17 and hospital records dated 7/11/17, R1 tested positive for opiates on 4/12/17, 7/5/17 and 7/11/17 while residing at the facility.</p> <p>Per nurses' notes, R1 was admitted twice during her pregnancy for diabetic management/ elevated blood sugar. R1 was admitted to the hospital on 3/18/17 and discharged back to the facility on 3/19/17 and admitted on 5/31/17 to the hospital and discharged back to the facility on 6/2/17. On 3/21/17 Z6 (High Risk Obstetrician) made a recommendation for R1 to be admitted to the hospital as soon as possible to receive intense insulin therapy to improve her glycemic control, but the recommendation was not followed per E11 (Director of Nursing).</p>	Z9999		
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Z9999	<p>Continued From page 15</p> <p>Per hospital records dated 5/15/17 and facility Consultation Form dated 5/15/17, R1 did not receive prenatal nutrition monitoring with a dietician until 5/15/17 at the university hospital.</p> <p>There was no documentation to support the following labs were drawn for R1: Rubella antibody titer, cervical cytology and viral hepatitis per hospital records and facility records. The facility was aware R1's pregnancy was high risk, but did not send her to a high risk obstetrician to receive necessary prenatal care until 5/31/17. On 10/05/17 at 11:00am E1 (Administrator) stated she could not find any labs or screenings that were done.</p> <p>On 9/19/17 at 4:01pm Z1 (Medical Director) stated "I'm in charge of the care of the residents." Z1 was asked why he didn't follow-up with the care of R1, Z1 responded "the attending physician should have read the consult and he should have followed up." Z1 continued to state, "I sent her to an OB, my friend. He did me a favor." Z1 referred R1 to Z7 a gynecologist.</p> <p>The facility's policy "Admission Care of Pregnant Residents" dated 2/1/14 states, "E. The resident will be referred to the facilities in house prenatal group if appropriate. F. The group will cover basic information regarding nutrition, changes to be expected to your body. H. The resident will be referred to an outside hospital for prenatal care."</p> <p>Per the universal progress notes dated 7/8/17 at 6:45am R1 returned to the building at 1:00am. The notes show R1 "appeared to be under the influence of something, which is unknown to writer."</p>	Z9999		

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Z9999	<p>Continued From page 16</p> <p>On 9/13/17 at 2:45pm E3 (Addiction Counselor) stated if a resident appears to be under the influence a drug screen is done.</p> <p>On 9/13/17 at 3:00pm E1 (Administrator) stated a drug screen was not done on 7/8/17 because one was done on 7/5/17. She was consistent in using opiates.</p> <p>The facility's policy "Urine Drug Screens" dated 5/19/17 states, "II. Procedure The facility will obtain an order for a urine drug screen when it is deemed medically appropriate by the treating physician. Drug screens may be appropriate when a resident is observed in an altered state, is newly admitted, or is participating in the work program. However since the test results are not available immediately, they are not useful for determining the immediate clinical needs of a resident who may need more direct support."</p> <p>The facility's Individual Treatment Plan (ITP) dated 3/14/17-6/13/17 shows R1 "denied any past or current drug use, but records from hospital indicate a history of street drugs as well as current drug use." The approaches listed are to discuss there is no judgment toward her, but the urge to help, discuss the effects of drug use on her health as well as the unborn child, note progress in universal notes and praise her for negative screens and her participation in the drug addiction program. No new approaches were listed when R1 tested positive for opiates on 4/13/17, 7/5/17 and on 7/11/17. The positive drug screen from 4/13/17 and 7/5/17 are not listed on the ITP. The ITP lists meeting with the addiction counselor as a short term goal for drug use. The ITP shows meeting should occur one time a week and above it, it lists twice a week. R1 never met with the addiction counselor. On 10/5/17 at</p>	Z9999		
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Z9999	<p>Continued From page 17</p> <p>2:30pm E2 (Case Manager) stated he is not responsible for writing the drug goals; it is the addiction counselor responsibility. The drug goals are supposed to be updated every time there is a relapse. On 10/5/17 at 3:00pm E1 (Administrator) stated E3 was no longer available for interview, he was terminated on 9/20/17 for inadequate documentation.</p> <p>The ITP show's on 5/13/17 R1 stayed out past curfew. R1 was reminded of the curfew policy. On 5/17/17 R1 stayed out past curfew and panhandled for money. No new approaches were listed on the ITP. On 10/5/17 at 2:30pm E2 stated resident goals and curfews are not updated on the ITP. The only time the ITP is updated is when the resident has drug violations or has aggressive behaviors. Surveyor asked E2 how many times R1 missed curfew, E2 stated he didn't know. Residents are supposed to sign in and out when they return/leave. Sometimes they don't, but there is a camera at the desk that lets us know who leaves and when they return. On 10/5/17 at 4:00pm E1 (Administrator) stated R1 missed curfew on 4/9/17, 4/13/17, 5/8/17, 5/13/17, 5/17/17 and 7/7/17. Only some of missed curfews are documented on the ITP.