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
	IL6004832	A. BUILDING: ______ B. WING ______	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 VIOLATIONS

300.610a)
300.1210a)
300.1210b)
300.1210d)3
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 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

Attachment A
Statement of Licensure Violations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: ____ B. WING ____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 1	S9999		

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:
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 made by nursing staff and recorded in the resident's medical record.
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 are not met as evidenced by:

Based on observation, record review and interview the facility failed to supervise and

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
	IL6004832	A. BUILDING: ______ B. WING ______	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 2	S9999		

monitor a resident with a known unsafe smoking behavior. This failure applies to one of three residents (R6) reviewed for behaviors, in a sample of eight.
As a result, R6 while smoking a cigarette during oxygen therapy, sustained facial burns and smoke inhalation

Findings include:
Medical record for R6 noted 54 year old admitted to facility on 7/8/2014 with Diagnoses to include Schizophrenia, Chronic Airway Obstruction and Alcohol Dependence.
A Minimum Data Set (MDS) assessment dated 7/15/2014 for R6 scored 7 out of a possible 15 on the Brief Intelligence Mental Status (BIMS). This indicated R6 had a impaired cognitive status.
Physician's Order sheet(POS) of 7/14/2014 for R6 had an order for Oxygen at 3 liters per nasal cannula.
On 2/18/2015 at 2:30PM and on 2/19/2015 at 10:00AM, residents were seen smoking outside the facility's building with staff supervision. R6's smoke risk assessment done upon admission 7/11/2014 scored 0-9 indicative of a safe smoker.
The following was documented in R6's record regarding the resident behavior and facility's actions:
On 11/4/2014 medical record for R6 documented social worker spoke with R6 in relation to report of him smoking in his room.
Actions post Smoking event by facility included counseling, education and signing of smoking contract by R6. Along with the above action by facility, smoking materials were removed from R6's room. Care plan noted education for R6.
On 11/19/2014 at 10:35AM, Z2 (Psychiatrist) documented (R6) smokes in room with oxygen and with interdisciplinary observations (R6) can be impulsive and forgetful. Behavior for R6 noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: ______ B. WING ______	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	**5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644**

(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 3 with impaired judgment and impaired insight. On 1/23/2015 at 13:56PM, nurse wrote, " nurse manager informed per staff housekeeper resident smoking in room with oxygen present. Upon entering room, resident sitting on side of bed and stated that he was smoking. Writer provided education regarding hazard of smoking while oxygen in use and /or present. Resident stated, " it won't happen again that was my last one anyway " . Actions post smoking event by facility on 1/23/2015 included education, and daily discussions with administrator along with search for alternative placement. No new intervention was documented in care plan to ensure behavior was not repeated. No other smoke assessment was done after two occurrences of smoking in room by R6. According to E1(Administrator) the smoke risk assessment is done yearly. An incident report of 2/15/2015 at 11:30PM documented, CNA (certified nurse aide) noted black around resident's nose and mouth. R6 stated "was trying to take a quick hit off his cigarette and it blew up in his face." The resident was assessed and noted with burns to resident's nose, lips, hair and blisters forming on his jaw. R6's nurses notes for 2/16/2015 at 11:03AM noted, "Spoke with charge nurse at hospital, made aware that resident was admitted with facial burns and smoke inhalation." On 2/19/2015 at 1:00PM, E1 presented new smoking supervision process which according to him was initiated after the incident of 2/15/2015. On 2/20/2015 at 11:55AM, Z2 (psychiatrist) said she could not remember when she saw R6 and she could not have done anything about his smoking in room. According to her, the facility had the responsibility to prevent the resident from obtaining cigarettes if they did not want him to	S9999		

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
	IL6004832	A. BUILDING: ______ B. WING ______	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 4 smoke in room. Smoking Policy for facility documented "Smoking is confined to designated areas of the building and at designated times," and "Residents are allowed to smoke in designated places, never in their rooms or hallways." On 2/18/2015 at 9:30AM and 2/19/2015 at 1:30PM, tour of facility noted no smell of cigarette smoke. Random check of residents' drawer in room with E2 (Director of Nurses, DON) noted no cigarettes or lighter. (A)	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: JACKSON SQUARE SKILLED NURSING AND LIVING
DATE AND TYPE OF SURVEY: COMPLAINT #1580729/IL74888 – February 20, 2015

300.610a)
300.1210a)
300.1210b)
300.1210d)3
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 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:

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

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)

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions to prevent reoccurrence. Policies and Procedures for Smoking Procedures and Abuse and Neglect will be reviewed and revised as necessary.

II. All staff will be in-serviced on Smoking Procedures as well as Abuse and Neglect Policy and Procedures and any revisions made as a result of Item I.

III All staff will be in-serviced regarding the following:

- Identifying residents with potential for being affected by deficient practice (Smoking Policy) by review of assessments, interventions, and updating of care plans. The facility will reflect condition/behavior changes, follow-up interventions, and reporting practices to physician(s) and family member(s) per facility policy;
- Systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning, and assessments;
- Monitor for compliance of assessment, intervention, and care planning per each occurrence as per occurrence;
- Review of smoking monitoring protocol with systems to control smoking material interventions as needed; and
- Quality Assurance (QA) tool with documentation and monitoring of compliance. All issues and concerns will be corrected immediately and reviewed during the monthly QA meeting.

IV. Documentation of in-service training will be maintained by the facility.

V. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this Imposed Plan of Correction.

Attachment B
Imposed Plan of Correction