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FORM APPROVED

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
	IL6005516	A. BUILDING: ______ B. WING ______	C 12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLN PARK	2732 NORTH HAMPDEN COURT CHICAGO, IL 60614

(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	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 Violation:

300.610a)
300.1210a)
300.1210b)
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 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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to order effective measures for one (R1) resident out of 3 residents in the sample of 3 who was cognitively impaired and who had a history of pulling out medical tubes.
This failure resulted in R1 pulling out trach tube and being hospitalized for lack of oxygen to the brain.

Findings Included:

Medical record for R1 documented she was an 86 year old admitted to facility on 10/16/2017 with Diagnoses to include Alzhiemers Disease and Acute/chronic respiratory failure.
Minimum Data Set (MDS) for R1 dated 10/23/2017 noted her cognition was severely impaired. She also had a tracheostomy tube attached to 35 percent oxygen.

Current POS for R1 noted Seroquel 12.5 milligrams(mg) every night was ordered on 10/19/2017. On the same day the order was

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S9999	Continued From page 3 changed to Seroquel 12.5mg via peg tube as needed for Dementia at bedtime. Facility's unusual occurrence report for R1 dated 10/27/2017 documented that at 12:33AM, bed alarm of R1 sounded and upon investigation, the entire trach tube was noted on the bed and out of place. Record also noted that attempt to reinsert the cannula failed. 911 was called and R1 was sent to community hospital. Discharge summaries for R1 in community hospital dated 11/28/2017 at 6:10AM by V8(Primary Physician) documented R1 was admitted on 10/27/2017 from facility due to Cardiac arrest provoked by pulling of her tracheostomy and subsequent anoxic encephalopathy and unresponsiveness. In addition, V8 wrote,' while in ICU at the hospital, patient (R1) had EEG(Electroendocardiogram) on 10/30/2017 that showed Electro Cerebral silence with poor prognosis and on 11/3/2017, R1 was placed under hospice care. R1 expired on 11/28/2017 at 6:10AM at community hospital On 12/6/2017 at 11:40AM V5 said she was the nurse for R1 on the night shift of 10/26/2017. She said R1 was on 15 minutes checks and she had just checked on R1 at 12:30AM and shortly after that time she went back to R1's room due to the bed alarm sound. She said she noticed R1 was still moving around in bed and waving hands per normal. V5 said R1's trach was out of place and she tried to reinsert trach and cannula, but was unsuccessful and administered full oxygen to R1 while 911 was called. She said 911 responded within minutes. According to her, R1 was still breathing with Oxygen Saturation between 74 percent(%) and 84% when paramedics arrived.	S9999		

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V5 said it was known to everyone that R1 had a tendency to pull out her trach and she herself had replaced it at least twice. She said R1 was being monitored every 15 minutes. V5 said she had training at facility prior to R1's admission and also had experience with Patients who had trach tubes.
R1 was not one on one and there was no intervention in place to deter R1 from pulling on her tubes during the 15 minute rounds.

On 10/17/2017 at 2:01PM, V8(Primary Physician/MD) wrote he was made aware by V7(Family) that R1 had tendency to pull out trach and Gastrostomy tubes when in unknown environment especially at nights. He also wrote," Mittens or Restraints are not allowed in Nursing home as per state law". He ordered Seroquel (Psychotropic Medication)12.5milligrams(mg) to be given every evening as needed on 10/19/2017.

Surveyor was unsuccessful in contacting V8 since 12/5/2017 and according to V2(Director of Nursing/DON) V8 said surveyor had to make appointment at his office and he would require that his lawyer be present.

On 12/5/2017 at 1:15PM, V2(Director of Nursing/DON) said the facility was a restraint free facility. She said V7 told them that R1 was at risk for pulling out her trach tube. When asked if and what non-pharmacological intervention and assessment was initiated to prevent R1 from pulling on her trach V2 said they monitored her every 15 minutes.
She said it was her expectation that nurses followed physician's orders.

On 12/7/2017 at 1:30PM, V6(Medical Director)

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S9999	Continued From page 5 said he did not know R1, however, a patient who was cognitively impaired with the behavior of pulling out tubes like trachea, he would have ordered a mitten. He said he as a medical doctor would never order psychotropic medications, but left that up to the Psychiatrist. Facility's policy on Physician's orders dated 2/20/2017 noted," All residents/patients' medications, treatment and plan of care must be in accordance to the Licensed Physician's orders". Facility's policy on Tracheostomy Decannulation dated 2/20/2017 noted,"unplanned removal of the tracheostomy needs to be dealt with in a safe manner which minimizes risk to the patient. (A)	S9999		