| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007967 | A. BUILDING: _____ B. WING _____ | 07/16/2015 |

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| SYMPHONY EVANSTON HEALTHCARE | 820 FOSTER STREET EVANSTON, IL 60201 |

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| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.7060a)<br><br>Section 300.7060 Environment<br>a) The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan.<br><br>This requirement IS NOT MET as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to assure that dementia units were free of hazards related to proper storage of medications, chemicals, sharp items and oxygen and access to electrical and construction hazards. This failure has the potential to affect three residents (R7, R10, R14) in the sample of 17 and nine residents (R26, R27, R30, R31, R32, R37, R38, R39, R40) in the supplemental sample out of 46 residents on the second and third floor dementia/memory care units.<br><br>Findings include:<br>On 7/13/15 at 1:00 PM, the medication cart was noted on the 2nd floor unlocked and unattended. E3 LPN (Licensed Practical Nurse), who was the nurse in charge of administering medication from the medication cart, acknowledged that the medication cart should have been locked stating "I was suppose to lock it, I'm sorry I just went around the corner." | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1 | S9999 | | |

The facility Medication Administration guideline presented dated 10/03 with revision date of 7/14 indicated guideline "Never leave the medication chart open unattended." This guideline was not followed.

On 7/13/15 at 11:30 AM during the initial tour of the third floor memory care unit, a bottle of Nystatin powder, 15 grams, 100,000 units per gram, was observed in the unlocked medicine cabinet of R30. R30's Physician Order sheet (POS) indicated the medication was ordered 1/13/15 and the Medication Administration Record (MAR) indicated R30 last received the medication on 2/2/15. E19 (Unit Manager) stated she was uncertain why the medication was in the cabinet or why the medicine cabinet did not have safety latches.
On 7/14/15 at 4:00 PM, E19 (Unit Manager) stated that R30 is ambulatory and wanders on the dementia unit.

On 7/13/15 at 10:49 AM during the initial tour of the second floor memory care unit, a pint bottle of Chlorhexidine oral rinse was observed in an unlocked storage cabinet in R27's bathroom. E20 (Social Service Director) was present during the tour and did not remove the medication when observed. R27's POS indicated no order for Chlorhexidine. On 7/16/15, E2 (Director of Nursing) stated R27's daughter is a dentist and obtained the medication that R27's spouse brought into the facility.

The facility policy, Medication Storage, 60.501, dated 11/1/14, reads: "It is the policy of [Facility] in coordination with [Pharmacy] and the Consultant Pharmacist that all medications will be

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|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

stored under conditions that are appropriate for that item, for safety and within regulatory guidelines. Procedures 1.d. Drugs shall be stored in an orderly manner in unit dose carts. Treatment items shall be stored in a locked cabinet, cart or room, inaccessible to residents or visitors."

On 7/13/15 at 10:25 AM in R7's bathroom cabinet, observed two disposable razors and the child proof lock did not latch.

On 7/13/15 at 10:29 AM in R26's bathroom cabinet, one disposable razor was noted and the child proof latch did not catch.

On 7/13/15 at 10:33 AM in R14's bathroom was a mechanical lift device and hanging from this equipment was a container of alcohol-based germicidal wipes. The Material Safety Data Sheet (MSDS) for this product is as follows: Hazards Identification includes potential short term health effects. Signs and Symptoms may include: redness, edema, drying, defatting and cracking of skin. Symptoms of over exposure may be headache, dizziness, tiredness, nausea and vomiting. Handling and Storage states: Avoid contact with eyes. Wash thoroughly after handling and to keep out of reach of children. Exposure Controls / Personal Protection states to wear safety glasses with eye shields.

On 7/13/15 at 11:40 AM, a cart for contact isolation supplies was noted outside of R10's room with a container of alcohol-based germicidal wipes inside. The cart was uncovered and unlocked. The cart was again noted on 7/15/15 at 3:15 PM with a container of the germicidal wipes on top of the cart of isolation supplies, and