</p> <p>On 9/14/17 at 3:15pm E1 was asked if residents are checked for drugs and alcohol when they return from the community, E1 responded "my security guard has been here for six months. He is the 3-11 and 11-7 shift Monday through Friday and Saturday and Sunday 11am-11pm and 11pm -11am. There is no one 7-3 Monday through Friday to do security checks. There is no policy [regarding security checks]. We got a security guard more for the community. Old residents would come because they knew when our trust fund days are and would harass the residents.</p>	Z9999		
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Z9999	<p>Continued From page 18</p> <p>When the residents come after three, their bags are checked. They don't do a body check. That's not within scope of practice. You would need a search warrant to check their person. He does rounds in the building. During that time he is not at the desk. From 3-11pm certified nurse assistants do room checks every hour. We just started to do the every hour. This was as a result of what happened to (R1)." E1 continued to state, hourly room checks were started after R1 died on 7/30/17. The facility has a receptionist at the desk 24 hours a day, 7 days a week.</p> <p>Per facility documents (1:1 documentation and universal progress notes) after two months in the facility, R1 did not receive treatment to address her addiction. On 4/13/17 R1's behavior became disruptive and aggressive, the facility committed R1 per Z8's request (Psychiatrist) and filed a "Petition for Involuntary/Judicial Admission." The facility's document "Petition for Involuntary/Judicial Admission" dated 4/13/17 states, "(R1) had episode of destroying facility property and becoming loud, disruptive, paranoid and non-responsive to staff redirections. She also tested positive for substance abuse and lacks insight to abuse. She is 18 weeks pregnant and currently represents a danger to self and others due to increased aggressive behavior says she is using drugs daily-heroin." R1 was admitted to the hospital on 4/13/17 and discharged on 4/20/17 back to the facility. R1 was admitted for detox of opiates.</p> <p>There were no changes in therapy or supervision between 4/20/17 and 7/11/17 when the facility once again petitioned for her admission per Z8. The facility's document "Petition for Involuntary/Judicial Admission" dated 7/11/17 states, "(R1) is increasingly becoming</p>	Z9999		
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Z9999	<p>Continued From page 19</p> <p>non-compliant with the facility's rules and regulations. She continues to leave the facility and returns late in the night and consequently puts her safety and others in great danger. She uses street drugs at will at her expense." R1 was admitted to the hospital and discharged on 7/17/17 back to the facility.</p> <p>On 9/14/17 at 3:25pm Z8 (Psychiatrist) stated he was her psychiatrist when she was admitted on 2/21/17. Z8 stated he was not aware of any heroin/opiate or other drug use. Z8 was unaware of the hospital admission on 2/22/17. Z8 was not aware of the heroin/opiate use until April and had nothing put into place. On 4/13/17 Z8 had R1 admitted to the hospital for detox. Z8 stated R1 was using heroin daily. On 5/11/17 Z8 saw R1 at the facility. R1 told him her anxiety was not as bad. Z8 continued to monitor R1. Z8 continued to state, R1 went to a university hospital on 5/31/17. Z8 spoke to the physician, R1 was refusing inpatient treatment. The university hospital returned her to the facility. Z8 stated, in patient treatment in the hospital means they are hospitalized because they are a danger to self or others and R1 stated she wasn't going to hurt herself. They had no choice but to send her back to the facility. She was not meeting the criteria for inpatient therapy. R1 signed a five day contract for inpatient treatment. They couldn't say she threatened to hurt herself, so they had to discharge her. You cannot force drug treatment on a resident if they don't want it.</p> <p>At that time, surveyor asked Z8 (Psychiatrist) why he didn't take R1 to court to protect the baby, since he/she was in danger, Z8 responded "I'm not sure which way to go, many addicts have babies. I didn't do it, but we should have. I could've done more in retrospect. Gone to court</p>	Z9999		

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Z9999	<p>Continued From page 20</p> <p>to protect the baby." Z8 was asked why he didn't put her on methadone, Z8 responded I didn't feel she needed it. Z8 continued, "we are now putting into place a catch all for people that use heroin. The plan is when we catch someone using, they get a positive screen, they will get a 30 day notice agree to inpatient therapy or get the 30 day notice. If they have a positive drug screen they will be referred to an inpatient drug treatment program. If they refuse they will be given a 30 day notice. We will be putting this in writing and we will be doing more drug drops."</p> <p>On 10/5/17 at 4:05pm E11 (Director of Nursing) stated Z8 was never notified about R1's admission to the hospital on 2/22/17 for benzodiazepine and opioid withdrawal.</p> <p>On 9/14/17 at 3:22pm E8 (Certified Nurse Assistant) stated, on 7/30/17 at 10:00pm during rounds, R1 was found in the bathroom, sitting on the toilet. R1 was fully clothed slumped to the side. R1 was unresponsive when shook. E8 called the supervisor and called code blue. E9 and E10 (Both Licensed Practical Nurses) responded to the code. The Certification of Death (Death Certificate) dated 8/22/17 documented R1 died on 7/30/17 at the facility.</p> <p>On 9/15/17 at 11:30am E9 stated, "I found her on the toilet, sitting up in a slouched position. I checked her airway to see if she was breathing. She was not breathing at all. I started compressions while she was sitting up on the toilet. Then the rest of the people responded." E9 continued to state the reason CPR was done on the toilet was because R1 was too heavy to get off the toilet.</p> <p>The facility's universal progress notes dated</p>	Z9999		
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Z9999	<p>Continued From page 21</p> <p>7/30/17 validate E9's statement about the conducting CPR while R1 was in the bathroom.</p> <p>On 9/15/17 at 2:46pm E13 (Certified Nurse Assistant) stated he heard the code blue and responded. By the time he reached the room, two nurses had already responded. E13 stated he could have moved R1 himself, she was not big.</p> <p>On 4/27/17 R1 was 5 feet 6 inches and weighed 172 pounds per Z7's consult report.</p> <p>On 9/15/17 at 12:54pm E10 stated she heard the overhead page and responded to the code blue. E10 continued "I grabbed my O2 tank (oxygen tank) and crash cart and went upstairs. When I went into the room (R1) was sitting on the toilet. (R1) arm was dangling. I checked her pulse, no pulse. We were doing two man CPR with (E9) the nurse. Compressions and mouth piece for breathing."</p> <p>On 9/19/17 at 9:00am E11 (Director of Nursing) stated "you are supposed to be on a flat surface when you do CPR. How will you get oxygen to the brain. Compressions are not effective. I asked (E9) and he told me he did CPR on the toilet. He said I'm not supposed to move a patient. I asked him why he didn't move her, he didn't answer. I did yell at him. I told him you have to take CPR again. This will not happen again or you will not be working for me, if this happens again. So now we are doing CPR for everyone again for the plan of correction. I want to know everyone knows CPR, so you can start compressions right away."</p> <p>On 9/20/17 at 1:00pm Z2 (Educator of American Heart Association CPR and Lead Trainer of teachers for CPR) stated, "you need a hard, firm</p>	Z9999		
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NAME OF PROVIDER OR SUPPLIER GRASMERE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4621 NORTH SHERIDAN ROAD CHICAGO, IL 60640
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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
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Z9999	<p>Continued From page 22</p> <p>surface to do CPR. Trying to do it, slumped would not allow for effective CPR because you can't find landmarks accurately when you push down. The American Heart Association requires you to push down 2 inches. You wouldn't be able to push straight down, it would be ineffective. Trying to pump blood to the brain, it would not yield a good result."</p> <p>The facility's policy "Heimlich Maneuver and CPR, Code Blue" dated 5/19/16, states "all staff shall receive training in CPR techniques and be certified according to the guidelines of the American Heart Association. IV PROCEDURE B. 3. g. If the victim loses consciousness, call 911 and immediately lower them to the floor and begin chest compressions and breaths in a full CPR."</p> <p>2. R11 was admitted to the facility on 8/25/17 with a diagnosis of Schizoaffective Disorder and is taking psychotropic medications. R11 is 12 weeks pregnant. Prior to admission, R11 was seen in a clinic on 8/22/17 for prenatal care. Discharge instructions from the clinic dated 8/22/17 state to return to the clinic in 4 weeks. As of 9/19/17 R11 has not returned to the clinic or been sent to see an obstetrician for prenatal care.</p> <p>On 9/19/17 at 11:30am E12 (Medical Record Clerk) stated, R11 has an obstetrics appointment on 10/5/17. E12 responded "I don't know what clinic she was at. I got a form that said schedule her an ob/gyn appointment. I scheduled her an appointment at the university hospital."</p> <p>On 9/19/17 at 11:30am E12 stated she was never informed by E11(Director of Nursing) where R11 received prenatal care prior to admission.</p>	Z9999		
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