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| S9999 | Continued From page 3<br>another container of the wipes inside the unlocked drawer. The wipes container listed ingredients of 72.5 percent Ethyl alcohol and 0.33 percent Didecyl Dimethyl Ammonium Chloride. The Material Safety Data Sheet reads "This Product is a Hazardous Chemical". E19 stated the wipes are not used to clean R10's room and was not sure why they were on and in the cart. E19 stated hazardous and cleaning products should not be accessible on the dementia/memory care unit.<br><br>On 7/13/15 at 4:00 PM, the common toilet and shower rooms adjacent to the day room on the third floor dementia/memory care unit were unlocked and did not have lockable door handles. Upon entering the shower room, an electrical outlet was noted to be uncovered and unsecured, allowing access to the wires of the GFCI (ground fault circuit interrupter) outlet. In the connected toilet room, a base cabinet approximately four feet high had a broken safety latch allowing access to the cabinet. A metal panel covered the back of the interior cabinet wall and was gaping open. Behind the metal panel was a space large enough to allow full body access to the rear of the shower stall, wall studs and construction hazards. E19 (Unit Manager) was informed of the observations, stated the rooms remain in use when construction work is not occurring and questioned if the doors should be locked. E19 identifed R30 and R37 as residents on the unit who tend to wander and enter rooms. E1 (Administrator) was called to the unit and stated the construction workers should not have left the electrical outlet and cabinet door unsecured and stated the doors should be locked. | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 7/13/15 at 4:20 PM on the second floor dementia/memory care unit, a double door with a keypad lock was noted to be open due to the two doors sticking in the middle. Inside the room were six oxygen cylinders and an emergency cart with the second drawer unlocked containing oxygen supplies. E22 (Activities) was informed of the open doors and stated the doors should be kept closed. The doors stuck again when the doors were allowed to close passively, needing a push to close them completely.<br><br>R7, R14 and R26 have Dementia and are on the second floor memory care unit. R10 has Dementia and is on the third floor memory care unit.<br><br>On 7/15/15, E2 (Director of Nursing) provided a list of residents highlighting those on the dementia/memory care units who are ambulatory or can independently propel their wheelchairs. The list included R31 and R32 on the second floor and R30, R37, R38, R39 and R40 on the third floor.<br><br>The facility policy, Environmental Safety, last revised 10/14 reads in part: "General: Dementia residents, due to their severe cognitive deficits, often misperceive and/or misuse their environment including the supplies, material,s equipment and furnishings within it. This may create a safety risk for themselves or other residents. Guideline: 1. Assess the environment for things that residents could misperceive as edible or drinkable such as: Carts with cleaning supplies and small hardware (nuts, bolts, etc) used in dementia resident accessible areas which should have locking storage compartments or | S9999 | | |

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| S9999 | Continued From page 5<br>should be draped with a sheet while in the area to reduce visibility and access."<br><br>On 7/16/15 at 3:15 PM, E2 (Director of Nursing) stated the facility does not have specific policies about oxygen or sharp item storage, but stated oxygen cylinders should be stored in locked rooms when not in use. E2 also stated disposable razors may be used more than once, but on the dementia units, must be kept out of site and in locked/latched cabinets.<br><br>(B)<br><br>300.615e)<br><br>Section 300.615 Determination of Need screening and Resident criminal History Record Information.<br>e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident ' s name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act).<br>This requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to perform criminal background checks on residents within 24 hours of admission for one resident ( R6 ) in a sample of 20 residents and | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

eight residents (R24, R34, R41, R42, R43, R44, R45, R46) in the supplemental sample reviewed for criminal background checks.

Findings include:
On 7/14/15 at 11:30 am, the background checks for the newly admitted residents were requested.
The facility's Admissions Log dated 4/13/15 to 7/13/15 documents that R6,R 24, R 34, R 41, R 42, R 43, R 44, R 45, R 46 were all admitted on 06/04/2015 .
According to documentation provided by the facility, R46 was admitted to the facility on 06/04/2015 and background checks were performed on 06/10/15.
The background checks for R 24, R 44, R 45 were performed on 06/25/15.
The background checks for R 34, R 41, R 42, R 43 background checks were performed on 07/06/15.
The background checks were not performed in the required 24 hour time frame after admission to the facility.
On 07/16/15 At 11:50 am, E1 (Administrator) stated, "Our Director of Nursing (DON) does the back ground checks on residents and they have to be done within 24 hours of admission. DON was doing the checks on a weekly basis and if the checks are not done in the time limit, it can lead to any threat to other residents if the result later found out to be an offender residing in the facility, there is always potential for harm " .
On 07/16/15 At 12:30pm, E2 (Director of Nursing-DON) stated, " I am the one that was doing the background checks. It falls on me. Background checks haven't been done within 24 hours of resident admission " .
On 07/16/15 at 2:20pm, Z2 stated " The facility don ' t rely on the hospital records for back ground check information, we do our own checks

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| S9999 | Continued From page 7<br>".<br>The facility's Abuse policy dated 1/11 and titled "Resident Back ground checks" documents:<br>1. When a resident is admitted to a facility, an electronic name-based Uniform Conviction Information Act (UCIA) back ground check must be ordered within 24 hours, unless the resident was admitted from a hospital AND the hospital notified the facility that the UCIA name check was ordered.<br><br>(B) | S9999 | | |